



FLORIDA HOSPITAL

EMERGENCY
MEDICINE RESIDENCY

PROGRAM MANUAL

2011-2012

Key:
Revised

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The following material is a program-specific supplement to the Graduate Medical Education (GME) manual. Referral to, and familiarity with, each manual is expected by your Program Director and the Graduate Medical Education Committee.

Program Mission & Education Statement

Mission:

The Emergency Medicine Residency is operated by Florida Hospital, a not-for-profit health care institution, to further its mission “To extend the healing ministry of Christ.” We do so by preparing compassionate and competent emergency medicine physicians.

In its striving for excellence, the residency program is committed to serving the community, the sponsoring institution, the faculty, staff, and resident physicians.

Education:

Emergency medicine is a specialty which focuses upon the initial evaluation, diagnosis, and stabilization of patients with acute illnesses or injuries. In addition, the emergency medicine physician initiates treatment, involves consultants, makes disposition decisions, and makes appropriate follow-up arrangements for patients discharged from the Emergency Department.

The purpose of the Emergency Medicine Residency is to provide a progressive, organized educational program with guidance and supervision which facilitates the resident’s personal and professional development while ensuring appropriate and safe patient care. Residents in our program join a department that emphasizes lifelong learning, creativity, and professionalism. Our aim is to provide this training through a continuity of didactic and clinical experience. Our goal is to produce a physician capable of a high level of performance who is certified by the American Board of Emergency Medicine.

The goal of our residency is to produce physicians trained to:

- Integrate basic medical sciences with clinical medicine in an orderly, progressive, and academic manner.
- Provide the recognition, resuscitation, stabilization, evaluation, and care of the acutely ill or injured patient.
- Arrange appropriate follow-up or referral as required.
- Participate in the management of the emergency medical system providing pre-hospital care.
- Provide appropriate patient education directed toward the prevention of illness and injury.
- Utilize the services of consultants and ancillary departments, as appropriate, in the treatment of patients
- Engage in the administration and teaching of emergency medicine, including mentoring of medical students, and be familiar with research methodologies and their application.
- Participate in department and committee meetings and didactic sessions.

We commit to:

- Provide residents the opportunity to learn the fundamentals of basic science as applied to emergency medicine.
- Require residents to participate in research and provide teaching and mentoring of medical students.
- Provide residents with the opportunity to learn continuity of care for the patients they have treated in the emergency setting by following their progress through their hospital stay through electronic medical records and consultation with their care team.
- Provide residents and faculty with educational goals and objectives at the beginning of each rotation and the opportunity to evaluate each other at the end of the rotation.
- Provide each resident with a summative evaluation of performance on a semi-annual basis to show progression of expertise.
- Provide each resident with supervisory lines of responsibility, fair grievance policies, and resources for mental/emotional support.
- Provide a sufficient number of cases, as determined by RRC standards of achievement, to advance skills and judgment.
- Provide 5 hours of planned educational experiences per week in a rotating 18 month cycle based on the Model Curriculum of Emergency Medicine... Attendance is mandatory.
- Provide a working environment that is optimal for resident education and patient care. This environment will be safe and will provide adequate space for sleep, food, and lounge/study facilities.

Program Personnel

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Zachary	Wilson	PGY-1	zachary.wilson.md@flhosp.org	7709

Florida Hospital East Orlando Main Telephone Numbers:

Critical EM: 407-832-8665
Non Critical EM: 407-832-6794
Graduate Medical Education, Planning and Research: 407- 303-2867
Radiology Dictation Line: 407-303-7944
Needle Stick Hotline: 1-866-258-6259
Transfer Center Number: 1-800-824-0085
Sexual and Assault Hotline: 407-497-6701

Florida Hospital South Main Telephone Numbers

ED: 407-303-1940
Orthopedic Trauma: 407-303-7689
General Surgery: 407-303-1974
Anesthesia: 407-303-1529

Accreditation Council of Graduate Medical Education (ACGME):

The ACGME is the accrediting body for the Emergency Medicine residency program. They may be contacted with questions via their website at: www.acgme.org or by mail and phone at: 515 North State Street, Suite 2000, Chicago, IL 60610-4322, Phone (312) 755-5000, and fax (312) 755-7498.

Recruitment, Eligibility & Selection:

Recruitment:

Goal: To recruit and train physicians committed to excellence in Emergency Medicine who:

- A. Will promote, practice, and respect the mission of Florida Hospital.
- B. Will be compassionate providers of whole person care.
- C. Will likely wish to practice in the State of Florida following their training.

Means:

- I. Provide organized recruitment teams who will focus on in-state medical schools and affiliates (Florida State University, University of Florida, University of Miami, University of South Florida, University of Central Florida, Florida International University, Lake Erie College of Medicine, Nova Southeastern University, and Loma Linda University).
- II. Recruit through ERAS and participate in NRMP selection process.
- III. Provide pertinent summary of the program through Florida Hospital's Graduate Medical Education website
- IV. Offer Clinical Clerkships to medical students from accredited Medical and Osteopathic schools

Eligibility:

- I. Medical School

- A. LCME (Liaison Committee of Medical Education) graduates:
- a) Doctor of Medicine diploma without reservations
 - b) Dean's Letter
 - c) Letter from residency program director (if applicable)
 - d) Successfully passed USMLE I and USMLE II (United States Medical Licensing Examination) at first attempt with a score of 200(80)
 - i. Transcript directly from the FSMB (Federation of State Medical Boards)
 - e) Acceptable explanation of any break in education (if applicable)
 - f) Demonstrated written and spoken fluency in English language
 - g) Proof of citizenship or resident alien status as required by Florida Hospital Human Resources
- B. AOA graduates:
- a) Doctor of Osteopathy diploma without reservations
 - b) Dean's Letter
 - c) Letter from residency program director (if applicable)
 - d) Successfully passed COMLEX (Comprehensive Osteopathic Medical Licensing Examinations) I and COMLEX II at first attempt with a minimum score of 500(80)
 - i. Transcript directly from the NBOME (National Board of Osteopathic Medical Examiners)
 - e) Acceptable explanation of any break in education (if applicable)
 - f) Demonstrated written and spoken fluency in English language
 - g) Proof of citizenship or resident alien status as required by Florida Hospital Human Resources.
- C. International Medical Graduates (IMG's):
- a) Doctor of Medicine diploma (or equivalent) without reservation (translation to English by certified translator and notarized if necessary)
 - b) Successfully passed USMLE at first attempt (see above, I. A. d.)
 - c) Current and valid ECFMG (Education Council of Foreign Medical Graduates) certificate
 - d) Letter from residency program director (if applicable)
 - e) Acceptable explanation of any break in education (if applicable)
 - f) Demonstrated written and spoken fluency in English language
 - g) Proof of citizenship or resident alien status as required by Florida Hospital Human Resources

II. ERAS Application

A. Completed application through ERAS (Electronic Residency Application Service) through the AAMC (American Association of Medical Colleges) and participation in the NRMP (National Resident Match Program) match.

- On-line application
- Personal statement
- CV
- Diploma (if IMG)
- ECFMG certificate (if IMG)
- Transcript
- Dean's Letter
- Three letters of recommendation by emergency medicine physicians
- USMLE Scores, Part I and II
- Photograph

III. Reasons for Ineligibility:

- A. Applicant does not demonstrate sufficient commitment to the specialty of Emergency Medicine:
- i. No advanced-level electives during medical school
 - ii. No letters of support from surgeons
- B. Applicant did not present favorable impression to faculty and/or resident physicians during elective time spent at Florida Hospital
- C. Quality of interaction during preliminary contact with staff suggests incompatibility with the mission and values of Florida Hospital
- D. Quality of personal statement (content, typographical and grammatical errors), including no obvious commitment to General Surgery
- E. Limited verbal and written English skills, including the inability to write clearly and legibly

IV. Non-eligible candidates will not be offered an interview or accepted into Florida Hospital Graduate Medical Education residencies.

V. Applicants must have successfully participated in formal clinical training, medical school, residency training, or full-time clinical practice within the last 24 months (from date of application to the residency program).

VI. The Program Director may permit the waiver of one or more of these requirements under special circumstances.

VII. A personal interview at the Florida Hospital Emergency Medicine program is required for applicants who meet the eligibility criteria.

Selection:

I. Applicant must complete the ERAS application process.

- II. Application must be complete by December 1st of application year and applicant must meet eligibility requirements in order to be considered for interview.
- III. When application is complete in ERAS, the file will be downloaded and reviewed by the selection committee.
- IV. If interview is offered, applicant will be contacted via letter, telephone, email, or through the ERAS post-office and applicant will be instructed to contact the Medical Education office to arrange for an appointment.
- V. Interviews will take place between mid-November and mid-January and must be in person at the Florida Hospital Emergency Medicine program office.
- VI. The interview process is conducted as follows:
 - A. The applicant reports to the Emergency Medicine Medical Education office at Florida Hospital, East at 7:00AM
 - B. The applicant is interviewed by: The Program Director and/or the Associate Program Director, the Behavioral Scientist, select Emergency Medicine Faculty and select current residents.
 - C. The applicant tours Florida Hospital East Emergency Medicine Department, Florida Hospital South Emergency Medicine Department and facilities.
- VII. Each interviewer completes an evaluation form which includes four areas:
 - A. Professional direction
 - B. Personal characteristics and interpersonal communication skills
 - C. Clinical competence
 - D. Overall potential as a resident in our program.

The scores are calculated and summarized (Interview Composite Score)
- VIII. The files are reviewed and screened by the Program Director and Residency Coordinator. The following criteria are utilized:
 - A. Personal statement
 - B. Transcript score
 - C. Dean's Letter
 - D. USMLE scores
 - E. Letters of recommendation

The scores are calculated and summarized (Screening Composite Score)
- IX. An overall score is calculated for each applicant based on 40% of the Interview Score and 60% of the Screening Score.

- X. The files are reviewed by the residents (when applicable) at the monthly resident meeting in January/February and a rank list is created.
- XI. All applicants who have been interviewed will be reviewed for ranking by the selection committee made up of faculty and resident leaders in early February with the resident rank list taken into account.
- XII. The Program Director will contact applicants to determine continued level of interest and to answer any questions. The rank order list will be compiled and submitted to the NRMP. The Match list is at the discretion of the Program Director and is confidential.
- XIII. New residents who have matched will be sent a Letter of Intent, sample contract, and other required documents within two weeks. Required documents will include a Resident Manual, GME Manual, schedule request form, malpractice application, training license application and vacation request form.
- XIV. Final personalized contracts are prepared, sent through the corporate approval process, and forwarded to the new residents within the next month.
- XV. Orientation schedules, dates and requirements are sent to the new residents as soon as available.

Examinations, Licensure & Certification:

USMLE:

All interns must complete USMLE Step 3 prior to the end of the PGY-1 year. We urge you to take USMLE Step 3 as soon as possible. The cost of application is paid by the program for your first attempt. All application paperwork should be submitted directly to the residency coordinator for processing.

To obtain an application for USMLE Step 3, go to their website and download it.

<http://www.fsmb.org>

Or you can call them directly at (800) 876-5396

Once you have filled out and submitted the application (along with a copy of your medical school diploma), please let the residency coordinator know immediately when you schedule the exam since the Department will need to adjust coverage for time you are off your service. Taking the exam means two days away from your rotation.

You will also need to submit a “Certification of Post-Graduate Training” form to the residency coordinator to fill out. This form can be obtained from the website when you download the application forms.

Licensure:

Until such time as the USMLE Step 3 is completed and the resident is eligible to apply for full licensure in the State of Florida, the resident must maintain a Florida Department of Health Training License. The application for this will be sent to the newly-matched resident directly after the Match results are in. The training license fees will be paid by the Program, and the application and all supporting documents must be sent to the Department of State by the Program not later than April 1st in order to give adequate time to process the application for a start date of July 1st in the training program.

Upon completion of USMLE Step 3, the resident will be expected to complete the application for full medical licensure in the State of Florida. The fee for this will be paid by the Program. Application for license can be obtained from the Program Coordinator or via the Department of Health website. Make sure to download all forms and read directions carefully to expedite your application (EBAHR, National Practitioner Data Bank Self Query, AMA Profile), also, request a fingerprint card from the coordinator or at the website.

MD Applicants: www.doh.state.fl.us/mqa/medical/me_applications.html

DO Applicants: www.doh.state.fl.us/mqa/osteopath/os_applications.html

Certifications:

Residents in the Emergency Medicine Program are required to maintain current certifications in ACLS, ATLS, and PALS in order to be able to participate in the training program. We encourage the resident to obtain these certifications at the time of matching with the program. Further recertification will be paid by the Program.

Copies of all certifications must be given to the residency coordinator for permanent record.

American Board of Emergency Medicine Requirements:

The American Board of Emergency Medicine has defined guidelines for certification eligibility after training. Senior residents applying for board certification should coordinate applications through the residency coordinator.

- **Procedure logs:** The Emergency Medicine Residency Review Committee has recently instituted a new guideline regarding the average minimum number of procedures and resuscitations that each resident must complete over the course of their training program. Documentation of these procedures and resuscitations will be used to determine each program’s compliance with the Program Requirements for Emergency Medicine and their ability to continue as an EM training program. Further, employers and hospitals are

increasingly asking for actual documentation of procedures performed by potential employees during their residency for purposes of hospital credentialing.

As such, each resident is required to document all procedures and resuscitations performed during their residency on New Innovations Medical Management Suite. This includes all medical resuscitations, pediatric resuscitations, and trauma resuscitations and ultrasound procedures. Procedure documentation will be one component of your semi-annual evaluation and one component of determining advancement to subsequent years of residency training. Failure by the resident to log in procedures will end up in placement on immediate probation. The policy for logging procedures on New Innovations is as follows:

1. Update procedure logs in NI on a weekly basis (Sunday to Saturday). **All residents will complete the procedures from the week before by 0900 every Monday morning.**
 - a. All information must be complete when filling out procedure log. Also required is adding a brief synopsis of patient presentation in the “comments” section.

*Residents are encouraged to keep a paper copy of their procedure logs, in addition to the New Innovations log.

- **The nine categories and minimum numbers:** The numbers in parentheses are the *average minimum number* recommended by the Emergency Medicine RRC, not what is necessarily considered “best practice” for residency training. The Residency Director makes ultimate determination of whether a resident is competent in performing a certain procedure.
 - **Resuscitation:**
 - Adult Medical Resuscitation (45)
 - Adult Trauma Resuscitation (35)
 - Peds Medical Resuscitation (15)
 - Peds Trauma Resuscitation (10)
 - **Airway:**
 - Rapid Sequence Induction
 - Orotracheal Intubation (35)
 - Nasotracheal intubation
 - Chricothyrotomy (3)
 - Procedural Sedation (15)
 - **Thoracic:**
 - Defibrillation/Cardioversion (10)
 - Thoracostomy Tube (10)
 - Pericardiocentesis (3)
 - Thoracotomy
 - Cardiac Pacing – Transcutaneous (6)
 - Cardiac Pacing – Transvenous

- **Vascular/Hemodynamic:** (20)
 - CVC – Femoral
 - CVC – Internal Jugular
 - CVC – Subclavian
 - CVC – Umbilical
 - Arterial Line Insertion
 - Swan Ganz Catheter
 - Intraosseous Infusion

- **Skin/Skeletal:**
 - Laceration Repair (50)
 - I & D – Abscess
 - Nailbed Repair
 - Regional Nerve Block
 - Dislocation Reduction (10)
 - Closed Fracture Splinting (20)
 - Arthrocentesis

- **OB/Gyn:**
 - Vaginal Delivery (10)
 - C-Section
 - Sexual Assault Exam

- **HEENT:**
 - Lateral Canthotomy
 - Nasal Packing
 - Nasal Cautery
 - Peritonsillar Abscess

- **Diagnostic Plus:**
 - Lumbar Puncture (15)
 - DPL Peritoneal Lavage
 - Paracentesis
 - Suprapubic Cath

- **Ultrasound (175):**
 - **FAST:** 25 scans (5 positive)
 - **Aorta:** 25 scans (2 positive)
 - **Ecocardiography:** 25 scans (5 positive)
 - **Biliary:** 25 scans (10 positive)
 - **Pelvic Ultrasound:** 25 scans (10 positive)
 - Transabdominal Pelvic: 15 scans
 - Transvaginal Pelvic: 10 scans
 - **Renal:** 25 scans (5 positive)
 - **Ultrasound Guided Procedures:** 15 scans

Central Venous Access: 5 scans

Peripheral IV lines: 5 scans

Procedural US (Abscess, FB, etc): 5 scans

- **Miscellaneous and Advanced Applications:** 10 scans

- **What procedures should be documented?** The preceding list of procedures, broken down into nine categories, should be documented throughout the residency. The list was developed from the new guidelines issued by the Emergency Medicine RRC, as well as for credentialing requirements from several regional hospitals. **Note that the minimum numbers of procedures and resuscitations required by the RRC include both clinical practice and laboratory simulations. Thus it is important to document simulated experiences performing resuscitations and procedures (i.e. ACLS/ATLS/PALS certification courses).** If you were a senior resident who closely supervised a junior resident for an entire procedure such as a central line or laceration repair, be sure to include this on your list of procedures. This will give you credit for the procedure in which you played an integral teaching and supervisory role.
- **What information should be documented?** The following table is an example of the information needed for your procedure log. You may set this up in a database or spreadsheet program. (Remember that *patient confidentiality* is of the utmost importance, and your log must be kept strictly confidential. If you are not able to activate password protection, do not share your PDA or home computer with anyone else.
- **In-Service Examination:** All residents are required to take the annual American Board of Emergency Medicine In-Service Examination each academic year. This examination is most helpful in the resident's and the faculty's assessment of clinical and basic science knowledge and allows the resident to be able to compare his own academic progress with his peers on a nationwide basis. Although performance on this examination alone is not the sole determinant in promotion and progression in the residency, it is a helpful tool in assessing that the resident will be able to pass the ABEM Certification Examination. Residents are expected to score above the 50th percentile nationally for the appropriate year in training. Emphasis is also placed on the In-Service results when applying for fellowship. All residents who score below the 50th percentile must participate in Academic Remediation program, which consists of concentrated program of study designed in collaboration with the resident, the resident's mentor, and the residency associate program director to support the successful mastery of the emergency medicine didactic curriculum. A score below the 25th percentile on the ABEM in-training examination will require that you be placed on academic warning. Failure to achieve improvement above the 25th percentile on successive in-training examinations or deterioration of consecutive scores that fall below the 25th percentile may result in formal academic probation including the possibility of delayed graduation and additional postgraduate training beyond thirty-six months. If poor performance on this exam is thought to be based on learning disabilities, the program director may refer the resident for evaluation and help. The examination is customarily given on the last Wednesday in February (date to be announced annually), and residents must inform their rotation preceptor that they will not be present on their rotation on that date.

Program Curriculum:

The curriculum of the Program will provide experience in all areas mandated by the Residency Review Committee. For any requirements not available at Florida Hospital, the Program will make such arrangements as necessary in order to provide the resident with the requisite experience. If such arrangements mandate rotations in remote sites, the Program will provide living facilities at its expense.

At this time, the only program not available at Florida Hospital is Trauma. Residents will therefore rotate at Lakeland Regional Medical Center during their PGY-1, PGY-2, and PGY-3 years in order to gain the necessary experience.

Through the collaborative efforts of Florida Hospital and Florida Emergency Physicians a premier Residency Program committed to excellence in Emergency Medicine began on July 2008. The focus of this program has been to provide well-trained Emergency Medicine Physicians to practice in any environment including rural Emergency Departments.

The Emergency Departments at all of the Florida Hospital seven campuses have been utilized for this program. The combined volumes for these institutions are well over 280,000 patients per year. The acuity breakdown ensures that between the institutions, the trainees will have an adequate exposure to critically ill as well as more routine patients. Our relationship with the Emergency Medical Services system also ensures that the residents will have an excellent exposure to patients in a pre-hospital setting.

Additionally, the program we have developed is unique in that it builds on the strengths of our Hospital, intensely involving, among others, the Department of Surgery, Anesthesiology, Internal Medicine, Radiology, Critical Care Medicine and the Neuroscience's institute all as described below. We will additionally involve our residents in the care of the critically ill patient and in the operating room environment in a collegial fashion. Further more, the trainees will have extensive exposure to community and rural medicine through our sights at:

1. Florida Hospital Orlando (FHO)
2. Florida Hospital Children's Hospital
3. Florida Hospital East Orlando (FHEO)
4. Florida Hospital Altamonte (FHAlt)
5. Florida Hospital Kissimmee (FHK)
6. Florida Hospital Celebration (FHC)
7. Florida Hospital Winter Park (FHWP)
8. Florida Hospital Apopka (FHA)
9. Lakeland Regional Medical Center (LRMC) –Should this be added since it is not a FH?

Our core faculty represents numerous prestigious Academic institutions and has participated at regional, national, and international meetings and as faculty and presenters in this area. Residents will be exposed to State-of-the-Art Information Technology including an Electronic Medical Records system and a fully integrated Informatics curriculum.

The presence of an Emergency Medicine training program will enhance Florida Hospital, Florida Medical Center and the College of Health Sciences in several ways:

1. We will create a cadre of physicians who will be of assistance to our institution in the future by training and sending throughout the state and the nation, physicians who will have an intense interest in referring patients to our institution.
2. Florida Hospital will become a national leader in Medical Education, Graduate Medical Education and Comprehensive medical care.
3. As new regional medical schools mature we will become a premier progressive training site.
4. Establishing Florida Hospital as a leader in comprehensive state medical education and expansion of our graduates and trainees into rural areas could increase Florida Hospital's Medicare funding for training and patient care.
5. Patient care will improve with a core group of team residents interested in the area and facility in which they are working. This collaboration with on-call specialists will shift the attitude to "on-duty" thus strengthening all members of our medical staff.
6. A strong Emergency Medicine residency at Florida Hospital East Orlando will form the foundation of a center of excellence.
7. Academic/research productivity will be improved, which will enhance the profile of the institution at the national level.

Florida Hospital

Florida Hospital is a 1,432-bed medical complex serving Central Florida, much of the Southeast, the Caribbean, and South America. The eight-campus health system is the largest healthcare provider in Central Florida, and the second largest private not-for-profit hospital in the state. Florida Hospital offers a wide range of health services for the entire family, including many nationally and internationally recognized programs in cardiology, cancer, women's medicine, neurology, diabetes, orthopedics and rehabilitation. For the last three years, U.S. News & World Report has recognized Florida Hospital as one of "America's Best Hospitals".

COMMITTED TO QUALITY

The hospital, which was founded by the Seventh-day Adventist church in 1908 as a 20-bed health facility, is still guided by its Christian mission. In 1992, Florida Hospital received the Healthcare Forum's prestigious Commitment Award and in 1994, the hospital received the Governor's Award for Quality.

CENTERS OF EXCELLENCE

Florida Hospital is a recognized leader in the following areas:

Internal Medicine:

Florida Hospital Medical Center is right in the middle of Orlando and is the largest hospital in Central Florida at nearly 1,000 beds. Florida Hospital offers medical care from primary through

quaternary levels including kidney, liver, pancreas, heart and lung transplant services, as well as world renowned robotic and minimally invasive surgeries.

The training program philosophy starts with a caring, humane attitude to each person we encounter. To this, we add the highest possible level of learning expectation of our residents, role modeled by highly dedicated faculty.

Neurosciences:

The Florida Hospital Neuroscience Institute is the first facility in Central Florida to offer interventional neuroradiology services and has the only Interventional Neuroradiologist in Central Florida. Interventional neuroradiology generally uses a minimally invasive approach with catheters placed through the arteries or veins to treat vascular diseases of the central nervous system. First dedicated SMART (Stroke Management and Rehabilitation Team) unit, established for the Central Florida region to provide aggressive therapies for stroke patients. Highlights The Institute treats the highest number of stroke patients in the state of Florida. The Institute performs the second highest number of neurosurgeries in the State of Florida-treating 1,272 patients, just 44 patients below Jackson Memorial Hospital. Bolstered by extremely strong neuroradiology and computer-assisted surgical planning divisions, physicians at the Brain Tumor Center use the latest diagnostic and treatment protocols for tumors of the central and peripheral nervous system. State-of-the-art neuroimaging (CT, MRI/MRA, biplane digital angiography and SPECT) is utilized and is essential in all phases of treatment.

On January 01, 2003 through a collaborative effort between the Neuroscience institute and the Department of Emergency Medicine Florida Hospital became the first designated Brain Attack center in Central Florida.

Oncology:

The Walt Disney Memorial Cancer Institute (WDMCI) at Florida Hospital offers comprehensive, state-of-the-art oncology treatment, research, education and support services to about 3,400 patients a year, making it one of the largest and busiest cancer centers in the Southeast.

The WDMCI offers some of the most powerful cancer treatment equipment in the country, including the Gamma Knife, which was added in April 1996. This unique and revolutionary tool incorporates noninvasive surgery with radiation therapy to treat various brain tumors, arteriovenous malformations and functional disorders of the brain. In October 1996, The WDMCI teamed up with the Duke Comprehensive Cancer Center to provide the only pediatric and adult bone marrow transplant unit of its kind in Central Florida.

Rehabilitation:

The Florida Hospital Rehabilitation Center offers comprehensive specialized programs for stroke, cancer, spinal cord injury, neurological disorders, amputation, head injury, trauma and orthopedic disabilities. Orthopedic services offer comprehensive care for total joint

replacements, joint injuries, back injuries and other extremity injuries. For outpatients, the Florida Hospital Center for Rehabilitation and Sports Medicine offers comprehensive programs for orthopedics, sports medicine, neurology, amputee, hand injury, stroke, speech, burn, vestibular, audiology and day treatment. The center offers one of the most sophisticated biofeedback programs in the United States for neuromuscular reeducation.

Psychiatry:

The Florida Hospital Center for Behavioral Health offers the only Psychiatric Medical unit in Central Florida in which services are provided for those experiencing a Psychiatric crisis whose medical condition would preclude treatment in traditional inpatient psychiatric programs.

Women's medicine:

The Florida Hospital Women's Center was designed for women by women. The center offers a menopause clinic, mammography, educational programs on women's health topics, a 38-bed Women's Pavilion, family-centered maternity care and a maternal-infant unit.

Obstetrics and Pediatrics:

Over 4,000 babies are delivered every year at Florida Hospital Orlando. A level III neonatal intensive care unit for critically ill babies is adjacent to the labor and delivery area.

New Innovative Healthcare Facility:

In November 1995, Florida Hospital broke ground on its new innovative healthcare facility, Celebration Health. The first phase of the health facility opened in the Fall of 1997 in the town of Celebration, a unique community created by The Celebration Company. Celebration Health will provide the very best diagnostic and medical procedures in the world for residents and visitors to Central Florida and eventually to the 20,000 residents of Celebration.

Education:

The Florida Hospital College of Health Sciences offers several associate-degree programs including nursing, radiation therapy, radiography and sonography. In 1996, the college, located on the campus of Florida Hospital Orlando, received full accreditation from the Southern Association of Colleges and Schools.

Services/Specialties:

Addictions treatment; Allergy; Anesthesiology; ASK-A-NURSE(r); Audiology; Auxiliary volunteers; Breast screening; Bronco-esophagology; Cardiac center; Cardiovascular surgery; Chemotherapy; Clinical dietetics; Colon/rectal surgery; Community health; Critical care medicine; CT scanner; Dentistry; Dermatology; Diabetes management; Dialysis; Eating disorders program; Emergency medicine; Endocrinology; Endoscopy; Family practice; Gastroenterology; General surgery; Genetics; Geriatrics; Gynecology; Head/neck surgery; Health promotion; Health testing laboratory; Heart catheterization; Helicopter transport; Home health care; Hyperbaric medicine; Immunology; Infectious diseases; Intensive care; Internal medicine; Kidney transplants; Laboratory services; Laryngology; Lithotripsy/lasertripsy; MRI; Mammography; Metabolic support; Microsurgery; Neonatology; Nephrology; Neurology; Neuro-ophthalmology; Neuroscience center; Neurosurgery; Nuclear medicine; Nursery, intensive care, sick baby, well baby; Obstetrics/gynecology; Occupational therapy; Oncology/hematology; Open-heart surgery; Ophthalmology; Organ procurement and transplantation; Orthopedic surgery; Osteoporosis education and screening; Outpatient services; Pain medicine; Parent education; Pathology; Pediatrics; Pediatric allergy, surgery, intensive care, cardiology, interventional cardiology, radiology hematology/oncology, bone marrow transplant, neurosurgery, endocrinology/metabolic disorders, neurology, dermatology, epilepsy, urology, development/growth/nutrition, gastroenterology, intensive care, emergency medicine, nephrology, infectious disease, cardiovascular surgery, ENT, pulmonary, neurology, orthopedics, ; Perinatal services; Peripheral vascular surgery; Physical medicine; Physical therapy; Plastic surgery; Podiatry; Preventive medicine; Progressive care; Psychiatry; Pulmonary medicine; Radiation medicine; Radiation therapy; Radiology; Rebound head injury unit; Recreational therapy; Rehabilitation and Sports Medicine; Respiratory care; Rheumatology; Same-day surgery; Sleep disorders center; SPECT camera; Speech therapy; Thermography; Thoracic surgery; Ultrasound; Urology; Vocational rehabilitation; Walk-in Medical Clinics; Women's medicine; Workers' compensation program; Wound care center.

Major Teaching Facilities:

Located in Orlando, Florida, **Florida Hospital Orlando** uses the latest technology to treat over 32,000 inpatients and 53,600 outpatients annually. This nearly 1,000-bed, acute-care community hospital also serves as a major tertiary facility for much of the Southeast, the Caribbean and South America. This campus is known for state of the art cardiac care (invasive diagnostic cardiology, including angiography and PTCA, and cardiac surgery program). Florida Hospital includes centers of excellence in Oncology, Internal Medicine, and Pediatrics. The Main Campus' Admission rates from the ED exceed 30% of the 76,000 plus visits, evidence of the advanced medical care available. The Children's Emergency Center is a 17 room state-of-the-art department within the ED. It is staffed with dedicated BC/BE Pediatric Emergency Medicine/Emergency Medicine specialists as well as board certified pediatricians, during 22 hours of the day. Dedicated X-ray and CT scanner are available 24 hours a day, with 24-hour radiologist coverage, and remote display of scanned films is available via the PACS. A 24 bed Critical Decision Unit/Emergency Department Admission Unit helps to move stable patients toward an inpatient bed. Cardiac surgery, thoracic surgery and neurosurgery cases are transferred to Florida Hospital Orlando from outlying campuses. Florida Hospital Orlando does provide

back up when Orlando Regional Medical Center, the central Florida Level I trauma center is unable to handle excess cases.

Florida Hospital East Orlando is located at the eastern end of metropolitan Orlando, and provides emergency services to the fast growing suburban communities in this locale. Further, as closest ED to Orlando International Airport, this is the first stop for acute air travel medical problems. In the past ten years, (since FEP began coverage) Florida Hospital East's ED census has risen from 16,000 to over 79,000 annually, and is currently the busiest Florida Hospital ED campus. A new 37-bed ED went into service in May 2001, providing separate areas for acute and subacute care, express care (less urgent ED visits), and recently an eight bed pediatric urgent care facility was added. Admission rates reflect the suburban nature of this population, at 13%. Inpatient OB/Gynecology and critical pediatric patients are transferred to Florida Hospital Orlando. Medical, surgical, and Pediatric care is available at the East campus. Florida Hospital East Orlando is a full-service hospital, licensed for 123 beds, serving the residents of East Orange County. Its services include Pediatric unit, Pediatric rehabilitation, Hearing Center, ICU and PCU, Cancer Center with full Oncology and Radiation services, Cardiac Cath center, Cardiology services and Cardiac rehabilitation. Surgical services include ENT, Urology, Orthopedics, Podiatry, Ophthalmology, General Surgery, and Thoracic Surgery. Community wellness programs, Diabetes services, Outpatient endoscopic services, and Outpatient Clinics for General Medical, and Pediatrics are also provided. Medical Students, Interns and Residents rotate through the Emergency Department every month. Out of the more than 44,000 visits in 1998, 33% were Pediatrics. The admission rate was 12%. Emergency services also include access to Florida Flight 1 helicopter transport, and a full radiology department 24 hours a day.

Experiential Curriculum:

The following sections contain and describe the comprehensive and experiential program curriculum. The curriculum follows the Emergency Medicine Model curriculum and involves a balanced set of clinical block rotations and a didactic curriculum, with each covering the model curriculum. Each block rotation has written major instructional goals and objectives (referenced back to the model), methods of achieving goals (implementation) and an evaluation and feedback component. The method of achieving these goals and the process of evaluation is listed under each block rotation with references back to the core model curriculum. Special emergency medicine skills such as resuscitation, Emergency medical services, critical care, and administrative aspects of emergency medicine are included as discrete block rotations when possible or included under objectives for the three levels of emergency medicine training. Emergency medicine has a great breadth of knowledge with learning objectives frequently spanning more than one discrete block rotation since the specialty overlaps a variety of fields.

The didactic curriculum follows the core content and includes general and specific goals and objectives. Under each topic are included methods of implementation such as core reading, additional readings, and lectures or case conferences presented on these topics. The didactic curriculum also lists and labs, demonstrations or workshops that are used to implement a particular topic. Finally there is a cross reference to on and off service rotations which teach a particular body of knowledge through patient care.

The didactic curriculum is presented over an 18 month period by emergency medicine faculty, residents, and specialists from within and outside the institution. The conference series includes five hours of planned educational experience weekly on Thursday mornings from 7:00 am-12:00 noon. A quarterly journal club will occur in addition to those already in the didactic curriculum. During the evening meetings, additional time will be spent to discuss various topics related to “the art of emergency medicine”. These topics are diverse and will include issues such as: the problem patient, interview techniques, how to respond to abusive patients, how to deal with families, how to discuss death etc...

At the beginning of the EM1 year, residents are certified in Advanced Cardiac Life support as developed by the American Heart Association along with Pediatric Advanced life support. Residents will also become certified in Advanced Trauma Life support as developed by the American College of Surgeons during their residency training. Residents will be encouraged to become ACLS instructors.

Between the block rotations and the didactic curriculum, the resident receives exposure to both clinical experiences and a lecture and literature based curriculum which together provide a comprehensive residency training experience. The expected outcome is for the residents to learn,

to synthesize, and to develop competence in each of these block rotations while integrating those clinical and interpersonal skills necessary to produce a skilled clinician and independent practitioner of emergency medicine .

There will be six, first year house officers in the usual situation. A house officer will participate in thirteen four week rotations during the first year. The general objectives of the first year rotations are:

1. Demonstrate proficiency in working up patients and in providing ongoing care for the patients in a variety of in-patient and out-patient settings
2. Participate as an assistant in some operations.
3. Perform procedures of a minor magnitude felt appropriate by the Resident Preceptor.

IMPLEMENTATION

The First Year:

Specific knowledge and procedural skills are acquired on each of the clinical rotations by resident participation in patient care activities. On each service during the first year, the resident is rotated into the call schedule and takes on physician responsibilities for the service which are appropriate to his/her level of training.

The in-patient and out-patient facilities at Florida Hospital are state-of-the-art. Florida Hospital prides itself on being a leader in high-tech medical advancements and has all major diagnostic and therapeutic modalities available to the training programs. Residents at the PGY-1 level work with a separate service "team" each month that report to a specific chief on that service. Each chief is responsible to the physicians in his/her department.

Every service on which the PGY-1 resident rotates has an attending supervisor. The attending are available to review cases at any time of the day and can provide direct bedside instruction for the in-patient and out-patient units. Attending rounds are conducted twice daily (morning and afternoon) on all inpatient services through which the PGY-1 rotates. On the out-patient services (clinics and E.D.) Attendings are immediately on-site to see all patients directly with the PGY-1 resident and to provide direct bedside teaching for physical exam and procedures.

Library facilities are available at the Florida College of Health Sciences and Florida Hospital. The Main Library for the Hospital has extensive collections of peer review journals and reference texts. The library index has been completely computerized and Med-line can be accessed at no charge to the resident from multiple sites in the Library and the Hospital.

In addition to the Main Library, each Hospital has a virtual-online library with collections that are specific to the hospital's departments. These hospital and departmental libraries are available to the residents rotating on service twenty-four hours per day.

Specialty consultants from every specialty service are available to both in-patient and out-patient units on a 24 hour per day basis. Consults are provided by Attendings on medical and surgical specialty services. OB/GYN consults are provided by a resident-attending team. Pediatric specialty consults are done by Attendings. All of these consult physicians are willing to provide bedside teaching and supervision for procedures.

Laboratory Services and Radiology Services operate twenty-four hours per day at Florida Hospital. All tests available during business hours in these services are available on

nights evenings and weekends including radio-immunoassays from the lab and MRI from Radiology. Laboratory Services provides a Drug Toxicology Screen at night. .

All services at Florida Hospital / Florida Medical Center have attending on-call at night. The Attendings for each specialty handle referrals from other hospitals directly. Attendings on-call for surgical services must come into the hospital at night if a patient is going to the O.R. and must be present in the O.R. at the start of any case. Therefore, on the surgery and Ob/Gyn cases, the Attendings are immediately available to teach during invasive procedures.

Lectures are given by each of the services on which the PGY-1 rotates. These occur in the Emergency Medicine curriculum Thursday's from 7:00am- 12:00. Quality Improvement conferences are held monthly by the Department of Emergency Medicine. Specialty conferences such as tumor conferences and research conferences are held monthly. These resources, conferences and teaching activities are available to the PGY-1 as he/she rotates through the services. Procedural skills and factual knowledge will be acquired through this experience.

The Second Year:

On each service during the second year, the resident is rotated into the call schedule and takes on physician responsibilities for the service which are appropriate to his/her level of training. All major diagnostic and therapeutic modalities are available to the training programs. Residents at the PGY-2 level work with a separate service "team" of that report to a specific chief on that service.

Every service on which the PGY-2 resident rotates has an attending. The attendings are available to review cases at any time of the day and can provide direct bedside instruction for the in-patient and out-patient units. Attending rounds are conducted twice daily (morning and afternoon) on all inpatient services through which the PGY-2 rotates. On the out-patient services (clinics and E.D.) attendings are immediately on-site to see all patients directly with the PGY-2 resident and to provide direct bedside teaching for physical exam and procedures.

Library facilities are available at the Florida College of Health Sciences and Florida Hospital. The Main Library for the Hospital has extensive collections of peer review journals and reference texts. The library index has been completely computerized and Med-line can be accessed at no charge to the resident from multiple sites in the Library and the Hospital.

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Lectures are given by each of the services on which the PGY-2 rotates. These occur in the Emergency Medicine curriculum Thursday's from 7:00am- 12:00 noon. Quality Improvement conferences are held monthly by the Department of Emergency Medicine. Specialty conferences such as tumor conferences and research conferences are held monthly. These resources, conferences and teaching activities are available to the PGY-2 he/she rotates through the services. Procedural skills and factual knowledge will be acquired through this experience.

The Third Year:

Each third year rotation is four weeks long. The Senior Resident will be responsible for coordinating Quality improvement conferences as well as coordinating the Journal Clubs and some of the daily lectures that will occur in the Emergency Department. The Senior Resident will also work with the faculty members on a clinical or basic research project that will result in a paper of publication quality. Most of the residents will have selected a topic during their second year and should be to a point during their research month where a concentrated effort will complete their investigational work.

The Senior Resident will be included in all meetings of the Quality Assurance Committee in the Department of Emergency Medicine. He/she will also be responsible for organizing student lectures during the month.

The third year also has a difference in the resident responsibilities while working in the Florida Hospital Emergency Department. Third year residents, when on duty, will not only participate in direct patient care but will also be responsible for interacting with the

pre-hospital care of the patients by directing the paramedics and will direct the nurse-paramedics on the Florida Flight One flight team which is based out of the Emergency Department at Florida Hospital. The senior resident will, in general, administer the Emergency Department when he/she is on duty and will be responsible for knowing every patient in the emergency department. The Senior Resident will also take presentations from senior medical students who are working as externs in the Florida Hospital Emergency Department.

With the institution of a residency program, the authority for giving physician orders would be delegated to the Senior Resident from Emergency Medicine working in the Emergency Department. The Senior Resident would be responsible for giving orders to paramedic personnel for pre-hospital care and would be responsible for giving orders to the Florida Flight One flight team.

For critical patients in the field or in other hospital emergency departments, the third year resident will be allowed to travel with the Florida Flight One Flight Program to administer care at the scene. This opportunity will be on a volunteer basis only. Residents will not be forced to fly on the Florida Hospital Helicopter Program if they do not wish to.

The senior resident returns to Lakeland for another month of the Lakeland Regional Medical Center Trauma Service functioning this time as a senior member of the team. At a third year level, the residents will take charge of trauma resuscitations under the watchful eye of the attending trauma surgeon. Also, the senior resident directs resuscitations in the SICU and is allowed to independently perform procedures such as arterial catheterization, endotracheal intubation, central line placement, and ventilator management. The resident is expected to take call during the month at the Trauma Center averaging every third night.

The senior resident rotates to the Neurotrauma service at Florida Hospital Orlando functioning at a more senior capacity. At a third year level, the residents will take charge of resuscitations under the watchful eye of the attending neurosurgeon. Also, the senior resident directs resuscitations in the NICU and is allowed to independently perform procedures such as arterial catheterization, endotracheal intubation, central line placement, and ventilator management. The resident is expected to take call during the month in the Neurotrauma ICU averaging every third night.

The senior residents in Emergency Medicine will be allowed to participate in paramedic education. All procedure labs and animal labs will utilize the Emergency Medicine Residents as teachers for the paramedics. The paramedic training is ongoing and includes skills such as endotracheal intubation, cricothyrotomy, needling of the chest for tension pneumothorax, the use of mast trousers, and various techniques for IV insertion.

Curriculum

ANESTHESIA Medicine (PGY-I, 4 Weeks)

Goals & Objectives:

1. Develop airway management skills.
2. Develop familiarity with pharmacologic agents used in anesthesia.
3. Learn standard monitoring techniques.
4. Learn relevant history and physical examination considerations.
5. Demonstrate correct use of the bag-valve-mask device.
6. Demonstrate knowledge of the anatomy of the upper airway.
7. Demonstrate basic familiarity, indications, and complications of nasotracheal and endotracheal intubation.
8. Understand all of the uses, indications and contraindications to the Laryngeal mask airway.
9. Demonstrate skill in all aspects of nasotracheal and endotracheal intubation.
10. State the dosages, indications and contraindications for intravenous analgesics, anesthetics, and neuromuscular blocking agents.
11. Demonstrate skill in the use of these agents in rapid sequence intubation and for conscious sedation.
12. Demonstrate ability to use standard monitoring techniques.
13. Demonstrate ability to manage a patient on a ventilator.
14. Demonstrate knowledge of the principles of regional anesthesia and successfully perform metacarpal, digital, radial, median, lunar tibia and sural nerve blocks.
15. Demonstrate ability to administer local anesthetics and be familiar with agents, dosing, side effects, and techniques to monitor pain.
16. Recognize and manage an obstructed airway.
17. Demonstrate ability to use standard emergency department monitoring techniques.
18. Perform procedural sedation. (This is always done with a faculty member present.)
19. Perform facial nerve blocks to include supraorbital, infraorbital, mental and auricular nerves.
20. Demonstrate appropriate judgment regarding the need for airway intervention.
21. Demonstrate ability to analyze and interpret arterial blood gases.

Methods of Achieving Goals:

1. Management of patients on assisted ventilation in critical care units.
2. Management of patient on Emergency Department rotations.
3. Intubation of patients in Critical Care Units under the supervision of Pulmonologist.
4. Intubation of respiratory failure, cardiopulmonary arrest and trauma victims in the Emergency Department.
5. Intubation of trauma victims on the Trauma Service.
6. Performance of nerve blocks.
7. Certification as ACLS and ATLS Provider/Instructor.

8. Attendance at teaching rounds in the CCU, Trauma, and Pulmonary Services.
9. Attendance at Emergency Medicine lectures on airway management.

Evaluation and Feedback on Goal Achievement:

1. Written formal evaluation by Anesthesiology attending physician staff.
2. Resident feedback:
 - A. Evaluation at end of rotation.
 - B. Semi-annual resident evaluation.
3. Successful completion of ACLS and ATLS Provider/Instructor Courses.
4. Performance on In-Training examination.

CPOU- (PGY-I, 4 Weeks)

Goals & Objectives:

1. Demonstrate the ability to stabilize patients who present in cardiopulmonary arrest.
2. Develop skills in the evaluation of patients who present with chest pain.
3. Demonstrate the ability to evaluate, stabilize, treat, and arrange for appropriate disposition of patients with cardiac disease processes.
4. Demonstrate the ability to develop a differential diagnosis for patients presenting with cardiac symptomatology (chest pain, shortness of breath, weakness, palpitations, etc.).
5. Demonstrate skill in the interpretation of diagnostic modalities (ECG, chest x-ray and cardiac ultrasonography).
6. Develop a familiarity with cardiac pharmacologic agents.
7. Demonstrate skill at cardiac related procedures: central venous lines, pericardiocentesis, defibrillation and cardioversion, pulmonary artery catheterization, and ultrasonography.
8. Demonstrate the ability to diagnose, stabilize, and apply thrombolytic therapy to patients presenting with acute early myocardial infarction.
9. Demonstrate the ability to perform an appropriate history and physical examination on the patient presenting with cardiac symptomatology.
10. List items elicited from the history of patients with chest pain to suggest a risk for cardiac etiology.
11. Discuss limitations in differentiation of cardiac chest pain from non-cardiac pain in patients with risk factors.
12. Describe the pathophysiology of cardiac ischemia, acute anginal chest pain, and acute myocardial infarction.
13. Describe the typical electrocardiogram findings of patients with myocardial ischemia, subendocardial infarction and myocardial and transmural infarction.
14. Discuss differential diagnosis of a typical chest pain.
15. Discuss atypical presentations for acute cardiac ischemia and myocardial infarction.
16. Discuss the sensitivity and specificity of ancillary studies for chest pain presentations including EKG, chest x-ray, cardiac enzymes, troponin-T and -I, and arterial blood gases.
17. Describe the appropriate triage considerations for patients presenting to the emergency department with chest pain.
18. Differentiate between stable and unstable angina and outline the initial treatment of patients with unstable angina including the use of nitrates, beta blockers, calcium channel blockers, etc.
19. Discuss the concept of "silent" myocardial infarction and ischemia.
20. Differentiate between transmural versus subendocardial infarction.
21. Discuss the significance of acute complete atrio-ventricular block with inferior myocardial infarction versus anterior myocardial infarction.
22. Demonstrate knowledge of AHA recommendation for the treatment of acute ventricular fibrillation, ventricular tachycardia, asystole, electromechanical dissociation, atrial flutter and fibrillation, junctional ectopy, pre-excitation, supraventricular tachycardia, and bradycardia, sick-sinus syndrome, atrial ventricular blocks (first degree, second degree and third degree) and bundle branch blocks.
23. Describe the clinical findings of and outline therapy for cardiogenic shock.
24. Differentiate cardiogenic shock from other etiologies for shock.

25. Describe the clinical presentation for and outline the appropriate initial therapy and management for pericardial disease.
26. Describe the presentations for myocardial infarction and their association with vessel involvement and outline initial treatment for myocardial infarction.
27. List the indications, contraindications and complications of thrombolytic therapy for acute myocardial infarction.
28. Describe the clinical presentation, etiologies for pathophysiology of, and current therapy for acute congestive heart failure.
29. Describe the valvular anatomy of the heart and list etiologies for valvular heart disease.
30. Describe the clinical findings of a mitral valve prolapse, valvular aortic stenosis, aortic regurgitation, tricuspid stenosis, tricuspid regurgitation, and pulmonary stenosis, and discuss management of each of these valvular abnormalities.
31. List complications of prosthetic cardiac valves and appropriate emergency department management.
32. Differentiate between congestive cardiomyopathy, hypertrophic cardiomyopathy and restrictive cardiomyopathy and discuss therapy for each.
33. Define myocarditis and describe the EKG findings and acute management of myocarditis.
34. Discuss the pathophysiology of acute pulmonary embolism and the predisposing factors for pulmonary embolism.
35. Discuss the sensitivity and specificity of the various tests used to diagnosis pulmonary embolism including arterial blood gases, EKG, chest x-ray, etc.
36. Discuss the sensitivity and specificity of ventilation-perfusion scan in acute pulmonary embolism.
37. Outline treatment for acute pulmonary embolism.
38. Differentiate between acute hypertensive emergencies, hypertensive urgency, and uncomplicated hypertension.
39. Discuss the indications for treatment of hypertension in the emergency department.
40. Describe the syndrome of hypertensive encephalopathy.
41. Outline the treatment for acute hypertensive emergency and differentiate treatment in the setting of thoracic aortic dissection.
42. Differentiate between primary agents for hypertensive emergency to include their advantages and disadvantages.
43. Describe the clinical presentation of acute mesenteric ischemia and discuss the inherent difficulties in the diagnosis as well as the emergency department management.
44. Discuss the pathophysiology, etiology, and overall morbidity or mortality of patients presenting with acute aortic dissection.
45. Explain the emergency department management of acute aortic dissection.
46. Differentiate between expanding, ruptured, and dissecting aortic aneurysms.
47. Describe the pathophysiology and clinical presentation of acute peripheral ischemia and outline the emergency department management.
48. Differentiate between superficial and deep venous thrombosis.
49. Outline the emergency management of acute thrombophlebitis.
50. Discuss the pathophysiologic connection between thrombophlebitis and pulmonary embolism.

Methods of Achieving Goals:

1. Management of patients on Cardiology rotation.
2. Management of patients on Emergency Medicine rotations.
3. Certification as ACLS Provider/Instructor.
4. Attendance at daily rounds.
5. Attendance at Emergency Medicine lectures on cardiology.

Evaluation and Feedback on Goal Achievement:

1. Written formal evaluation by Cardiology attending physician staff.
2. Resident feedback:
 - A. Evaluation at end of rotation.
 - B. Semi-annual resident evaluation.
3. Performance on In-Training examination.

CRITICAL CARE UNITS – Adult: SICU (PGY-II, 4 Weeks), MICU (PGY-II, 4 weeks)

Goals & Objective

1. Develop the ability to rapidly evaluate, diagnose, stabilize, and make a disposition on critically ill adult patients.
2. Learn respiratory, cardiovascular, renal and neurologic physiology and the pathophysiology of trauma, shock, sepsis, cardiac failure, and respiratory failure which affect critically ill patients.
3. Learn the principles of medical instrumentation and hemodynamic monitoring and be able to utilize them in the care of critically ill patients.
4. Learn the indications and develop the technical skills needed to perform diagnostic and therapeutic interventions in critically ill patients.
5. Learn the rational use of laboratory, radiographic and other diagnostic tests in the management of critically ill patients.
6. Demonstrate ability to rapidly perform history and physical exams on critically ill patients.
7. Demonstrate the ability to perform the following procedures: oral endotracheal intubation, nasotracheal intubation, cricothyrotomy, needle thoracostomy, tube thoracostomy, central intravenous placement, pulmonary artery catheter placement, transvenous cardiac pacing, arterial line placement, and indwelling urinary-bladder catheterization.
8. Demonstrate the ability to use and interpret data from ECG's and monitors, cardiac outputs, hemodynamic monitoring, arterial blood gases, pulse oximetry, end tidal CO₂ monitors and ventilators.
9. Describe the dosages, indications and contraindications of pharmacological interventions for shock, cardiac failure, dysrhythmias, sepsis, trauma, respiratory failure, hepatic failure, renal failure, and neurologic illnesses.
10. Demonstrate the ability to manage a patient on a ventilator.
11. Demonstrate appropriate judgment in the management of critically ill patients.
12. Demonstrate appropriate prioritization of diagnostic and therapeutic interventions in critically ill patients.
13. Demonstrate ability to diagnose and treat shock, sepsis, fluid and electrolyte abnormalities, cardiac failure, cardiac dysrhythmias, renal failure, hepatic failure, and toxicological emergencies.
14. Demonstrate an understanding of the appropriate use of consultants for critically ill patients.
15. Demonstrate an understanding of the ethical and legal principles applicable to the care of critically ill patients.

Methods of Achieving Goals:

1. Management of patients in critical care units.
2. Management of patients on Emergency Medicine rotations.
3. Performance of invasive monitoring procedures.
4. Certification as ACLS Provider/Instructor.

5. Attendance at daily rounds.
6. Attendance at Emergency Medicine lectures on critical care topics.

Evaluation and Feedback on Goal Achievement:

1. Written formal evaluation by Critical Care attending staff.
2. Resident feedback:
 - A. Evaluation at end of rotation.
 - B. Semi-annual resident evaluation.
3. Successful completion of ACLS Provider/Instructor Courses.
4. Performance on In-Training Examination.

CRITICAL CARE UNIT – Pediatric: PICU (PGY-II, 4 Weeks)

Goals & Objectives

1. Demonstrate the ability to work-up critically ill children of all ages and generate a differential diagnosis.
2. Demonstrate the ability to manage critically ill children while in the hospital to include admission, daily management, and discharge planning.
3. Demonstrate ability to work as a team member in a multi-disciplinary approach to patient problems.
4. Demonstrate a thorough understanding of pediatric fluid and electrolyte calculations and management.
5. Demonstrate the ability to calculate proper drug dosages for pediatric patients.
6. Demonstrate the ability to perform certain invasive procedures in pediatric patients, to include: central venous access (femoral, subclavian, internal jugular), arterial lines, nasogastric tubes, peripheral IV, Foley catheter, lumbar puncture, endotracheal intubation.
7. Demonstrate an understanding of ventilator management in the pediatric patient to include: volume cycled ventilators, pressure cycled ventilators, time cycled ventilators, IMV, assist control, CPAP, PEEP, interpretation of arterial blood gases in relation to assisted ventilation, interpretation of end-tidal CO₂ monitors and pulse oximeters.
8. Demonstrate the ability to resuscitate a pediatric patient in cardiopulmonary arrest.
9. Demonstrate the ability to search the literature to guide therapy, make group presentations and teach fellow residents.
10. Demonstrate an in-depth knowledge of all patients in the PICU on a daily basis.
11. Demonstrate knowledge of similarities and differences in treatment of various types of patients in the PICU.
12. Demonstrate an in-depth knowledge of hemodynamic parameters particularly the method of calculation and significance of cardiac output and index, systemic vascular resistance, left ventricular stroke work, pulmonary vascular resistance, myocardial oxygen consumption, correlation coefficient, serum lactic acid, creatinine clearance, urine electrolytes, and urinary output.
13. Demonstrate in-depth knowledge of complicated pulmonary care including the meaning and therapeutic significance of tidal volume, intermittent mechanical ventilation, positive end expiratory pressure, continuous positive airway pressure, and intrapulmonary shunt.
14. Demonstrate the ability to write ventilator orders and physically perform critical changes with the ventilators on pediatric patients.
15. Demonstrate the ability to independently insert arterial lines, chest tubes, subclavian catheters, cut-downs, and endotracheal tubes.
16. Demonstrate the ability to perform bed planning based on nurse staff and clinical load.

Methods of Achieving Goals:

1. Management of patients in pediatric critical care unit.
2. Management of pediatric patients on Emergency Medicine rotations.
3. Performance of invasive monitoring procedures.
4. Certification as PALS Provider/Instructor.
5. Attendance at daily rounds.
6. Attendance at Emergency Medicine lectures on pediatric critical care topics.

Evaluation and Feedback on Goal Achievement:

1. Written formal evaluation by Pediatric Critical Care attending staff.
2. Resident feedback:
 - A. Evaluation at end of rotation.
 - B. Semi-annual resident evaluation.
3. Successful completion of PALS Provider/Instructor Courses.
4. Performance on In-Training Examination.

EM-I (PGY-I, 23 Weeks)

ADULT

Goals & Objectives

1. Develop basic skills of emergency medicine patient evaluation.
2. Learn principles of emergency medicine care.
3. Develop physician-interpersonal skills.
4. Develop competence in the diagnosis and management of acute and common problems seen in patients presenting to the Emergency Room, with particular emphasis on the following symptoms:
 - A. Headache.
 - B. Altered mental status.
 - C. Dizziness, weakness, syncope, vertigo.
 - D. Shortness of breath.
 - E. Chest pain, palpitations.
 - F. Abdominal pain.
 - G. Nausea, vomiting, diarrhea, feeding problems, weight loss.
 - H. Gastrointestinal bleeding.
 - I. Dysuria, hematuria.
 - J. Vaginal/obstetrical complaints.
 - K. Minor trauma, soft tissue and bone injuries.
 - L. Fever, chills.
 - M. Skin rashes.
 - N. Earache, sore throat, eye complaints, nose bleeds.
 - O. Overdose, drug interactions.
 - P. Human/animal bites.
 - Q. Urogenital complaints.
5. Become familiar with the indications for and interpretation of state-of-the-art diagnostic modalities:
 - A. Plain film radiography and contrast studies.
 - B. Ultrasound.
 - C. Tomography.
 - D. Computerized axial tomographic (CAT) scanning.
 - E. Magnetic resonance imaging (MRI).
 - F. Nuclear Medicine studies.
 - G. Electrocardiography.
 - H. Endoscopy.
 - I. Arterial blood gases.
 - J. Chemistry and hematologic studies.
 - K. Urinalysis.
 - L. Slit lamp examination.
6. Acquire expertise in the following skills:
 - A. History and physical examination.
 - B. Initial stabilization.

- C. Patient - physician communication.
 - D. Fluid, electrolyte and blood component therapy.
 - E. Oxygen therapy.
 - F. Venous catheterization, arterial puncture.
 - G. Urinary bladder catheterization.
 - H. Wound closure, wound care.
 - I. Nasogastric tube, gastric lavage - bowel decontamination.
 - J. Pharmacologic intervention.
 - K. Incision & drainage procedures.
 - L. Nasal packing.
 - M. Eye patching.
7. Develop competence in the following areas of wound management:
- A. Demonstrate ability to perform appropriate history and physical exams on patients with traumatic wounds.
 - B. Demonstrate an understanding of wound pathophysiology, including cellular response, static and dynamic wound tensions, growth factors and tensile strength.
 - C. Demonstrate an understanding of the predictors of wound sepsis.
 - D. Demonstrate effective wound cleansing skills.
 - E. Describe the appropriate use, limitations and potential complications of wound cleansing solutions.
 - F. Describe the appropriate use, limitations and potential complications of antimicrobials in the management of traumatic wounds.
 - G. Demonstrate an understanding of various imaging modalities in the detection of soft tissue foreign bodies.
 - H. Demonstrate appropriate use of universal precautions in wound treatment.
 - I. Demonstrate skill in various wound closure techniques including intradermal suture, fascial closure, interrupted skin sutures, running skin sutures, vertical and horizontal mattress sutures, half-buried horizontal mattress sutures, tape closure and use of staples.
 - J. Demonstrate appropriate use of delayed closure techniques.
 - K. Demonstrate appropriate management of special wound types, including skin ulcers, human bites, animal bites, snake bites, plantar puncture wounds, dermal abrasions and tar burns.
 - L. Demonstrate skill in the management of complex lacerations.
 - M. Demonstrate skill in the provision of analgesia and anesthesia to patients with traumatic wounds including use of local infiltration, topical administration and conscious sedation.
 - N. Demonstrate ability to apply wound dressings.
 - O. Demonstrate ability to thoroughly document historical and physical exam data relating to wound care.
 - P. Describe indications for specialty referral of traumatic wounds.
 - Q. Demonstrate ability to diagnose and manage complication of traumatic wounds.

Methods of Goal Achievement:

1. Responsibility as clinical chief resident while on shift in the Emergency Room.
2. Optional responsibility as administrative chief resident to plan resident's schedules, assign selected conference topics, direct monthly resident administrative meeting.
3. Resident demonstration of clinical and administrative skills under direct Emergency Medicine faculty supervision.
4. Attendance at Emergency Medicine lecture series.
5. Attendance at Emergency Medicine faculty meetings.
6. Presentations at Emergency Medicine Trauma Conference.
7. Article presentation, critique, and discussion at Journal Club.
8. Teaching ACLS, ATLS, suture techniques.
9. Teaching third year and fourth year medical students.
10. Consultations with various medical subspecialists.
11. Attendance at Neurology and Trauma rounds.
12. Journal and textbook readings.

Evaluation and Feedback:

1. Bedside evaluation of residents' history and physical examinations, oral presentations, clinical, and procedural skills by Emergency Department attending staff.
2. Written formal evaluation by Emergency Department attending staff.
3. Daily Quality Assurance review of resident's charts.
4. Performance evaluation of resident management of Case Conference patient simulations.
5. Performance evaluation at Journal Club and Trauma Conferences.
6. Evaluation by junior residents.
7. Performance on In-Training Examination.
8. Resident feedback:
 - A. Evaluation at end of rotation.
 - B. Semi-annual resident evaluation.

PEDIATRIC (Longitudinal during PGY I, II, & III EM Rotation)

Goals & Objectives

1. Develop skills in performance of appropriate pediatric history and physical exam, including general growth and development, assessment and knowledge of current immunization requirements.
2. Learn the etiologies, significance, and treatment of fever and infection in the child.
3. Learn the manifestations and significance of abdominal-related complaints in the child.
4. Learn the etiologies and treatment of neurologic emergencies in the child.
5. Learn the physiology and derangements of fluid and electrolyte management in children.
6. Learn the indications of social and/or psychological disturbances.
7. Learn the manifestations and treatment of pediatric cardiac abnormalities.
8. Learn the pathophysiology, etiologies, and treatment of respiratory disorders of children.
9. Learn the pathophysiology, etiologies, and treatment of common serious endocrine and hematological disorders of children.
10. Learn the pathophysiology, etiologies, and treatment of common serious gynecological and urological conditions of children.
11. Learn to recognize and provide appropriate treatment for orthopedic and soft tissue problems of childhood.
12. Learn the common dermatological diseases and manifestations of systemic diseases in children.
13. Learn to recognize and treat children with common and/or serious problems of the head and neck.
14. Learn the specific problems of pediatric trauma victims.
15. Demonstrate correct airway management including pediatric endotracheal intubation.
16. Demonstrate ability to obtain and utilize intravenous access including venipuncture, intraosseous needle placement, and administration of appropriate dosages of emergency medications.
17. Demonstrate knowledge of the significance of fever in children of various ages, and the ability to perform an "optimal resuscitation" of the febrile child.
18. Demonstrate knowledge of common infectious diseases of childhood, including appropriate work-up and treatment of meningitis, sepsis, pneumonia, urinary tract infection, and bacteremia.
19. Demonstrate ability to properly perform a pediatric lumbar puncture.
20. Demonstrate knowledge of the pathophysiology and manifestations of common and/or serious diseases of the gastrointestinal tract and abdominal cavity of children, including gastroenteritis, intussusception, volvulus, Meckell's diverticulum, anaphylactoid purpura, and appendicitis.
21. Discuss the differential and preliminary work-up of abdominal masses found in the pediatric patient.
22. State the appropriate management of children with seizures, both febrile and afebrile.
23. Demonstrate familiarity with the diagnosis and management of Reye's syndrome.
24. Demonstrate knowledge of hydrocephalus, its differential diagnoses, treatment and the management of neurologic shunt problems.
25. Calculate fluid and electrolyte requirements of a dehydrated child.

26. Discuss the diagnostic work-up and disposition when child abuse and/or neglect is suspected.
27. Demonstrate ability to perform a history and physical exam of an alleged victim of sexual abuse.
28. Demonstrate ability to direct pediatric trauma resuscitation.
29. Demonstrate knowledge of the significance and correct treatment of various patterns of burns in pediatric patients.
30. Interpret a series of pediatric EKG's, showing awareness of the normal physiologic differences from adult EKG's.
31. Discuss the common pediatric dysrhythmias, their diagnosis and treatment.
32. Discuss the types of congenital cyanotic and noncyanotic heart disease, their complications and treatment.
33. Demonstrate ability to read pediatric chest x-rays.
34. Demonstrate ability to properly treat a patient who needs prophylaxis for rheumatic fever or subacute bacterial endocarditis.
35. Discuss the differential diagnosis of chest pain in children and adolescents, noting differences from adults, and demonstrating knowledge of proper work-up and treatment.
36. Discuss the differential of congestive heart failure in the pediatric patient and demonstrate knowledge of appropriate treatment.
37. Discuss the anatomy and physiology of the respiratory tract in children.
38. Demonstrate correct performance of peak expiratory measurements, pulse oximetry and end-tidal CO₂.
39. Demonstrate management of patients with upper airway infection suspected of having epiglottitis.
40. Correctly interpret soft tissue lateral neck x-rays in children.
41. Discuss the etiologies and demonstrate correct management of children with lower and upper airway diseases including asthma, bronchiolitis, cystic fibrosis, pneumonia.
42. Demonstrate correct management of foreign bodies of the upper airway and ability to diagnose and arrange disposition for patients with lower airway foreign bodies.
43. Demonstrate correct management of the pediatric patient with diabetes and/or diabetic ketoacidosis.
44. Demonstrate knowledge of the etiologies of anemia in children and the appropriate diagnostic evaluation.
45. Demonstrate knowledge of the differential diagnosis and work-up of the jaundiced child.
46. Discuss the differential diagnosis and work-up of the child with evidence of a bleeding disorder.
47. Demonstrate correct evaluation and treatment of a child with dysuria or a suspected urinary tract infection.
48. Discuss the indications for, and interpretation of, the intravenous pyelogram of a child.
49. Demonstrate knowledge of and treatment for phimosis, paraphimosis, balanitis, and testicular lesions including torsion.
50. Discuss the differential diagnosis and required workup for a pediatric patient with a limp.
51. Demonstrate x-ray interpretation and perform proper splinting for a variety of pediatric fractures including the clavicle, distal radius and ulna, and distal tibia and fibula.
52. Demonstrate ability to perform and interpret the results of an arthrocentesis.

53. Discuss the findings and disposition of a patient with a suspected autoimmune syndrome such as juvenile rheumatoid arthritis, lupus, or dermatomyositis.
54. Demonstrate ability to perform reduction of a dislocated joint.
55. Discuss the etiology and treatment of acute soft tissue infections and the performance of an incision and drainage procedure.
56. Correctly diagnose common pediatric exanthemas including varicella, measles, monilia, roseola, rubella, pityriasis, scabies, and erythema infectiosum.
57. Demonstrate knowledge of the differential diagnosis and evaluation of children with petechiae.
58. Demonstrate ability to correctly perform and interpret the exam of the ears, nose and throat.
59. Demonstrate knowledge of pediatric facial and orbital infections and their treatment.
60. Discuss the causes of neonatal shock and demonstrate the ability to perform an infant resuscitation, including endotracheal intubation and insertion of an umbilical venous catheter.
61. Explain and demonstrate how to perform a suprapubic bladder aspiration.
62. Discuss the findings and differential diagnosis of sudden infant death syndrome, and demonstrate knowledge of the proper legal steps and ability to support the family when presented with this syndrome.
63. Discuss the differential diagnosis and acute treatment of the weak infant and child, including polio, botulism and Landry-Guillain-Barre syndrome.
64. Demonstrate knowledge of the evaluation and treatment of children with diarrheal illness.
65. Demonstrate knowledge of the common poisonings of childhood and their treatments.
66. Demonstrate knowledge of the management and care of the child with immersion/drowning.
67. Demonstrate knowledge of the management and care of the child with a foreign body ingestion, discussing the complications, diagnostic steps and treatment.
68. State the differential diagnosis of a child with upper- or lower- GI bleeding, and discuss the evaluation and treatment.
69. Discuss the differential diagnosis and work-up of renal failure or anuria in children.
70. Demonstrate ability to evaluate children with syncope and discuss its differential diagnosis.
71. Discuss the signs, symptoms, treatment and complications of Kawasaki disease.
72. Discuss the risk factors associated with teenage suicide.
73. Discuss the differential diagnosis of abnormal vaginal bleeding in childhood and demonstrate ability to perform a complete genital exam on children of various ages.
74. Demonstrate ability to evaluate and treat a child with altered mental status and interpret a pediatric cranial CAT scan.
75. Discuss the technique for reducing an incarcerated inguinal hernia.
76. Discuss the common pediatric malignant tumors.
77. Differentiate between the presentation, diagnostic test results and treatment of transient synovitis and the septic joint.

Methods of Achieving Goals:

1. Management of patients in the Pediatric ICU.
2. Management of patients on Pediatric Emergency Medicine rotation.
3. Management of patients on Emergency Medicine rotations.
4. Performance of pediatric procedures.
5. Attendance at pediatric rounds and Pediatric Departmental conferences.
6. Attendance at Emergency Medicine lectures in Pediatrics.
7. Assigned Readings – 2 chapters/week

Evaluation and Feedback on Goal Achievement:

1. Written formal evaluation by Pediatric attending physician staff.
2. Clinical performance under supervision of the Pediatric attending staff
3. Resident feedback:
 - A. Evaluation at end of rotation.
 - B. Semi-annual resident evaluation.
4. Performance on In-Training examination.

EM-II (PGY-II, 32 Weeks)

ADULT

Goals & Objectives:

1. Become competent in resuscitation and stabilization of critically-ill patients in the Emergency Department, with particular emphasis on the following:
 - A. Triage - recognition of life/limb threatening disease processes.
 - B. Cardiovascular instability.
 - C. Unstable cardiac arrhythmias.
 - D. Cardiac arrest.
 - E. Respiratory arrest.
 - F. Obstructed airway.
 - G. Shock: cardiogenic, septic, hypovolemic, anaphylactic, neurogenic.
 - H. Increased intracranial pressure.
 - I. Fluid overload.
 - J. Major trauma.
 - K. Organ failure: hepatic, renal, endocrine, bone marrow.
 - L. Burn (thermal, chemical, electrical) patients.
2. Acquire expertise in the following skills:
 - A. ACLS, ATLS and PALS.
 - B. Fluid and electrolyte resuscitation.
 - C. Airway access and control.
 - D. Cerebrospinal stabilization.
 - E. Hemorrhage control.
 - F. Drug/electrocardioversion.
 - G. Arrhythmia recognition and interpretation.
 - H. Pharmacologic intervention.
 - I. Circulatory and ventilatory support.
 - J. Pericardiocentesis.
 - K. Closed tube thoracostomy.
 - L. Open thoracostomy.
 - M. Peritoneal lavage.
 - N. IV access, peripheral and central venous catheterization.
 - O. Arterial catheterization.
 - P. Blood component therapy.
 - Q. Initial interaction with pre-hospital care personnel.
 - R. Serial patient evaluation.
3. Learn to manage multiple patients simultaneously.
4. Acquire educational skills and teach medical students.

Methods of Goal Achievement:

1. Responsibility as clinical chief resident while on shift in the Emergency Room.
2. Optional responsibility as administrative chief resident to plan resident's schedules, assign selected conference topics, direct monthly resident administrative meeting.
3. Resident demonstration of clinical and administrative skills under direct Emergency Medicine faculty supervision.
4. Attendance at Emergency Medicine lecture series.
5. Attendance at Emergency Medicine faculty meetings.
6. Presentations at Emergency Medicine Trauma Conference.
7. Article presentation, critique, and discussion at Journal Club.
8. Teaching ACLS, ATLS, suture techniques.
9. Teaching third year and fourth year medical students.
10. Consultations with various medical subspecialists.
11. Attendance at Neurology and Trauma rounds.
12. Journal and textbook readings.

Evaluation and Feedback:

1. Bedside evaluation of residents' history and physical examinations, oral presentations, clinical, and procedural skills by Emergency Department attending staff.
2. Written formal evaluation by Emergency Department attending staff.
3. Daily Quality Assurance review of resident's charts.
4. Performance evaluation of resident management of Case Conference patient simulations.
5. Performance evaluation at Journal Club and Trauma Conferences.
6. Evaluation by junior residents.
7. Performance on In-Training Examination.
8. Resident feedback:
 - A. Evaluation at end of rotation.
 - B. Semi-annual resident evaluation.

PEDIATRIC

Longitudinal as detailed under PGY-I Emergency Medicine Block Rotation.

Methods of Achieving Goals:

1. Management of patients in the Pediatric ICU.
2. Management of patients on Pediatric Emergency Medicine rotation
3. Management of patients on Emergency Medicine rotations.
4. Performance of pediatric procedures.
5. Attendance at pediatric rounds and Pediatric Departmental conferences.
6. Attendance at Emergency Medicine lectures in Pediatrics.

Evaluation and Feedback on Goal Achievement:

1. Written formal evaluation by Pediatric attending physician staff.
2. Clinical performance under supervision of the Pediatric attending staff.
3. Resident feedback:
 - A. Evaluation at end of rotation.
 - B. Semi-annual resident evaluation.
4. Performance on In-Training examination.

EM-III (PGY-III, 32 Weeks)

ADULT

Goals & Objectives

1. Develop expertise in overall clinical management of a busy Emergency Department, including:
 - A. Applying ethical principles relevant to emergency medicine.
 - B. Applying emergency medicine and ethical principles to patient encounters to assist in decision making.
 - C. Managing patient flow
 - D. Teaching and supervision of medical students and junior residents.
 - E. Communicating with consultants and private attending physicians.
 - F. Mediating intra-departmental and interdepartmental medical disputes.
 - G. Learning basic legal principles relevant to emergency medicine.
 - H. Directing cardiac and trauma codes.
 - I. Recognizing dysrhythmias associated with cardiac arrest and their treatment.
 - J. Learning AHA recommendations and develop skill in the performance of standard resuscitative procedures.
 - K. Learning the principles of pharmacotherapy and the routes and dosages of drugs recommended during cardiac arrest and following resuscitation.
 - L. Learning standard monitoring techniques.
 - M. Learning indications for withholding and terminating resuscitation.
2. Recognize the interplay among the various elements of the regional EMS System including Base Station Medical Command for paramedics.
3. Develop ED administrative skills to facilitate resolution of interdepartmental difficulties, facilitate patient transfers into the hospital and to other facilities.
4. Develop leadership skills and understand the concept of teamwork.
5. Demonstrate knowledge of the various etiologies of adult and pediatric cardiac arrest and the corresponding therapeutic approaches.
6. Demonstrate knowledge of the factors affecting blood flow, oxygen delivery and consumption during cardiac arrest.
7. Demonstrate ability to recognize dysrhythmias associated with cardiac arrest and knowledge of ACLS protocols for their treatment.
8. Demonstrate ability to manage the airway during cardiac arrest, including mouth-to-mouth ventilation, bag-valve-mask ventilation, endotracheal intubation, cricothyroidotomy, and recognition of the obstructed airway.
9. Demonstrate ability to perform external closed chest cardiopulmonary resuscitation according to American Heart Association guidelines.
10. Discuss the dosages, indications, and contraindications for pharmacologic therapy during cardiac arrest and following resuscitation.
11. Demonstrate knowledge of the techniques for drug administration including peripheral and central venous, endotracheal, intraosseous and intracardiac administration.
12. Demonstrate ability to safely perform internal and external defibrillation.
13. Demonstrate ability to safely perform internal and external cardiac pacing.

14. Demonstrate ability to perform standard monitoring techniques during cardiac arrest and resuscitation including arterial blood gases, blood pressure monitoring, right heart and pulmonary artery catheterization and end-tidal CO₂ monitoring.
15. Demonstrate understanding of “Do Not Resuscitate” orders, advance directives, living wills and brain death criteria.
16. Discuss the historical, philosophical, and practical implications of beneficence, autonomy, justice, truth-telling and confidentiality to emergency medical practice and research.
17. Demonstrate ability to assess patients’ decisional capacity/competency.
18. Discuss the role of the expert witness in medicolegal proceedings.
19. Discuss the importance of proper documentation in medicolegal proceedings.
20. Demonstrate ability to apply ethical principles to resuscitation, including advance directives, decision to forego resuscitation, euthanasia, and organ transplantation.
21. Demonstrate knowledge of cost containment, resource allocation, quality of care and access to care issues.
22. Describe basic principles of medical malpractice.
23. Demonstrate familiarity with managed care plans.
24. Discuss the components of hospital administration and interactions as they relate to emergency medicine.
25. Discuss the components and responsibilities of physician-physician relationships.
26. Demonstrate knowledge of laws regarding reportable diseases, patient care, and patient transfers.
27. Demonstrate knowledge of laws regarding reporting of deaths and appropriate documentation.
28. Discuss laws relating to drug dispensing, regulation, and abuse.

Methods of Goal Achievement:

1. Responsibility as clinical chief resident while on shift in the Emergency Room.
2. Optional responsibility as administrative chief resident to plan resident's schedules, assign selected conference topics, direct monthly resident administrative meeting.
3. Resident demonstration of clinical and administrative skills under direct Emergency Medicine faculty supervision.
4. Attendance at Emergency Medicine lecture series.
5. Attendance at Emergency Medicine faculty meetings.
6. Presentations at Emergency Medicine Trauma Conference.
7. Article presentation, critique, and discussion at Journal Club.
8. Teaching ACLS, ATLS, suture techniques.
9. Teaching third year and fourth year medical students.
10. Consultations with various medical subspecialists.
11. Attendance at Neurology and Trauma rounds.
12. Journal and textbook readings.

Evaluation and Feedback:

1. Bedside evaluation of residents' history and physical examinations, oral presentations, clinical, and procedural skills by Emergency Department attending staff.
2. Written formal evaluation by Emergency Department attending staff.
3. Daily Quality Assurance review of resident's charts.
4. Performance evaluation of resident management of Case Conference patient simulations.
5. Performance evaluation at Journal Club and Trauma Conferences.
6. Evaluation by junior residents.
7. Performance on In-Training Examination.
8. Resident feedback:
 - A. Evaluation at end of rotation.
 - B. Semi-annual resident evaluation.

PEDIATRIC

Longitudinal as detailed under PGY-I Emergency Medicine Block Rotation

Methods of Achieving Goals:

1. Management of patients in the Pediatric ICU.
2. Management of patients on Pediatric Emergency Medicine rotation.
3. Management of patients on Emergency Medicine rotations.
4. Performance of pediatric procedures.
5. Attendance at pediatric rounds and Pediatric Departmental conferences.
6. Attendance at Emergency Medicine lectures in Pediatrics.

Evaluation and Feedback on Goal Achievement:

1. Written formal evaluation by Pediatric attending physician staff.
2. Clinical performance under supervision of the Pediatric attending staff.
3. Resident feedback:
 - A. Evaluation at end of rotation.
 - B. Semi-annual resident evaluation.
4. Performance on In-Training examination.

BEHAVIORAL MEDICINE (PGY I, II, & III, Didactic and Longitudinal)

Goals & Objectives

1. Enhance personal resilience skills as a means of maintaining psychological well-being
2. Develop the skills to build an effective doctor-patient relationship.
3. Develop the skills for interviewing and psychological history taking.
4. Apply the understanding of life-cycles, developmental tasks, and stressors (including family violence) to patient care.
5. Apply the understanding of family systems to patient care.
6. Develop the skills to diagnose common disorders and provide appropriate treatment and counseling plans including adjustment disorders, mood disorders, anxiety disorders, substance abuse disorders, attention deficit disorders, and eating disorders.
7. Develop the skills to effectively interact with patients with personality disorders including antisocial, borderline, compulsive, dependent, histrionic, and passive-aggressive.
8. Develop the skills to provide appropriate stress management plan to deal with the impact of illness within the context of the patient and family system.
9. Develop the skills to perform spiritual assessment when appropriate.
10. Develop an understanding of basic behavioral modification methodologies.
11. Develop an understanding of basic principles for cognitive – behavioral therapy.
12. Develop the skills for counseling those facing death and dying issues.
13. Demonstrate ability to perform a mental status exam in patients with normal and altered mental status.
14. Discuss the indications for emergent psychiatric consultation.
15. Discuss the indications for routine psychiatric consultation.
16. Demonstrate ability to assess suicide risk.
17. Discuss the process of voluntary and involuntary commitment.
18. Discuss the indications for physical and chemical restraint and demonstrate ability to use restraint appropriately.
19. Discuss organic causes of altered mental status including dementia and delirium.
20. Demonstrate ability to differentiate organic and functional causes of altered mental status.
21. Develop an understanding of life-cycles, developmental issues and stressors.
22. Develop an understanding of family systems.
23. Develop an understanding of family violence.
24. Develop an understanding of the basics for brief cognitive and behavioral therapy techniques.
25. Develop familiarity with common psychotherapeutic agents.
26. Develop the skills for literature and/or web searches to provide scientific evidence for beneficial interventions on behavioral topics.
27. Develop the skills for building therapeutic relationships and negotiations with patients.
28. Develop the skills for appropriate communications regarding medical information, dealing effectively with the patient's and/or family's emotional reactions.
29. Develop an understanding for the development of moral and spiritual values.
30. Develop the skills to exercise cultural sensitivity and proficiency.
31. Identify dysfunctional systems and intervene for referral to the appropriate resources.

Methods of Achieving Goals

1. Participation in weekly PGY-1 Resiliency Training group
2. Management of patients in the E.D. presenting with psychological diagnoses
3. Consultation with Psychiatry Dept. staff on patients believed to be suicidal
4. Attendance at EPCDU rounds.
5. Attendance at Emergency Medicine lectures on Psychiatry

Evaluation and Feedback on Goal Achievement:

1. Formal evaluation by E.D. attending physicians.
2. Resident feedback:
 - A. Evaluation at end of rotation.
 - B. Semi-annual resident evaluation.
3. Performance on In-Training examination.

EMS (PGY-I, 2 Weeks)

Goals & Objectives

1. Learn common organizational structures of emergency medical services.
2. Learn the skill levels of various EMS providers.
3. Learn principles of EMS system operations.
4. Learn basic principles of disaster and mass casualty management, including bioterrorism.
5. Learn principals of prehospital triage and emergency medical care delivery.
6. Learn medicolegal principles relating to EMS.
7. Understand EMS system management.
8. Understand local, state and national components of EMS.
9. Participate in EMS quality assurance conferences.
10. Participate as an observer or team member in ground and optional air medical transport systems.
11. Discuss EMS prehospital care protocols.
12. Discuss basic concepts of disaster management.
13. Develop competence in medical base station command.

Methods of Achieving Goals:

1. Simulated and actual radio operator calls.
2. Participation with paramedic ground ambulance units optional participation with helicopter runs.
3. Participation in pre-hospital stabilization.
4. Participation in Quality Assurance conferences and chart review.
5. Optional teaching of paramedics.
6. Attendance at city and county EMS functions.
7. Attendance at Emergency Medicine lectures in EMS.

Evaluation and Feedback on Goal Achievement:

1. Formal written evaluations by preceptors on EMS rotation.
2. Case presentation, participation, and critique at quarterly prehospital care conferences.
3. Resident feedback:
 - A. Evaluation at end of rotation.
 - B. Semi-annual resident evaluation
4. Performance on In-Training examination.

INFECTIOUS DISEASES (PGY-I, 2 weeks)

Overview

Your experience during the patient-care experience on the wards will be process for learning and develop your clinical skills and management of the different infectious diseases. This rotation has been developed based on the ACGME outlined competencies with emphasis on applying them on the infectious diseases patients.

You will be supervised by an Infectious Diseases faculty member. You will also be responsible for assisting the consult team with the initial evaluation of patients with infections and will formulate a plan for their evaluation and treatment, which you will then present to the attending faculty member during rounds.

Learning Resources

Didactic lectures with the attending, bedside rounds on all new consults and hospital follow ups, assigned readings and review articles. During the discussions, physiology, pathogenesis, clinical presentations and natural history of infectious disorders is reviewed. Relevant topics of Up to Date will be assigned. You are also expected to perform routine searches of the medical literature relevant to the patient care issues encounter during your rotation. The hospital provide a wide variety of medical journals available on-line free of charge.

Goals and Objectives

Patient Care

1. Communicate effectively and demonstrate caring and respectful behaviors when interacting with patients and their families.
2. Identify the common and important syndromes in infectious diseases and outline their general management.
3. Learn to focus on the infectious disease differential diagnosis in the appropriate clinical setting.
4. Use the clinical history, laboratory, and X-ray database to derive an infectious disease differential diagnosis for a give patient.
5. Take a careful history including travel, sexual, occupational, and environmental exposures to aid in the differential diagnosis of the patient with suspected infection.
6. Counsel and educate patients and their Families

Medical Knowledge

1. Understand the approach to the febrile patient, including fever of unknown origin.
2. Know immunization recommendations for adults and children.
3. Identify infectious diseases with prominent cutaneous manifestations.
4. Understand the diagnosis and management of HIV as appropriate for the emergency medicine physician.
5. Understand the diagnosis and management of tuberculosis and interpretation of PPD skin testing.
6. Have knowledge of CNS infections diagnosis and treatment, including bacterial meningitis, the aseptic meningitis syndrome, and encephalitis.
7. Recognize and manage soft tissue infections, including cellulites and necrotizing fasciitis.
8. Identify major infection control procedures for communicable diseases.
9. Manage bacteremia.
10. Know how to diagnose and treat endocarditis.
11. Know the diagnosis and treatment of sexually transmitted diseases including syphilis, gonorrhea, Chlamydia, genital herpes, and trichomoniasis.

12. Know how to manage septic arthritis and osteomyelitis.
13. Manage upper and lower respiratory infections.
14. Know the diagnosis and treatment of gastrointestinal and intra-abdominal infections and hepatitis.
15. Manage urinary tract infections.
16. Know the rational use of the clinical microbiology laboratory.
17. List one or two reasonable antibiotic choices if given a clinical scenario and identify the major toxicities of each antibiotic chosen.
18. List the major infectious pathogens for a given clinical scenario.
19. Select appropriate antibiotic(s) for a given infection or clinical scenario, be able to justify use and list major side effects.
20. Perform and interpret Gram stains.

Practice Base Learning and Improvement

1. Search and integrate evidence of scientific studies related to their patients infectious health problems
2. Using a systematic methodology residents will apply practice base improvement activities to develop and implement treatment plans to help manage patients with infectious diseases
3. Support their own education with the use of on line medical journals and technology to be able to improve or contribute in improving patient care.
4. Search information based on their diverse patient population census.

Interpersonal and Communication Skills

1. Communicate the diagnosis, treatment plan and follow up care with sensibility and empathy to the patients and family
2. Develop an ethically based relationship with patients and family to be able to give the best therapeutic care.
3. Respect patient confidentiality for sensitive issues
4. Work effectively with medical students, residents from other services, consultants and nursing staff
5. Have recognition of stigma associated with certain infections (tuberculosis, STD's, HIV) so that patients' unspoken fears and concerns can be addressed.

Professionalism

1. It is expected that the resident will arrive on time everyday and be dressed in professional attire.
2. Demonstrate respect, compassion, integrity, and empathy to every patient
3. Be committed to the ethical principles in all aspects of clinical care, confidentiality of patient information and informed consent
4. The resident should be sensitive and respond to the patient's culture, gender, age and disabilities.

5. Overcome stereotyping and negative attitudes toward patients with HIV/AIDS.

System Based Practice

1. Residents will learn to develop, implement and evaluate treatment plans for infectious diseases patients
2. Will learn when to obtain consultations from infectious diseases specialists
3. Will develop the ability to select the most cost effective treatment plans for infectious diseases patients always meeting the national quality standards
4. Residents will learn the different roles of the local health department
5. Learn to advocate for quality patient care

Methods of Achieving the Goals

1. Management of patients in the Emergency Department and the Infectious Diseases Ward
2. Management of patients on the Emergency Department Rotations
3. Attendance at teaching rounds and Infectious diseases conferences
4. Attendance at Emergency Medicine lectures on infectious diseases.

Evaluation and Feedback on Goal Achievement :

1. Formal evaluation by Infectious Diseases attending physician staff.
2. Resident feedback:
 - A. Evaluation at the end of rotation
 - B. Semi- annual resident evaluation.
3. Performance on In- Training examination

INTERNAL MEDICINE (PGY-I, 4 weeks)

General description of the rotation including educational purpose, rationale or value:

The General Medicine teams form the basis of inpatient medical services. Patients are admitted from the emergency room, medical clinics or private physicians' offices. Residents care for patients with a broad variety of medical illnesses under the guidance of full-time faculty. Through the use of patient care rounds and teaching rounds by the attending, residents learn the basic and advanced clinical skills necessary for internal medicine. Emphasis is placed on cost containment, medical ethics and preventative medicine when applicable. Residents are encouraged to use computer applications to obtain current citations to answer their questions about disease processes and clinical management.

Resident responsibilities and Supervision:

The resident team is supervised by the attending physician. The resident is expected to function as the supervisor of all other members of the team and guide the clinical care of the patients and the educational development of the interns and students. The interns have primary care responsibility for all patients admitted to them, including a complete history and physical examination, daily progress notes, documentation of all procedures. All residents are expected to attend Morning Report, Continuity clinic and Core Conference.

Residents are expected to read the material from the reading list. Readings are assigned for each month of wards and at each resident level. They will be posted prior to the beginning of the rotation.

Educational Objectives: An expanded version of the competencies is listed under Core Competencies in Internal Medicine. Those listed here are specific to this rotation.

During this rotation, the resident will:

Patient Care

1. Develop increasing independence in patient evaluation and management.
2. Admit up to 5 patients in 24 hours (or 8 in 48 hours); detailing comprehensive history, physical examination, evaluation and management plan.
3. Write daily progress notes for all patients assigned to the intern.
4. Develop efficiency in providing cross-coverage to patients cared for by other interns and on other teams.
5. Evaluate the causes of and initiate the appropriate diagnostic and therapeutic processes for the following common medical conditions in hospitalized patients: chest pain, dyspnea, headache, delirium, coma, abdominal pain, fever, rashes, edema, nausea/vomiting, diarrhea, hematemesis, hematochezia, cough, arthritis, and weakness.

Medical Knowledge

1. Expand knowledge base in internal medicine.
2. Begin certification in diagnostic procedures, e.g., thoracentesis, paracentesis, joint aspiration, lumbar puncture, arterial puncture for arterial blood gas determination and therapeutic procedures, e.g., central line placement.
3. Become familiar with the causes, diagnostic processes and treatment procedures for the medical conditions listed in Patient Care.
4. Read the assigned readings for the rotation and take the test.

Practice-Based Learning

1. Locate, appraise, and assimilate evidence from scientific studies related to their patients' health problems

Interpersonal and Communication Skills

1. Enhance their leadership, interpersonal and teaching skills.

Professionalism

System-Based Practice

1. Practice cost-effective health care and resource allocation that does not compromise quality of care.
2. Advocate for quality patient care and assist patients in dealing with system complexities.
3. Partner with health care managers and health care providers to assess, coordinate, and improve health care through interdisciplinary rounds.

Check all principal teaching methods used during this rotation:

- Attending teaching and management rounds
- Patient Management discussions
- Individual instruction of procedures
- Review of diagnostic studies, including radiology
- Other: _____

Describe the most important educational content, including the mix of diseases, patient characteristics, types of clinical encounters, procedures and services:

Residents care for patients with a broad mix of general medical illnesses. The service attending is the physician of record for patients without a designated physician who comprise much of the service. The service attending teaches on all patients. Clinical encounters include bedside rounds, work rounds, attending rounds, direct primary care by R-1's and clinical evaluation and supervision by upper level residents. Procedures are done by R-1's when appropriate under the guidance and supervision of a certified resident and the attending.

Check the principal ancillary education materials used:

- Reading lists
- Radiologic studies
- Other noninvasive studies
- Core conferences
- Pathologic material

Methods used to evaluate the resident and the rotation:

- Evaluation of resident performance by attending
- Evaluation of attending teaching skills and other attributes by resident
- Review of the resident's history/physical exam, progress notes and documentation of procedures in the chart.
- Mini CEX
- Resident's attendance of rounds and conferences monitored
- Evaluation of resident performance by peers

NEUROTRAUMA (PGY-III, 4 Weeks)

Goals & Objectives:

1. Describe the systematic assessment of polytrauma patients.
2. Rank management priorities in polytrauma patients appropriately.
3. Discuss principles of resuscitation of polytrauma patients including appropriate fluid resuscitation, and explain the anticipated effects of shock and resuscitation on fluid shifts and electrolyte balance.
4. Name an initial choice for intravenous fluids for a newly admitted Intensive Care Unit (ICU) patient with the following diagnoses and explain changes in that choice based upon specific changes in the patient's diagnosis, clinical condition, electrolyte and volume status:
 - C. head injury
 - D. stroke
 - E. tumor
 - F. infection
 - G. hydrocephalic
5. Propose appropriate initial ventilator settings for patients with different types of common neurosurgical conditions and explain changes in that choice based upon specific changes in the patient's metabolic or pulmonary status.
6. List the mechanisms of action and potential complications of commonly used pressors and hypotensive agents.
7. Discuss indications, pharmacologic mechanism, duration of action, and effect on the neurologic examination for sedative, paralytic, and analgesic agents commonly used in the ICU.
8. Explain the indications, advantages, and risks for various hemodynamic monitoring tools (e.g., pulmonary artery catheters, indwelling arterial lines) used in critically ill patients.
9. Discuss the pathophysiology and management of coagulopathy after head injury.
10. Describe basic principles of nutritional management in neurosurgical critical care.
11. Explain the treatment of posttraumatic seizures.
12. Outline basic principles of ICU management of patients with spinal cord injury.
13. Name the major structures supplied by the major vessels of the brain and spinal cord.
14. Discuss the evaluation, treatment, and prognosis of subarachnoid hemorrhage, both traumatic and spontaneous.
15. Explain the pathophysiology and treatment of cerebral vasospasm.
16. Formulate a diagnosis and treatment plan for patients with cerebral ischemia.
17. Explain the evaluation and management of birth-related intracranial hemorrhage, spinal cord injury, and brachial plexus injury.
18. Describe a systematic approach to the examination of the peripheral nervous system.
19. Describe the basic principles of management of peripheral nerve injuries.
20. List principles of rehabilitation of different types of neurosurgical patients.
21. Define brain death and discuss methods of making such a diagnosis.
22. Describe the pathophysiology of electrical injuries to the nervous system and review treatment of same.

Methods of Achieving Goals:

1. Management of patients in the Emergency Department and Stroke Unit.
2. Management of patients on the Emergency Medicine rotation.
3. Attendance at teaching rounds and Neuroscience conferences.
4. Attendance at Emergency Medicine lectures on Neuro Trauma.

Evaluation and Feedback on Goal Achievements:

1. Written formal evaluation by Neurosurgical attending physician staff
2. Resident feedback:
 - A. Evaluation at end of rotation.
 - B. Semi-annual resident evaluation.
3. Performance on In-Training examination.

OBSTETRICS/GYNECOLOGY

Site: Florida Hospital Medical Center

Director: Mark Crider, MD

Length: Four week block

The Emergency Medicine residents rotate in the Obstetrics and Gynecology (Ob/Gyn) service at the EM1 level. The program is extremely pleased with the educational opportunities offered to the Emergency Medicine residents as they rotate through this service. The purpose, educational objectives, methods, resident responsibilities, educational materials, as well as interdepartmental relationships are outlined below. These objectives will be accomplished by way of direct patient care, evaluation of patients as they are admitted and within the emergency department, daily supervisory rounds in which specific patients and illnesses are discussed, weekly grand rounds, as well as formal daily conferences devoted to specific subject matters. Upon completion of the month's rotation, residents will receive written evaluations from the attending staff. These evaluations will focus specifically on patient assessment and management skills, as well as completion of educational objectives. The focus of the end of rotation evaluations will be the completion of Core Competency objectives. The Program Director and Assistant Program Director will review all evaluations and make them available to the resident during regular business hours.

Purpose

1. Learn the anatomy, pathophysiology, presentation, and management of common Obstetrics and Gynecology system disorders.
2. Develop skills in the performance of screening and detailed evaluation of Obstetrics and Gynecology patients.
3. Develop skills in the use and performance of diagnostic procedures in the evaluation of Obstetrics and Gynecology patients.
4. Integrate components of the ACGME-defined Core Competencies into the resident's practice of emergency medicine, including patient care, expanded medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice.

Educational Objectives

Patient Care

1. Gather accurate, essential information in a timely manner from all sources, including medical interviews, physical examinations, medical records, and diagnostic/therapeutic procedures.
2. Integrate diagnostic information and generate an appropriate differential diagnosis.
3. Competently perform obstetrics and gynecology therapeutic procedures considered essential to the practice of emergency medicine.
4. Demonstrate ability to appropriately prioritize and stabilize multiple patients and perform other responsibilities simultaneously.

Medical Knowledge

1. Demonstrate ability to adequately perform gynecologic history and exam.

2. Discuss pathophysiology and clinical presentation of the following conditions:
 - a. abnormal vaginal bleeding
 - b. pelvic inflammatory disease
 - c. sexually transmitted diseases
 - d. vaginal discharge
 - e. acute and chronic pelvic pain
 - f. ectopic pregnancy
 - g. hydatidiform mole
 - h. hyperemesis gravidarum
 - i. premature rupture of membranes
 - j. pre-eclampsia / eclampsia
 - k. placenta previa
 - l. abruptio placenta
 - m. third trimester vaginal bleeding
 - n. ovarian torsion
 - o. Contraceptive methods
 - p. culdocentesis
3. Demonstrate ability to adequately perform vaginal deliveries in the various presentations.
4. List the indications for cesarean section and for post-mortem cesarean section.
5. Discuss the clinical characteristics and emergency management of incomplete, threatened, and complete abortion.
6. Demonstrate ability to diagnose postpartum complications including retained products, endometritis, and mastitis.
7. Discuss the adequate procedure in the evaluation of sexual attack victims.

Practice – Based Learning

1. Locate, appraise, and assimilate evidence from scientific studies related to the health problems of their patients
2. Obtain and use information about their own population of patients and the larger population from which the patients are drawn
3. Apply knowledge of study designs and statistical methods to the appraisal of clinical studies and other information on diagnostic and therapeutic effectiveness
4. Use information technology to manage information, access online medical information, and support their own education
5. Facilitate the learning of students and other health care professionals

Professionalism

1. Arrive on time and prepared for work
2. Appropriate (inoffensive) dress and cleanliness
3. Appropriate use of symptomatic care
4. Complete medical records honestly and punctually
5. Treat patients/family/staff/paraprofessional personnel with respect
6. Protect staff/family/patient's interests/confidentiality
7. Demonstrate sensitivity to patient's pain, emotional state, and gender/ethnicity issues
8. Actively seek feedback and immediately self-corrects
9. Unconditional positive regard for the patient, family, staff, and consultants
10. Accept responsibility/accountability
11. Open/responsive to input/feedback of other team members, patients, families, and peers
12. Uses humor/language appropriately

Interpersonal and Communication Skills

1. Demonstrate ability to perform adequate history and physical examinations in patients with obstetrics and gynecology disorders.
2. Demonstrate the ability to respectfully, effectively, and efficiently develop a therapeutic relationship with patients and their families
3. Demonstrate respect for diversity and cultural, ethnic, spiritual, emotional, and age-specific differences in patients and other members of the health care team
4. Demonstrate effective listening skills and be able to elicit and provide information using verbal, nonverbal, written, and technological skills
5. Demonstrate ability to develop flexible communication strategies and be able to adjust them based on the clinical situation
6. Demonstrate effective participation in and leadership of the health care team
7. Demonstrate ability to negotiate as well as resolve conflicts
8. Demonstrate effective written communication skills with other providers and to effectively summarize for the patient upon discharge
9. Demonstrate ability to effectively use the feedback provided by other

Systems- Based Practice

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

Methods of Achieving Goals and Objectives

1. Management of patients in OB/GYN Outpatient Clinic.
2. Management of patients in Labor and Delivery.
3. Management of sexual assault patients in the Crisis Center.
4. Management of patients on Emergency Department rotations.
5. Attendance at OB/GYN rounds.
6. Attendance at Emergency Medicine lectures.

Resident Responsibilities

The program has designed a four-week rotation in the Obstetrics and Gynecology Department at the Florida Hospital Medical Center. The Emergency Medicine (EM) residents will:

1. Spend four weeks with the Ob/Gyn team and will participate in direct patient care under attending supervision at all times.
2. Have the same duties and responsibilities as a first year resident of the Family Medicine residency program while rotating Ob/Gyn service.
3. Be assigned to the obstetrics evaluation room, areas of acute care and evaluation.
4. Be on duty as frequently as any Family Medicine PGY-I.
5. Attend lectures, journal clubs and other academic activities of the Department during the rotation. The trainee is encouraged to actively participate in these activities.

6. Attend the EM program academic activity scheduled every Thursday at 7:00 a.m. The Department of Obstetrics and Gynecology be informed in advance in case of any additional EM academic activities to which the resident must attend.
7. EM 1 Residents will spend one week in night float system while rotating through Ob/Gyn rotation. During that week, and that week only, EM 1 in Ob/Gyn rotation will be excused from the EM program academic activity.
8. EM 1 residents are to follow duty hours rules as specified by ACGME guidelines. It is the responsibility of the Emergency Medicine resident to notify the Emergency Medicine Program Director of potential duty hours violations in order to avoid possible disciplinary action. This will also be monitored through the New Innovations online system.
9. Be called on short notice for duty at the Florida Hospital ED in case of an emergency or special situation due to an impending or developing disaster.
10. Residents are required to keep a log of the procedures done in this rotation in New Innovations online system.

Educational Material

1. Residents attend Emergency Medicine conferences in which the Obstetrics and Gynecology curriculum is incorporated. Additionally, the Obstetrics and Gynecology attending will review specific topics during the rotation.
2. The education resources and facilities of the Florida Hospital Medical Center will be available to each resident. These resources include the medical library, including books and periodical reference materials, abstract and literature research services, as well as audio-visual references. Additionally, the medical records department will be available to the resident for completion of charts and chart reviews.
3. Residents will also be required to complete the following reading requirements throughout the Ob/Gyn rotation
 - a. Rosen's Emergency Medicine 7th Ed: Chapters 96,98,175-179
 - b. Roberts and Hedges, Clinical Procedures in Emergency Medicine , 5th Ed: Chapters 56-59
 - c. Other optional readings are:
 - i. Tintinalli's Emergency Medicine, 7th Ed: Chapters 99-109
 - ii. Carol River's Written Board Review for Emergency Medicine 6th Ed: Urogenital Emergencies section

Evaluation

The Obstetrics and Gynecology faculty will evaluate EM residents using the evaluation form provided by the Emergency Medicine Department. Close interaction with supervisors is encouraged in order to maximize learning experiences. The evaluation sheet will be forwarded at the end of the rotation to the Obstetrics and Gynecology Department office. It will then be returned to the EM Department at the FH East Orlando. Obstetrics and Gynecology Department faculty is encouraged to notify Program Director or Assistant Program Director of any difficulties with an EM resident as soon as these arise, preferably **within the first two weeks** of the rotation.

In order to pass a rotation, the resident must earn an average score of three (3) (A score of 3 equals "Meets expectations") or higher in each of the following six general competencies: patient

care, medical knowledge, practice-based learning, interpersonal and communication skills, professionalism, and systems-based practice. A resident who receives two (2) “marginally meets expectations” (assigned score 2) or “fails to meet expectations” (assigned score 1) **WILL NOT** pass the rotation, regardless of how high the other scores may be

Each resident’s knowledge will be tested throughout the year specifically with their performance on In-Training examination, simulation performance, procedural competencies and content specific questions throughout the academic year.

Feedback

The Program Director and/or Assistant Program Director are responsible of notifying residents of any problems noted as soon as possible. Written/online evaluations are available for formal review with the residency director at semi-annual progress meetings. At the end of the rotation, the resident will evaluate the strengths and weaknesses of the Obstetrics and Gynecology rotation using the “Clerkship Evaluation Form” available through New Innovations. Feedback will also be given in a semi-annual resident evaluation.

OPHTHALMOLOGY (PGY-I, 1 Week)

Goals & Objectives:

1. Develop relevant history and physical ophthalmological examination skills.
2. Learn to recognize and treat emergent causes of visual loss.
3. Learn the principles of ocular trauma management.
4. Learn the evaluation and management of common ophthalmologic complaints.
5. Demonstrate an understanding of normal ocular anatomy.
6. Demonstrate ability to perform an ocular exam.
7. Recognize and discuss the differential of abnormal funduscopy findings.
8. Demonstrate the technique of slit lamp examination.
9. Demonstrate ability to measure intraocular pressures.
10. Demonstrate ability to patch an eye.
11. Demonstrate knowledge of the dosages, indications and contraindications of topical and systemic ophthalmologic medications.
12. Discuss the differential diagnosis of acute loss of vision.
13. Discuss the differential diagnosis and demonstrate correct evaluation of patients presenting with a painful eye.
14. Discuss the differential diagnosis and demonstrate correct evaluation of patients presenting with a red eye.
15. Demonstrate ability to evaluate and manage chemical injuries of the eye.
16. Demonstrate ability to evaluate and manage blunt and penetrating trauma to the eye and surrounding tissues.
17. Demonstrate ability to evaluate and manage ocular foreign bodies.
18. Discuss the presenting signs, symptoms and management of acute angle closure glaucoma.
19. Discuss the presenting signs, symptoms and management of orbital and periorbital cellulitis.
20. Describe and identify the various patterns seen on fluorescein staining of the eye.
21. Discuss the ocular manifestations of systemic disease.
22. Discuss the indications for emergent ophthalmologic consultation.
23. Discuss the indications for routine ophthalmologic consultation.

Methods of Achieving Goals:

1. Management of patients in the Eye Clinic.
2. Management of patients on Emergency Department rotations.
3. Performance of ophthalmological procedures.
4. Attendance at Ophthalmology Rounds.
5. Attendance at Emergency Medicine lectures in Ophthalmology.

Evaluation and Feedback on Goal Achievement:

1. Written formal evaluation by Ophthalmology attending physician staff.
2. Written evaluation by Emergency Department attending physician staff.
3. Performance of procedures under supervision.
4. Resident feedback:
 - A. Evaluation at end of rotation.
 - B. Semi-annual resident evaluation.
5. Performance on In-Training examination.

ORAL & MAXILLOFACIAL SURGERY (PGY I, 1 Week)

Goals & Objectives:

1. Become familiar with the diagnosis and treatment of common oral surgery problems, including:
 - A. Dental caries.
 - B. Alveolar abscess.
 - C. Infections of oral mucosa; viral, bacterial, fungal
 - D. Oral and maxillofacial trauma.
 - E. Oral neoplasia.
2. Develop expertise in the following skills:
 - A. Regional nerve blocks.
 - B. Plastic closure of intraoral and circumoral lacerations
 - C. Interpretation of diagnostic radiologic studies for facial tractures.
 - D. Pharmacological intervention with systemic and topical agents.
3. Develop relevant history and physical exam skills.
4. Learn the evaluation and management of common problems of the head and neck.
5. Learn the evaluation and management of facial trauma.
6. Develop skill in the evaluation and management of upper airway disorders.
7. Learn use of the diagnostic imaging modalities available for evaluation of head and neck disorders.
8. Demonstrate ability to correctly perform a history and physical in patients with disorders of the head, ears, nose, pharynx, neck and larynx.
9. Demonstrate ability to diagnose and treat infections of the head and neck including rhinitis, otitis, labyrinthitis, sinusitis, mastoiditis, laryngitis, pharyngitis, epiglottitis, stomatitis, and gingivitis.
10. Demonstrate ability to control anterior and posterior epistaxis including placement of nasal packing.
11. Demonstrate ability to diagnose and treat disorders of the tympanic membrane and middle ear perforation.
12. Demonstrate ability to perform incision and drainage of oropharyngeal abscesses.
13. Demonstrate knowledge of common dental emergencies and indications for emergent referral.
14. Demonstrate ability to evaluate and manage disorders of the mandible, including fractures, dislocations, and infections.
15. Demonstrate ability to evaluate and manage trauma to the head, neck, face, teeth.
16. Demonstrate ability to diagnose and treat disorders of the salivary glands.
17. Demonstrate ability to remove foreign bodies from the ears, nose and throat.
18. Demonstrate ability to perform direct, indirect and fiberoptic laryngoscopy.
19. Demonstrate knowledge of the indications, contraindications and complications of surgical airway techniques and demonstrate ability to perform a cricothyroidotomy.
20. Demonstrate ability to obtain airway control in patients with major facial trauma.
21. Demonstrate ability to perform facial nerve blocks including supraorbital, infraorbital, mental, auricular and dental blocks.

22. Demonstrate knowledge of uncommon but life threatening infections of the head and neck including cavernous sinus thrombosis, Ludwig's angina, and malignant otitis.

Methods of Achieving Goals:

1. Management of patients in the Oral Surgery Clinic.
2. Management of patients on Emergency Department rotations.
3. Attendance at Oral Surgery rounds and Oral Surgery Departmental conferences.
4. Attendance at Emergency Medicine lectures in Oral Surgery.

Evaluation and Feedback on Goal Achievement:

1. Written formal evaluation by Oral & Maxillofacial Surgery attending physician staff.
2. Resident feedback:
 - A. Evaluation at end of rotation.
 - B. Semi-annual resident evaluation.
3. Performance on In-Training examination.

PEDIATRIC EMERGENCY MEDICINE (PGY I, II, & III)

We have this included in the EM Block Rotations earlier in the curriculum.

RADIOLOGY SERVICE (PGY I, II & III, Longitudinal)

Goals & Objectives

1. Develop the ability to select and interpret a wide variety of radiologic images.
2. Learn use of the diagnostic imaging modalities available to the radiologic specialist such as contrast material, ultrasound, nuclear medicine, computed tomography and magnetic resonance imaging (MRI).
3. Describe how conventional radiographic projections are defined (i.e. A.P., P.A., etc.).
4. Learn to distinguish a nutrient artery from a fracture.
5. Describe the five classifications of Salter-Harris fractures.
6. Develop the ability to know how and when skull and facial films are indicated and how to interpret them.
7. Demonstrate the ability to evaluate cervical spine radiographs (i.e. lines of integrity, open mouth, prevertebral space, pseudosubluxation of C2-C3).
8. Describe the abnormality mechanism, and radiographic findings of the following fractures: hangman's, clay shoveler's, compression or wedge, teardrop, odontoid, and Jefferson ("burst").
9. Review the anatomy of the thoracic and lumbosacral spine on A.P. and lateral.
10. Demonstrate the ability to interpret a normal chest x-ray.
11. Describe the significance of upper, lower, and pediatric rib fractures.
12. Describe some of the classic findings for pulmonary edema, emboli, and ARDS.
13. Review normal anatomy as seen in abdominal, upright plain films.
14. Review the normal anterior, posterior, and lateral pelvic anatomy.
15. Review the normal skeletal anatomy of the upper extremity and lower extremity, alone with common fractures.
16. Demonstrate knowledge of contrast medium reactions and methods of prophylaxis and prevention.
17. List an indication for barium enema in the Emergency Department.
18. Describe the study of choice for evaluating patients with possible traumatic rupture of the aorta and when it is ordered.
19. Discuss an approach to evaluate the lower extremities in the diagnosis of deep venous thrombosis.
20. Describe how ultrasound is used in diagnosing appendicitis.
21. Review the normal CT anatomy of the head and its inner structure along with subdural, epidural, SAH, and contusions.
22. Review the normal CT anatomy of the chest, abdomen, and pelvis.
23. Describe in basic terms how nuclear medicine imaging is done.
24. Discuss when the bone scan is most useful in diagnosing osteomyelitis.
25. Choose the clinical situation in which MRI is useful in the Emergency Department.
26. Describe in basic terms how MRI functions and any hazards of its use.

Methods of Achieving Goals:

1. Evaluation of radiographs on Emergency Medicine rotations.
2. Evaluation of radiographs and other diagnostic modalities while on Emergency Department rotation.
3. Attendance at Radiology teaching rounds and lectures.
4. Attendance at Emergency Medicine lectures in radiology.

Evaluation and Feedback on Goal Achievement:

1. Written, formal evaluation as part of Emergency Medicine rotations by Emergency Medicine attending physician staff.
2. Performance on In-Training examination.

RESEARCH (PGY-III, 2 Weeks)

Goals & Objectives

1. Demonstrate the skills necessary to write a publishable manuscript by completing a research project.
2. Understand methods of hypothesis development and testing.
3. Understand various types of study design and methodology.
4. Learn various methods of obtaining consent for biomedical research.
5. Understand basic statistical methods.
6. Learn techniques of analyzing biomedical research.
7. Understand the ramifications of ethical considerations in research.
8. Learn the skills to develop a manuscript that is acceptable for publication in a peer-reviewed journal.
9. Understand grantsmanship and funding of research.
10. Demonstrate an understanding of the advantages and disadvantages of various study designs, including the randomized clinical trial, case-control, cohort, and cross-sectional studies.
11. Demonstrate an understanding of null and alternative hypotheses.
12. Demonstrate an understanding of the practical and ethical ramifications of implied and non-implied consent as they apply to hospital and pre-hospital research.
13. Understand the differences between interval, ordinal, nominal, parametric, and non-parametric data.
14. Understand the differences between independent and dependent variables.
15. Demonstrate an understanding of methodologies and variable types analyzed by the following statistical tests: t-test, analysis of variance, chi-squared, Fischer exact test, and non-parametric tests for interval and nominal data.
16. Demonstrate an understanding of the terms “paired” and “tailed” (one and two).
17. Demonstrate an understanding of type I and type II errors as they relate to sample size and variance.
18. Demonstrate an understanding of alpha, beta, and statistical power.
19. Demonstrate an understanding of the differences between statistical and clinical significance.
20. Define sensitivity, specificity, positive predictive value, and negative predictive value.
21. Define mean, median, mode, standard deviation, and variance.
22. Demonstrate an understanding of confidence intervals.
23. Describe correlation and regression to the mean.
24. Discuss the advantages of single- and double-blind studies.
25. Demonstrate facility with at least one computer statistical program.
26. Demonstrate an understanding of basic ethical issues in research including consent and researchers’ interactions with corporate funding sources.
27. Demonstrate an understanding of research funding.

Methods of Goal Achievement:

1. Attendance at Emergency Medicine lecture and research series.
2. Article presentation, critique, and discussion at Journal Club.
3. Presentations at Emergency Medicine Trauma Conference and Multidisciplinary Trauma Conference.
4. Journal and textbook readings.
5. Research project.

PRACTICE MANAGEMENT (PGY-III, 2 Weeks)

GOAL: To expose residents to the administrative aspect of Emergency Medicine and research methodology.

During the rotation, the resident is expected to:

1. Attend four predetermined administrative meetings which may include:
 - ED clinical standard
 - Florida Hospital Pharmaceutical and Therapeutic Committee
 - ED Medical Directors and Leadership
 - Florida Hospital East Orlando Patient Safety and Quality Assurance
 - Medical Ethics
 - Medical Informatics or ED IT
 - Acute Coronary Syndrome
2. Perform eight (8) junior attending teaching ED shifts. This role includes:
 - Clinical teaching of medical students and interns
 - Engage in a leadership role during ED work rounds
 - On call for ED
 - Coordinate the weekly lecture series and logistic with the chief residents or the Program Directors
3. Complete or start finalizing current research projects:
 - Attend a meeting with Research coordinator and Florida Hospital GME Research Director
 - Give a 30 minutes lecture on research methodology assigned by the Research Coordinator
 - Attend an exit interview with the research coordinator

Goals & Objectives

The resident shall obtain the body of knowledge and skills necessary to choose a practice location, evaluate a contract, efficiently manage a physician's practice, and negotiate with managed care organizations.

1. Procedures for establishing a practice:
 - A. Developing a personal mission statement
 - B. Preparing a CV
 - C. Choosing a practice group
 - D. Choosing a community (personal and professional)
 - E. Interviewing
 - F. Checklist and general timetable of application and forms to be completed prior to entering practice, i.e., privileges, business cards, Medicare provider number, etc.

- G. Negotiating with managed care organizations for employment
- H. Evaluating a contract
- 2. Practice Facilities:
 - A. Location
 - B. Design and cost
 - C. Equipment
 - D. Inventories and supplies
- 3. Office Organization:
 - A. Types of practice, i.e., solo, corporation, partnership, association, pre-paid plans
 - B. Other systems of health care delivery
 - C. Forms
 - D. Inventories and supplies
 - E. Assignment duties
- 4. Office and business management:
 - A. Practice accounting
 - I. Reading/understanding financial statements
 - II. General understanding of two column accounting
 - B. Monitoring profitability
 - I. Cash flow
 - II. Cost analysis
 - III. Financing
 - IV. Operating practices
 - V. Accounts receivable
 - VI. Incoming splitting
 - C. Ancillary services
 - D. Personal financial planning
 - I. Retirement planning and savings
 - II. Insurance issues: life, disability, overhead, umbrella, etc.
 - III. Budget
 - IV. Investing
- 5. Computer utilization:
 - A. Clinical applications
 - B. Business
 - C. Practice analysis (QM) and research
- 6. Personnel Management:
 - A. Employee relationships
 - I. Salaries
 - II. Benefits
 - III. Employee motivation
 - IV. Employee recruitment, retention and discharge
 - V. Accountability
 - B. Job descriptions
 - C. Labor laws and Federal regulations
 - D. Personnel records
- 7. Patient management:
 - A. Patient education

- B. Consultation and referrals
- C. Processing patients – ICD-9-CM and CPT Coding
- 8. Medical-legal aspects of practice:
 - A. Professional liability insurance
 - B. Relationships with legal profession
 - C. Giving a deposition
 - D. Governmental regulations
 - I. CLIA
 - II. OSHA
 - III. ADA
 - III. Medicare fraud and abuse rules
- 9. Hospital issues:
 - A. Selection of hospitals
 - B. Staff appointment and privileges
 - C. Medical staff and departmental responsibilities

Skills:

The resident should develop skills in:

1. Selection of practice type (involves decisions on life-style, residence location and professional interrelationships)
2. Prudent selection and utilization of advisors and vendors
3. Personnel management and delegation of responsibilities
4. Computer competency
5. Time management
6. Personal and public (oral and written) communication
7. Resources management
8. Income slitting and expense allocation

ORTHOPEDIC TRAUMA (PGY II, 4 Weeks)

Goals & Objectives

1. Develop relevant history and physical exam skills.
2. Learn use of the diagnostic imaging modalities available for the evaluation of orthopedic disorders.
3. Develop skill in the evaluation and management of musculoskeletal trauma.
4. Develop skill in the diagnosis and treatment of inflammatory and infectious disorders of the musculoskeletal system.
5. Learn principles of acute and chronic pain management in patients with musculoskeletal disorders.
6. Develop ability to correctly perform a history and physical in patients with musculoskeletal disorders.
7. Demonstrate ability to correctly order and interpret radiographs in patients with orthopedic injuries.
8. Demonstrate understanding of the anatomy, mechanism of injury, presentations, complications, management and prognosis of common musculoskeletal injuries.
9. Demonstrate knowledge of standard orthopedic nomenclature.
10. Demonstrate knowledge of appropriate aftercare and rehabilitation of orthopedic injuries.
11. Demonstrate knowledge of the differences in pediatric and adult skeletal anatomy and indicate how those differences are manifest in clinical and radiographic presentations.
12. Demonstrate ability to apply orthopedic devices, including compressive dressings, splints and immobilizers.
13. Demonstrate skill in performance of the following procedures: fracture/dislocation immobilization and reduction, arthrocentesis, extensor tendon repair.
14. Demonstrate ability to prioritize and manage the treatment of orthopedic injuries in multiple trauma patients.
15. Describe the presentation of patients with inflammatory and infectious disorders and demonstrate ability to diagnose and treat them.
16. Demonstrate ability to diagnose and treat soft tissue foreign bodies.
17. Describe the presentations, complications, diagnosis, management and prognosis of patients with human and animal bites.
18. Describe the presentations, complications, diagnosis and management of compartment syndromes.
19. Demonstrate ability to provide regional anesthesia, including hematoma blocks, Bier blocks and radial, ulnar median, axillary, posterior tibial and sural nerve blocks.
20. 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.
21. Discuss the dosages, indications, contraindications, side effects and relative potency of standard oral analgesics used in treatment of patients with musculoskeletal disorders.
22. Discuss the differential diagnosis, historical features, physical and examination findings of patients with low back pain.

23. Demonstrate ability to recognize and treat soft tissue infections involving muscle, fascia, and tendons.
24. Describe diagnosis and treatment of overuse syndrome.
25. Describe how to evaluate and preserve amputated limb parts.
26. Demonstrate knowledge of joint injuries, evaluation and grading of joint injuries, treatment of joint injuries and prognosis.
27. Discuss evaluation and treatment of soft tissue injuries such as strains, penetrating soft tissue injuries, crush injuries, and high-pressure injection injuries.

Methods of Achieving Goals:

1. Management of patients on Orthopedic Trauma /Sports Medicine rotation.
2. Management of patients on Emergency Department rotations.
3. Management of patients with orthopedic trauma on the Trauma Service.
4. Performance at splinting and casting workshops and demonstrations.
5. Attendance at Emergency Medicine lectures in orthopedics.

Evaluation and Feedback on Goal Achievement:

1. Written formal evaluation by Orthopedic attending physician staff.
2. Resident feedback:
 - A. Evaluation at end of rotation.
 - B. Semi-annual resident evaluation.
3. Performance on In-Training examination.

GENERAL SURGERY (PGY-I, 4 Weeks)

The General Description of the Rotation

The general surgery rotation consists of 4 weeks of an immersive experience in caring for the general surgical patient. It is expected that during these weeks the resident will be focused on the history taking, physical exam, differential diagnosis, appropriate investigation and management of the patient. This will include pre-operative assessment, intra-operative considerations and post operative care. It will be expected that the resident is able to follow a patient on their journey from admission to surgery and immediate post op care, as well as an office follow up after discharge from the hospital.

Goals & Objectives

1. Develop skill in the overall assessment of the general surgical patient.
2. Develop familiarity with common general surgical disorders.
3. Develop procedural skills relevant to general surgery.
4. Learn indications for consultation and surgical intervention in patients with acute abdominal pain.
5. Learn the principles of care of the pre and post-operative patient.
6. Demonstrate ability to perform an appropriate history and physical exam in patients with general surgical disorders, including an appropriate preoperative evaluation.
7. Discuss the differential diagnosis of acute abdominal pain and demonstrate ability to evaluate, treat and obtain appropriate consultation.
8. Demonstrate ability to diagnose and treat common disorders of the breast.
9. Demonstrate ability to diagnose and treat common disorders of the anus and rectum.
10. Demonstrate ability to perform common procedural skills including gastric intubation, tube thoracostomy, placement of central venous lines, wound closure and abscess incision and drainage.
11. Demonstrate ability to assist in the operative and perioperative therapy of surgical patients.
12. Discuss the common fluid and electrolyte disturbances in surgical patients and demonstrate ability to manage patients with these disorders.
13. Demonstrate appropriate prophylaxis and treatment of surgical infections.
14. Demonstrate ability to manage pain in surgical patients.
15. Discuss the role of abdominal radiographs in the evaluation of abdominal pain and demonstrate ability to appropriately order and interpret imaging modalities in surgical patients.
16. Demonstrate ability to manage patients with soft tissue infections.
17. Demonstrate ability to diagnose common structural defects of the abdominal wall.

The General Surgical rotation will address core competencies as outlined below:

Patient Care

1. Excellence in surgical patient care is expected.

Medical Knowledge

1. The resident is expected to show analytical thinking and apply the concepts of basic science.

Practice-Based Learning

1. Locate, appraise, and assimilate evidence from scientific studies related to their patients' health problems

Interpersonal and Communication Skills

1. Enhance their leadership, interpersonal and teaching skills.

Professionalism

1. The resident is expected to show ethically sound practice and be sensitive to cultural issues.

System-Based Practice

1. Practice cost-effective health care and resource allocation that does not compromise quality of care.
2. Advocate for quality patient care and assist patients in dealing with system complexities.
3. Partner with health care managers and health care providers to assess, coordinate, and improve health care through interdisciplinary rounds.

Structure of rotation

The general surgical rotation will consist of 1 week of night float duties. The resident will be on call for assessment of the emergency patient in the ER, in-house surgical coverage and critical patient post-operative assessment. There will be one half day a week attendance at the post operative resident clinic and one half day a week at the attending led clinic. There will be opportunities to attend the Operating Room and assist with surgery.

Methods of Achieving Goals:

1. Management of patients on General Surgery rotation.
2. Management of elective and emergency surgical admissions Emergency Medicine Block Rotations.
3. Management of patients on Emergency Medicine rotations.
4. Participation with operative procedures.
5. Performance of minor surgical procedures.
6. Attendance at surgical rounds.
7. Attendance at Emergency Medicine lectures on general surgical conditions.

Evaluation and Feedback on Goal Achievement:

1. Evaluation of resident performance by attending
2. Evaluation of attending teaching skills and other attributes by resident
3. Review of the resident's history/physical exam, progress notes and documentation of procedures in the chart.
4. Performance on In-Training Exam
5. Resident evaluation of rotation
6. Semi-Annual Evaluation of Resident

TRAUMA SERVICE (PGY I, II & III, 4 Weeks)

Goals & Objectives:

1. Learn basic principles of care of the trauma victim.
2. Develop an organized approach to the assessment, resuscitation, stabilization and provision of definitive care for the trauma victim.
3. Learn use of the diagnostic imaging modalities available for evaluation of the trauma victim.
4. Develop procedural skills needed in the evaluation and management of trauma.
5. Learn to recognize immediate life and limb threatening injuries.
6. Learn special considerations in the evaluation and management of the pregnant trauma victim.
7. Learn special considerations in the evaluation and management of the pediatric trauma victim.
8. Learn special considerations in the management of the geriatric trauma victim.
9. Learn principles of disaster management.
10. Learn principles of burn management.
11. Learn a systems approach to trauma management at the local and state levels.
12. Learn the principles of pre-hospital trauma care.
13. Demonstrate ability to rapidly and thoroughly assess victims of major and minor trauma.
14. Demonstrate ability to establish priorities in the initial management of victims of life-threatening trauma.
15. Demonstrate ability to manage fluid resuscitation of trauma victims.
16. Demonstrate ability to manage the airway of trauma victims.
17. Discuss the definitive care of the trauma victim, including operative, post-operative and rehabilitative phases of care.
18. Demonstrate ability to perform the following procedures: oral and nasogastric intubation, venous cutdowns, 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, cardiorrhaphy, aortic cross-clamping and extensor tendon repair.
19. Demonstrate ability to interpret radiographs on trauma patients, including chest, cervical, thoracic and lumbar spine, pelvis and extremity films.
20. Discuss the importance of mechanism of injury in the evaluation and treatment of the trauma victim.
21. Demonstrate ability to calculate the Glasgow Coma Score and discuss its role in the evaluation and treatment of head injured patients.
22. Demonstrate ability to use spine immobilization techniques in trauma victims.
23. Demonstrate ability to diagnose and manage trauma victims with extremity fractures, dislocations and subluxations.

24. Demonstrate ability to manage soft tissue injuries including lacerations, avulsions and high-pressure injection injuries.
25. Discuss the diagnosis and management of compartment syndromes.
26. Discuss the diagnosis and management of urogenital injuries.
27. Demonstrate appropriate use of analgesics and sedatives in trauma patients.
28. Demonstrate appropriate use of antibiotics in trauma patients.
29. Demonstrate ability to direct a trauma team during complex resuscitations.
30. Demonstrate ability to coordinate consultants involved in the care of multiple trauma patients.
31. Demonstrate ability to use and interpret imaging modalities in the evaluation of trauma patients.
32. Demonstrate ability to arrange appropriate consultation and disposition of trauma patients.
33. Demonstrate ability to direct the care of trauma victims in the pre-hospital setting.
34. Discuss principle of disaster management and participate in disaster drills.
35. Discuss the role of pre-hospital systems in the management of trauma patients.
36. Demonstrate ability to direct pediatric trauma resuscitations.
37. Demonstrate ability to direct geriatric trauma resuscitations.
38. Discuss the evaluation and management of spinal cord injuries.
39. Demonstrate ability to diagnose and manage tendon injuries.
40. Demonstrate ability to manage amputation injuries and discuss the potential for reimplantation.
41. Demonstrate the ability to manage the acutely burned patient, including minor and major injuries.
42. Demonstrate the ability to diagnose and treat smoke inhalation.
43. Demonstrate the ability to assess and manage facial trauma.
44. Demonstrate the ability to evaluate and manage anterior neck injuries.
45. Demonstrate the ability to assess and manage penetrating and blunt chest trauma.
46. Demonstrate the ability to evaluate and manage blunt and penetrating abdominal trauma.
47. Demonstrate the ability to diagnose and treat pelvic fractures.
48. Learn teaching & supervision skills. (PGY-III only)

Methods of Achieving Goals:

1. Management of patients on trauma rotations.
2. Management of patients on Emergency Department rotations.
3. Performance of trauma related procedures.
4. Certification in ATLS Provider/Instructor.
5. Presentations and attendance at Emergency Medicine trauma case conferences.
6. Attendance at trauma surgery lectures given on trauma related topics.
7. Attendance at Emergency Medicine lectures given on trauma related topics.

Evaluation and Feedback on Goal Achievement:

1. Formal written evaluation by Trauma Service attending physician staff.

2. Performance and evaluation of technical skills under direct attending physician supervision.
3. Evaluation of trauma case presentations at trauma case conferences and at multidisciplinary trauma rounds.
4. Resident feedback:
 - A. Evaluation at end of rotation.
 - B. Semi-annual resident evaluation.
5. Successful completion of ATLS Provider/Instructor course.
6. Performance on In-Training examination.

TOXICOLOGY (PGY I, II, & III, LONGITUDINAL)

Goals & Objectives:

1. Learn the pertinent aspects of the history and physical exam relative to acute poisoning with particular emphasis on clinical recognition of major toxic syndromes (toxidromes).
2. Learn the generic aspects of clinical management of poisoning, including stabilization and decontamination.
3. Understand the principles, methods, and controversies of decontamination and enhancement of elimination of toxins.
4. Learn the presenting signs, symptoms, laboratory findings, pathophysiology and treatment of common therapeutic drug poisonings, drugs of abuse, natural toxins, and general household poisons.
5. Learn the common hazardous materials (HAZMAT) of the workplace and prehospital operations with regard to HAZMAT incidents.
6. Learn the principles of clinical operational toxicology and the major occupational toxins of Western society.
7. Learn the fundamentals of poisoning epidemiology, pharmacokinetics, and biotransformation, including the effects of pregnancy and lactation.
8. Learn to recognize, diagnose, assess and emergently manage acute and chronic complications of substance abuse.
9. Learn the use of adjunctive services, including the toxicology laboratory and poison center, in the management of acute poisonings.
10. Learn the specific indications and implementation of specific therapeutic modalities, such as the use of antidotes, hemodialysis, and hyperbaric oxygen.
11. Demonstrate the ability to perform gastric lavage, whole bowel irrigation, skin and eye decontamination, and administration of activated charcoal.
12. Discuss the indications, contraindications, dosages, and side effects of the currently available antidotes and antivenoms.
13. Demonstrate clinical recognition of toxidromes associated with drug overdose and drug withdrawal.
14. Demonstrate knowledge of the principles of hemodialysis and hemoperfusion and the toxic agents that can be removed by these methods.
15. Demonstrate ability to recognize common venomous animals and poisonous plants and their clinical presentations and treatments.
16. Demonstrate knowledge of the diagnostic laboratory including methods, limitation and costs.
17. Demonstrate knowledge of the drug interactions, side effects, and therapeutic levels of the commonly used therapeutic agents.
18. Demonstrate the proper technique for handling a HAZMAT contaminated patient in the Emergency Department and the prehospital environment.
19. Demonstrate knowledge of the common household poisons, pesticides, hydrocarbons and metals, their effects and treatments.

20. Demonstrate the knowledge and clinical skills necessary to manage a patient poisoned by any of the following: acetaminophen, amphetamines, anticholinergics, aspirin, barbiturates, benzodiazepines, beta blockers, calcium channel blockers, carbon monoxide, caustics, cocaine, cyanide, cyclic antidepressants, digitalis, ethanol, ethylene glycol, INH, iron, lithium, methanol, opiates, organophosphates, phenytoin, theophylline and venomous animals.
21. Demonstrate knowledge of basic principles of drug absorption, redistribution, metabolism, and elimination.

Methods of Achieving Goals:

1. Evaluation of lab reports on Emergency Medicine rotations.
2. Chart review of related cases of patients admitted to the hospital.
3. Attendance at Emergency Medicine lectures on toxicology.

Evaluation and Feedback on Goal Achievements:

1. Chart review of related cases by attending physician.
2. Resident feedback via peer evaluation.
3. Performance on In-Training examination.

ULTRASOUND

Goal:

Provide the knowledge, skill, and experience to perform focused ultrasound (US) examinations in the standard applications outlined by the American College of Emergency Physicians (ACEP) guidelines and to incorporate its uses in daily practice as a means to provide immediate information and answer specific questions about patients' physical conditions.

A. Core US Curriculum:

1. First year residents (PGY-I)

a. Introductory Course

Emergency Medicine (EM) residents will begin their US experience during their first month of orientation, receiving a five-day comprehensive course covering all primary applications over a twenty (20) hour period. Didactic lectures and practical education will be included in the Sonography Lab at Florida Hospital College utilizing ultrasound simulation, phantoms, and student volunteers. During the orientation month, one day each week (Thursday) will be dedicated for ultrasound education and training, from 1pm-5pm. Two forty-five (45) to sixty (60) minute lectures will be given per day followed by an hour of scanning after each presentation. This course will also cover ultrasound physics, instrumentation (Refer Table 2), and primary indications as outlined by ACEP guidelines²⁻⁵.

1. Define necessary terms to include:
 - a. Piezoelectric effect
 - b. Resolution
 - c. Attenuation
 - d. Echogenicity
 - e. Doppler

2. Understand the role of instrumentation in image acquisition:
 - a. Image mode
 - b. Gain
 - c. Time gain compensation
 - d. Basic transducer technology
 - e. Depth
 - f. Focus
 - g. Calipers

3. Understand types of ultrasound artifacts and their role in image acquisition
 - a. Reverberation
 - b. Side lobe
 - c. Mirror
 - d. Shadowing
 - e. Enhancement
 - f. Ring-down

Primary Indications for EM Ultrasound Evaluation:

1. **FAST (Focused Assessment with Sonography for Trauma).** This examination is used to evaluate the peritoneal, pericardial and pleural spaces by combining several focused ultrasound assessments of the chest, heart, abdomen, and pelvis. The primary indication for this application is in the rapid identification of pathological free fluid released from injured organs or structures. Residents will learn all four standard views of the FAST (Morrison's pouch, Left splenorenal, pelvic, subxiphoid and long parasternal views) in order to facilitate trauma care as well as extended views in order to recognize pneumothorax and hemothorax.
2. **Abdominal Aorta Aneurysms (AAA).** Ultrasound has been shown to be accurate in identifying both aneurysmal and normal aortas. Training will include complete evaluation of the abdominal aorta from diaphragm to its bifurcation for recognition of aneurysm. A complete examination will include transverse and longitudinal views of proximal, middle segment, and distal aorta, including iliacs. If an AAA is identified, the resident will also need to assess for free intraperitoneal fluid suggestive of rupture.
3. **Echocardiography.** The primary applications of cardiac emergency ultrasound examinations are in the diagnosis or exclusion of pericardial effusions, cardiac tamponade, and the evaluation of gross cardiac function, especially in patients undergoing active resuscitation. Residents will also learn the advanced ultrasound techniques of gross estimation of intravascular volume status and identification of right ventricular dysfunction in the setting of unexplained chest pain, dyspnea, or hemodynamic instability. Residents will learn the following four standard views: subxiphoid, short parasternal, long parasternal, and apical.
4. **Biliary.** Residents will learn to incorporate ultrasound assessment in the evaluation of abdominal pain, especially right upper quadrant (RUQ) and epigastric pain, for diagnosis of biliary disease. The gallbladder will be evaluated with emphasis on identification of cholelithiasis and identification of signs of cholecystitis. Residents will learn to evaluate gallbladder wall thickness, the size of the common bile duct (CBD), pericholecystic fluid, and the sonographic Murphy's sign.
5. **Pelvic Ultrasound.** Residents will learn transabdominal and transvaginal sonographic techniques for the limited evaluation of first and second trimester pregnancies. First trimester evaluation will focus on evaluation of the uterus to detect first trimester

intrauterine and ectopic pregnancies. Second and Third trimester evaluations will focus on detection of fetal heart rate (FHR) and fetal movement.

6. **Renal Ultrasound.** The primary indication for evaluation of the kidneys and bladder is to assess for obstructive uropathy and acute urinary retention. Residents will learn to recognize hydronephrosis, and evaluate bladder size for outlet obstruction.
7. **Procedural Ultrasound.** The major use for ultrasound-guided procedures is for central venous access. The Agency for Healthcare Research and Quality highlighted ultrasound-guided central line placement as a key intervention that should be implemented immediately into twenty-first century patient care to reduce procedural complications. Research has shown utility of ultrasound imaging in the evaluation of abscess formation, foreign bodies, nerve blocks, pericardial effusions, pleural effusions, ascites, and lumbar punctures. Residents will be expected to learn procedural ultrasound with special emphasis to central venous access and peripheral access. Also residents will learn to assess for difficult central venous access, venous thrombosis, and small caliber vessels as part of the initial scanning of the vessel to be cannalized. Other ultrasound procedures will be taught as part of the ultrasound curriculum.
8. **Deep Venous Thrombosis (DVT).** The primary application for venous imaging with ultrasound is in the evaluation for DVT in the proximal lower extremities. Residents will learn limited DVT screening for examination of the common femoral vein to its bifurcation and the popliteal area to trifurcation, searching for compressibility and augmentation. Additionally, all central lines will require anatomic visualization of the vessel before placement.
9. **Miscellaneous and Advanced Ultrasound Applications.** Residents will have the opportunity to learn advanced applications to include ocular ultrasound and testicular ultrasound as part of an elective as senior residents.

Emergency Ultrasound Indications Requirements:

Total of 175 scans

FAST: 25 scans (5 positive)
Aorta: 25 scans (2 positive)
Ecocardiography: 25 scans (5 positive)
Biliary: 25 scans (10 positive)
Pelvic Ultrasound: 25 scans (10 positive)
 Transabdominal Pelvic: 15 scans
 Transvaginal Pelvic: 10 scans
Renal: 25 scans (5 positive)
Ultrasound Guided Procedures: 15 scans
 Central Venous Access: 5 scans
 Peripheral IV lines: 5 scans
 Procedural US (Abscess, FB, etc): 5 scans

Miscellaneous and Advanced Applications: 10 scans

Venous Thrombosis (5 scans and 2 positive required)

Abscess (recognition and drainage)

Cellulitis

Foreign bodies

Pneumothorax

Paracentesis

Thoracentesis

Musculoskeletal

Ocular

Testicular

Nerve Blocks

Lumbar Puncture

- 1) PGY-I objective: Familiarize first year residents with ultrasound terminology, imaging fundamentals, and applications of focused bedside ultrasound.
- 2) PGY-I requirements:
 - i. Complete a twenty-hour introductory course.
 - ii. Save and submit ultrasound scans from ED rotations.
 - iii. Machine maintenance.

Residents will need to save images and submit them as evidence of completion of 175 scans requirement, to obtain certification at the end of three-year period (Refer image submission Section B.1).

b. First Year Ultrasound Rotation

A four-week rotation will be included in the core curriculum during the first year (PGY- I) as part of the anesthesia rotation to further strengthening ultrasound skills. Residents will start their rotation, Monday through Friday from 1pm to 5pm, after completing their morning duties in anesthesia. This experience will provide an opportunity for residents to perform bedside ultrasound in the emergency department, and complete requirements for graduation, under direct supervision and image review with the Emergency Ultrasound Director (Dr. Tirado) or credential faculty members.

- 1) Objectives for 4 weeks rotation:
 - i. Complete 175 scans required for certification before graduation.
 - ii. Acquire competency in the primary indications for EM Ultrasound Evaluation (as describe in Table 3)
 - iii. Literature review with reading assignments.
 - iv. Involvement in administrative aspects of ultrasound training program to include: machine maintenance, supplies, and record keeping.

- v. Learn video storage and data management from different video formats.
- vi. Involve resident in on-going ultrasound research.
- vii. Incorporate focused ultrasound in clinical practice.

2) Requirement for 4 week rotation:

- i. Pre-elective meeting for outlining objectives of rotation.
- ii. Review online ultrasound modules.
- iii. Eight to 10 hours of direct supervised scanning over elective period.
- iv. An additional sixty hours of time spent independent scanning.
- v. Assigned reading will be provided, from journals and ultrasound textbooks.
- vi. Ultrasound review sessions will be provided Thursdays in the afternoon.
- vii. Submission of two ultrasound cases for teaching file will be required.
- viii. Practical evaluation will be required at end of rotation.
- ix. Completion of ultrasound questions from available modules (passing 70%) available online.
- x. Completion of online evaluation form.

Residents will need to save images and submit them as evidence of completion of 175 scans requirement, to obtain certification at the end of three-year period (Refer image submission Section B.1). Non-completion of these requirements will earn the Resident an incomplete (I) in their rotation. Ultrasound education is a requirement by the Residency Review Committee (RRC) for maintaining accreditation status. If a resident does not complete requirements by graduation they will not pass the ultrasound rotation and consequently fail to graduate.

Evaluation form. The rotation will be evaluated using the evaluation sheet provided in Appendix A. Each resident will be required to complete this evaluation form at the end of each rotation.

2. **Third year residents (PGY-III)- US Elective**

Third year residents will have the option to take a two or four week elective as senior residents with a focus on completing requisites for graduation and advanced ultrasound applications. Seniors will be involved in administrative, teaching, and research aspects of EM Ultrasound.

- a. Objectives for senior elective:
 - i. Complete 175 scans required for certification before graduation.
 - ii. Acquire competency in the advance indications for EM Ultrasound Evaluation (as describe in Table 3)

- iii. Involvement in administrative aspects of ultrasound training program including video review for quality assurance (QA process).
 - iv. Involve senior resident in teaching and proctoring PGY-I and PGY-II residents as well as medical students.
 - v. Involve resident in on-going ultrasound research.
 - vi. Incorporate focused ultrasound in critical care thinking.
- b. Senior elective requirements
- i. Pre-elective meeting for outlining objectives for elective.
 - ii. Review online ultrasound module.
 - iii. Six to eight hours of direct supervised scanning during elective period.
 - iv. An additional hundred hours of time spent independent scanning.
 - v. Senior residents will be in charge of ultrasound journal club.
 - vi. Ultrasound review sessions will be provided Thursdays in the afternoon.
 - vii. Submissions of four ultrasound cases are required for teaching file.
 - viii. Practical evaluation will be required at end of rotation with direct supervision.
 - ix. Completion of online evaluation form

Residents will need to save images and submit them as evidence of completion of 175 scans requirement, to obtain certification at the end of three-year period (Refer image submission Section B.1). Non-completion of these requirements will earn the Resident an incomplete (I) in their rotation. Ultrasound education is a requirement by the Residency Review Committee (RRC) for maintaining accreditation status. If a resident does not complete requirements by graduation they will not pass that rotation and cannot graduate.

Evaluation form. The rotation will be evaluated using the evaluation sheet provided in Appendix A. Each resident will be required to complete this evaluation form at the end of each rotation.

B. Emergency Ultrasound Education/Credentialing

1. Submission of Ultrasound Scans

Residents will need to submit 175 scans in a three-year period as described in the Emergency Ultrasound Indications Requirements section. Residents will learn photo and video modalities for capturing findings as part of the certification process. For chart documentation, residents will be required to fill the Radiographic Interpretation/Ultrasound T-Sheet in the T-System. Residents will also be required to save and submit images using the commercially available EHealthConx portal review system. For this purpose, a USB drive will be provided for storage of images. Residents will be responsible for entering patient information from their log-book (since images are saved without patient information for HIPAA compliance) and report findings. The Ultrasound Director or credential reviewers will review images. They will assess for

presence of standard views, identification of pathology, and adequacy of images for credit. Residents can also save videos for credit.

2. QA of Submitted Ultrasound Scans

The Ultrasound Director will review sonographic images and videos with the resident and provide feedback regarding quality and accuracy using EHealthConx portal review system. All ultrasound examinations performed in the emergency department will require confirmatory testing which may include computed tomography (CT), Magnetic Resonance Imaging (MRI), and/or complete sonographic examination if not observed by a Level III sonographer.

3. Ultrasound Logging System (EHealthConx)

The EHealthConx ultrasound portal is a web-based service that allows physicians to securely upload ultrasound images and case information for timely review and feedback to facilitate hospital credentialing and quality assurance needs. It also provides image archiving solutions. EHealthConx portal review system will be available to residents for submission of their ultrasound examinations and other procedures as requested by Ultrasound Director for accurate log of the quantity of examinations performed in the three-year period. All scans must document patient information, the physician's name, and images for reviewing.

4. Completion of Ultrasound Requirements is a Pre-requisite to Graduation

Residents need to complete 175 ultrasound examinations by the end of the third year in order to meet ultrasound requirements and to be certified. Successful completion of the ultrasound requirement is a pre-requisite for graduation from the EM residency program. If the resident has not met requirements by the midpoint of the third year, the resident will be required to complete them during the elective time. At the end of the three-year period, residents will be tested on knowledge of sonographic anatomic and pathology through written examination and through image evaluation.

5. Florida Hospital College Sonography Lab

As part as their ultrasound experience, residents will have use of the Florida Hospital College sonography lab, managed by the Chair and Professor Charlotte Henningsen. This lab contains 6 stretchers, 6 ultrasound machines (including one GE Logic e and a Sonosite M Turbo), an ultrasound simulation machine and various phantoms for scanning and performing procedures (Refer Appendix C). Residents will be able to scan each other and student volunteers from the Florida Hospital College to gain ultrasound knowledge and apply techniques. The lab will be available once a week for resident practice while on their 2-week rotation and elective rotation. Also, the lab will be used to present cases and clinical scenarios to assess competency in ultrasound at the end of each rotation.

6. Final Written Examination

To obtain the ultrasound certificate of completion and future letters for US privileges, residents will be required to complete an forty question written examination. Residents will take examination at the midpoint of the third year of residency after completing 175 scans and ultrasound rotations. 75percentis required for successful completion. In case of failure, the senior elective will be mandatory as means of remediation and an examination will be provided at the end of their rotation, with expected pass rate of 75%. In case of second attempt failure, it will be the ED Ultrasound Directors prerogative to permit the resident to attempt the examination a third time. This will depend on the residents overall ultrasound performance and availability of time. Failure to pass the test will result in inability to receive ultrasound certification and future letters of recommendations for US privileges. Ultrasound Education Methods

7. Ultrasound conferences

Emergency medicine residents will start their ultrasound education as first years with a five-day comprehensive course, covering all primary applications over twenty (20) hour period. Lectures will be forty-five minutes to an hour in length followed by one hour of hands-on practical experience. Each lecture will have well-defined objectives with pertinent anatomic review, ultrasound technique with protocol, and pathologic findings. Residents will receive a USB flash drive that will contain handouts of all lectures to review content and make notes on specific topics.

8. Ultrasound Web-Based Learning

Ultrasound lectures will be available for self-directed learning and ongoing resident education in articulate online server. Articulate Online is a user-friendly hosted service that allows you individual interaction with learning courses, assessments, and presentations. This program also permits monitoring of resident progress and documentation of completion. These lectures with voice over and videos will help solidify knowledge learned from conferences and enhance image recognition of normal and abnormal anatomy required for accurate diagnosis of bedside emergency ultrasound.

9. Bedside learning

Residents will be provided eight to ten hours of direct supervised scanning over the ultrasound rotation period, providing for an excellent opportunity for bedside teaching by supervising physicians. Residents will have the opportunity to learn with each patient interaction as they apply sonographic findings pertinent to anatomy and pathology, while improving patient care. Residents do not make clinical decisions without direct supervision, and when findings are equivocal or non diagnostic, official studies must be ordered.

10. Ultrasound Conferences for Grand Rounds

Ultrasound education will also be included in the Grand Round lecture series with at least four dedicated ultrasound conferences given each year to emphasize core and advanced ultrasound applications. Conferences will also be available for review on the resident web page.

11. Ultrasound Journal Club

Once every two months, residents will review up to date ultrasound articles from current and pertinent medical journals. During ultrasound rotations residents will discuss these articles for learning and as means of encouraging research. It will be the senior resident duty to select pertinent articles and facilitate one article discussion.

b. Objective:

- ii. Learn how to select journal club
- iii. Improve knowledge
- iv. Critically appraise an article
- v. Review current literature
- vi. Review classic article

b. Requirements:

- i. Advance Med Search
- ii. Discussion of article with US Director
- iii. Organize journal club
- iv. Discuss journal club
- v. Develop research

C. Ultrasound Resources

Core Text books:

1. Emergency Ultrasound Second Edition by O. John Ma, James R. Mateer and Michael Blaiwas. New Edition 2007.
2. Practical Guide to Emergency Ultrasound. Karen Cosby and John Kendall. Lippincott Williams and Wilkins. 2006.

Both texts are new and will provide excellent images and helpful commentaries on scanning techniques and interpretation of ultrasound examinations in the Emergency Department.

D. Internet resource:

1. <https://www.portal-us.com/>
2. <http://www.sonoguide.com/>
3. <http://www.slredultrasound.com/onlineresources.html>

E. Emergency Ultrasound Faculty:

1. Alfredo Tirado-Gonzalez, MD
Director of Emergency Ultrasound
Ultrasound Fellowship Trained at Brown University
2. Charlotte Henningsen, MS RT, RDMS, RVT, FSDMS
Chair & Professor
Diagnostic Medical Sonography Department
Florida Hospital College of Health Sciences

F. Resources:

1. Mayron R, Gaudio FE, Plummer D, R. A, Elsperger J. Echocardiography performed by emergency physicians: impact on diagnosis and therapy. *Ann Emerg Med* 1988;17(2):150-4.
2. ACEP Emergency Ultrasound Imaging Compendium. *Annals of Emergency Medicine*. Oct 2006; 48:487-510
3. ACEP Policy Statement. Emergency Ultrasound Guidelines. June 2001.
4. AMA (resolution 802) support of ultrasound in different specialties
5. AMA Policy 230.989

G. Appendices:

1. **Appendix A:** Ultrasound Evaluation
2. **Appendix B:** Clinical Competency Evaluation

ULTRASOUND ROTATION EVALUATION

Program: _____ Rotation Location: _____
Period of Rotation: _____ Faculty Member(s): _____

Directions: Please take a moment to assess the clinical rotation using the scale below. If an item is not applicable to this rotation, please circle N/A.

4 = Excellent
3 = Very Good
2 = fair
1 = Poor
N/A = Not applicable

Organization

Clinical duties and assignments, education goals and learning objectives, and evaluation process were presented 1 2 3 4 N/A

Daily Schedule for scanning and teaching was structured efficiently 1 2 3 4 N/A

Faculty Leadership and Role Modeling

Demonstrated good "bedside manner" and positive interpersonal communication skills with patients, family members, and staff 1 2 3 4 N/A

Treated each team member in a courteous and respectful manner 1 2 3 4 N/A

Was usually prompt for teaching assignments and always available and accessible as a supervisor 1 2 3 4 N/A

Showed respect for physicians in other specialties/subspecialties and other health care professionals 1 2 3 4 N/A

Recognized own limitations and used these situations as opportunities to show me how he/she learns in order to keep up-to-date 1 2 3 4 N/A

Patient Care

Patient volume was sufficient to meet the educational goals and objectives 1 2 3 4 N/A

Variety of patient problems provided adequate learning experiences 1 2 3 4 N/A

Opportunities to perform scans were sufficient to achieve the learning objectives 1 2 3 4 N/A

Overall patient management emphasized an interdisciplinary team care approach 1 2 3 4 N/A

Patient Care Teaching

The faculty member(s) devoted an appropriate amount of time to discussing patients and patient care decisions 1 2 3 4 N/A

The faculty member(s) observed my scans and provided instructive feedback and guidance 1 2 3 4 N/A

The faculty member(s) communicated their thoughts and ideas clearly but also allowed me to exercise my clinical judgment 1 2 3 4 N/A

The faculty member used relevant medical/scientific literature to support clinical advice 1 2 3 4 N/A

Didactic (Classroom Instruction)

The faculty gave well-organized presentations and provided opportunities for questions and interactions 1 2 3 4 N/A

The faculty provided references, articles, or other materials that stimulated me to read, research, and review pertinent topics. 1 2 3 4 N/A

Evaluation and Feedback

My overall performance was reviewed at the end of the rotation pointing out my strengths and areas for improvement 1 2 3 4 N/A

The faculty member demonstrated “fairness” by adhering to established criteria, explaining reasons for the scores, and allowing me to respond 1 2 3 4 N/A

OVERALL, I WOULD RATE THIS CLINICAL ROTATION AS:

POOR (No Benefit)

FAIR (Little Benefit)

VERY GOOD (Beneficial)

EXCELLENT (Very Beneficial)

Would you recommend that this rotation be continued in this program? Yes/No

Would you recommend that the faculty member(s) continue to teach this program? Yes/No

COMMENTS,

CLINICAL COMPETENCY EVALUATION – ED Ultrasound Program

Student _____ Clinical Site _____

Date _____ Type of exam _____ Evaluator _____

(See back for grading criteria)

Clinical Competency Evaluation	1	2	3	4
PERFORMANCE CRITERIA				
1. Demonstrates Scanning Skills (appropriate for current level of training) – appropriate patient positioning & position changes; correlates patient history, lab work, other imaging studies; correct transducer orientation; demonstrates relevant anatomy				
2. Demonstrates Appropriate Use of Equipment - selects correct transducer & technical factors; adjusts gain & focal zone appropriately; identifies artifacts & optimizes image				
3. Works Efficiently —performs in professional manner; recognizes when to obtain an image; performs complete exam in appropriate time & in a logical sequence				
CRITERIA FOR EVALUATION OF IMAGE				
4. Recognizes Anatomical Representation – identifies & demonstrates anatomy properly; area of interest is centered on image; anatomic landmarks are identified; measurement are accurately made				
5. Identifies Patient & Correctly Annotates – clearly identifies patient, date of exam, “right & left”, and sectional plane				
6. Analyzes Completed Exams (for thoroughness, technical components, secondary findings) – analyzes the sonographic exam for completeness; recognizes pathology, & scanning artifacts				
MEDICAL KNOWLEDGE				
7. Correlates findings (with patient history & Clinical assessment) – correlates sonographic anatomy to academic knowledge; correlates findings to patient’s clinical history, lab data; uses available information to provide differential diagnosis				
8. Analyzes findings (review of exam with supervising sonographer or physician; discussion of findings & differential diagnosis, as appropriate) – analyzes the sonographic exam for completeness; recognizes pathology, & scanning artifacts				
COMMUNICATION SKILLS				
9. Communicates Effectively – addresses patient appropriately; makes patient feel comfortable; uses correct terminology to describe exam; presents exam in professional manner & with confidence; recognizes deficiencies in the exam; presents organized & complete case for interpretation.				

TOTAL: _____

"PATIENT TYPE": Circle the correct degree of difficulty.

- 1 = Easy
- 2 = Average
- 3 = Difficult
- 4 = Very Difficult

- SCORING:
- 4 Superior
 - 3 Satisfactory
 - 2 Needs Improvement
 - 1 Unsatisfactory

Document examples of why any skill (by number) did not receive a "2",

Resident _____ EVALUATOR _____

Florida Hospital
EMERGENCY MEDICINE

Block Rotations

The block rotation system offers a background of specialty information to balance the emergency medicine experience. While the emergency medicine aspects of specialty fields are learned in the emergency department, these short blocks add additional depth to the emergency physician's training. We are committed to a quality program. Each rotation has been carefully selected to offer the maximal educational benefit to our residents. Since curriculums are rarely static, we will carefully audit our residents' rotation experiences and continuously modify the residency curriculum based upon this feedback.

Block Rotation Schedule

EM-1

EM – 23wk
Anesthesia – 4 wk
Surgery – 4 wk
Internal Medicine - 4 wk
OBGYN – 4 wk
Trauma – 4 wk
ID/EMS - 4 wk
Ophthalmology/OMFS - 2 wk
VAC – 20 days

EM-2

EM – 28 wk
SICU – 4 wk
P ICU – 4 wk
MICU - 4 wk
Trauma – 4 wk
Orthopedics Trauma 4wk
VAC – 20 days
CME- 1 wk

EM-3

EM – 32 wk
NeuroTrauma-4wk
Trauma - 4 wk
Practice Mgmt-2 wk
Research-2wk
Elective - 4 wk
VAC – 20 days
CME- 1 wk

Block Rotation Locations

<u>Rotations</u>	<u>Rotation Locations</u>
EM: ER Pediatrics (Emergency Medicine)	FHO
EM:East ER (Emergency Medicine)	FHEO
Emergency Medical Services (Emergency Medicine)	Orange County Fire Rescue
Anesthesia (Off-Site Rotation)	FHO
Internal Medicine (Off-Site Rotation)	FHO
Infectious Disease (Off-Site Rotation)	FHEO
Medical ICU (Off-Site Rotation)	FHO
Neurosurgery (Off-Site Rotation)	FHO
Ophthalmology (Off-Site Rotation)	Eye Physicians of Central Florida
Oral & Maxillofacial Surgery (Off-Site Rotation)	Central Florida Orlando Oral & Maxillofacial Surgery
Orthopedic Trauma (Off-Site Rotation)	FHO
Peds ICU (Off-Site Rotation)	FHO
Practice Management (Off-Site Rotation)	Orange County Office of Medical

	Director
Research (Off-Site Rotation)	FHEO
OB	FHO
Anesthesiology/Ultrasound	FHO/FHEO
Off-Site:EM:Surgical Intensive Care Unit (Off-Site Rotation)	FHO
Off-Site:EM:Trauma (Off-Site Rotation)	Lakeland Regional Medical Center
Surgery	FHO

Electives:

Residents have one 4-week block of elective time in the PGY-3 year. Elective opportunities should be discussed with Program Director before the start of the PGY-3 year.

**FLORIDA HOSPITAL
EMERGENCY MEDICINE RESIDENCY PROGRAM
Evidence Based Medicine and Informatics Curriculum**

The Evidence Based Emergency Medicine curriculum consists of didactic and workshop type sessions. They are held during the Thursday conference day.

An emphasis will be placed on how to locate the latest high quality information at the bedside. PDA resources and the Florida Hospital Library Online will be used in the teaching sessions and while “on duty” in the Emergency Department. The aim is to simplify the gathering of information and integrate this into patient care in real time.

Using technology in a patient encounter has its own considerations and special attention will be paid to this situation.

The expectations of the residents during the didactic and workshop sessions will vary by postgraduate year. They will become progressively more comprehensive as they go through the program.

PGY 1 will be expected to formulate a question based on a clinical encounter and be able to design a search strategy.

PGY 2 will be expected to critically appraise an article for Journal Club.

PGY3 will be expected to put the whole process together and formulate a critically appraised topic.

Each year will have a Record of Achievement to complete.

**FLORIDA HOSPITAL
EMERGENCY MEDICINE RESIDENCY PROGRAM
RESEARCH/SCHOLARLY ACTIVITIES CURRICULUM**

REQUIRED: *PYG-1, PGY-2 and PGY-3*

DURATION: Longitudinal

AVAILABLE TIME: Two (2) weeks of research elective could be requested for both research/scholarly projects but must be pre-approved by respective research mentor. Arrangements could be made through Residency Coordinator.

FACULTY

RESEARCH COODINATOR: Ademola Adewale, MD

RESEARCH MENTOR: Faculty of choice

GOAL

Upon completion of the research/scholarly activities, the resident will meet the goal of AGME in advancing the residents' knowledge of the basic principles of research, including how research is conducted, evaluated, explained to patients, and applied to patient care.

OBJECTIVES

The resident will demonstrate competency in his/her ability to:

- Understand the concepts of and principles behind evidence based medicine.
- Critically evaluate medical literature and its applicability to clinical practice.
- Participate in scholarly activities and convey findings to peers.

PROCESS

This requirement will be accomplished through one-on-one mentoring by faculty of choice and/or team work with peers and staff. The resident will also be responsible for completion of certain task on own and through guidance from faculty and research coordinator.

REQUIREMENTS

In order to graduate from the Emergency Medicine Residency Program, residents are required to complete:

1) **IRB certifications (NIH, Research HIPAA & CV)**

→ PGY-1 will complete these requirements within the first 3 months of residency. *See Page 3 for more information*

2) **Scholarly projects**

→ Conduct research project (elective time given) - investigator initiated,
or

→ Write a case report submitted for publication in peer review journal,
or

→ Write a literature review article submitted for publication in peer review journal, *or*

→ Present a poster or an oral presentation at a regional or national conference.

EVALUATION

- 1) Completion of items 1 and 2 listed in the requirements section upon graduation.
- 2) Present an oral or poster presentation of chosen scholarly activity project to peers during research week prior to graduation during OGME-3.
- 3) Submit a written paper in a publishable format on the chosen scholarly project prior to graduation.

REQUIRED READING/RESOURCES

- Tutorial for Human Participant Protections Education for Research Team - <http://phrp.nihtraining.com>
- Protecting Personal Health Information in Research: Understanding the HIPAA Privacy Rule – *See Page 3 for more information*

RECOMMENDED READING/RESOURCES

- Florida Hospital Institutional Review Board Handbook
- International Committee of Medical Journal Editors. Uniform requirements for manuscripts submitted to biomedical journals: Writing and editing for biomedical publication. <http://www.icmje.org/>
- Outlines and articles of how to write up case report, literature review, or scientific papers are available through research coordinator.
- Guidelines on how to prepare presentations available through research coordinator.

INSTITUTIONAL REVIEW BOARD (IRB) CERTIFICATION

COMPLIANCE REQUIREMENTS

Please submit the following documents to Research Coordinator by the end of the 3rd month of PGY-1:

- 1) **Current CV**
 - signed and dated at top right corner of front page

- 2) **Certification of completion of the NIH tutorial** for Human research protection.
 - go to <http://phrp.nihtraining.com>
 - register as new user
 - complete quiz from all 4 modules
 - print out certificate

- 3) **Verification of Research HIPAA Privacy Rule.**
 - go to www.flhosp.org
 - click on [“All Services”](#)
 - click on [“Institutional Review Board”](#)
 - click on [“Requirements to Conduct Research at Florida Hospital”](#)
 - read through “HIPAA in Research Booklet” (pdf.)
 - print, sign and date “Verification of HIPAA Privacy Rule Information”

IMPORTANT REMINDERS **FOR RESEARCH OR PUBLISHABLE PROJECTS**

- 1) ALL research projects must be submitted to the Office of Research Administration (ORA) and Institutional Review Board (IRB).
- 2) DO NOT begin study until IRB approval has been obtained.
- 3) Data collected prior to IRB approval cannot be included in the current research.
- 4) Any changes to a research protocol and/or investigators must be submitted to and approved by IRB.

BASIC REQUIREMENTS FOR RESEARCH PROJECTS

- 1) IRB/FDA Requirements:
NIH certificate, Research HIPAA Verification Form, CV, License
- 2) Protocol
- 3) IRB Applications (contact Research Coordinator to decide which forms are needed pertaining to your project).

- All documents should be typed and submitted to Research Coordinator electronically.
- Contact Info: (407) 303-7369 or sara.leftwich@flhosp.org

Timeline:

The timeline below is created to help Residents pace their research project in a timely manner. Tasks can be completed ahead of schedule but must be completed no later than the last day of the corresponding month, unless prearranged with mentor.

Residents may choose their own topics or they may select one from the list provided by the Residency Faculty.

PGY-1:

Complete and submit NIH certificate, Research HIPAA Verification, and CV (signed and dated) September

Meet with mentor to decide on scholarly project i.e. Research/ Case Report/Literature Review Article, etc. March

Meeting with mentor to discuss research topic and/or design. Do literature search on chosen topic. May

PGY-2:

Write up research protocol (Research) August

Contact Research Coordinator and complete IRB application (Research) September

Collect Data once IRB approval obtained Ongoing

PGY-3:

Data analysis (Research)	January
Submit abstract of Research/Case Report/Literature Review Article	February
Prepare Poster/Oral presentation	March
Prepare final draft of paper	April/May
Poster/Oral presentations of projects	TBD
Submit final Draft Paper	June

Research Award:

A winner from each DME campus will be awarded the “Research Investigator of the Year”. The recipient of this award demonstrates outstanding skills in the investigation, preparation, presentation, and submission of all documents in a timely manner. This Resident makes a significant contribution to the program’s research endeavors that far exceed curricular expectations.

Faculty from the Research Committee will judge each eligible research paper based on the following criteria: Problem statement, literature review, hypothesis, variables, study design, analysis, conclusion, implications, organizations, scientific value and clinical application.

Scholarly Achievement Award

The Scholarly Achievement Award will be presented to any resident who has his or her research paper/case report accepted for publication in a peer review journal during the course of residency program. The resident will be presented with a certificate and a cash award.

National/Regional Poster Presentation

In order to promote active participation in national/regional medical conferences, DME will pay for the resident’s trip and registration fee if the oral or poster presentation submission of the resident’s research project is accepted during the course of residency program. This will be covered apart from the resident’s allotted CME allowance.

Conferences and Teaching Rounds:

At least 5 hours of planned educational activities will be arranged per week. Residents will be expected to attend and will be given dedicated time to participate. Attendance will be monitored via sign-in sheets. Conferences will meet the goals and objectives as outlined in the model curriculum for Emergency Medicine. Both Faculty and Residents will be responsible for conferences. Presentation of conferences is a good learning experience as well as teaching experience. PGY-1 residents will present adult and pediatric case conferences along with toxicology and trauma case conferences .PGY-2 residents will present multitrauma Case Conferences, core lectures and journal club. At the PGY-3 level, residents will present Senior grand rounds and core lectures along with a variety of case conferences. The conferences will include Rosen Reviews, Trauma cases, campus cases along with Roberts & Hedges procedural reviews, toxicology presentations and critical literature updates.

EM Resident Conferences

Adult or Pediatric Case Conference

Residents should prepare a 30 minute case with a discussion at the end. Residents will be paired with a faculty member for the presentation. Contact the faculty member at least 2 weeks prior to the presentation to review the case and the teaching points. Residents may select any interesting case but it should be applicable to emergency medicine. The case should be presented as an unknown and the audience should attempt to derive the diagnosis. This presentation should be highly INTERACTIVE with audience.

Toxicology Case Conference

Residents should prepare a 30 minute toxicology case with a discussion at the end. Residents will be paired with a faculty member for the presentation. Contact the faculty member at least 2 weeks prior to the presentation to review the case and the teaching points. Residents may select any interesting case but it should be applicable to emergency medicine. The case should be presented as an unknown and the audience should attempt to derive the diagnosis. This presentation should be highly INTERACTIVE with audience.

Core Lecture

Residents will present a comprehensive lecture on a topic from reading in 40 minutes. Preparation is essential. Any sources may be used, including EM textbooks and current literature. The goal is to effectively present the material using audio-visual aids and summarizing key points.

Trauma Case Conference

Residents should prepare a one hour Trauma case with a discussion at the end. Residents will be paired with a faculty member for the presentation. Contact the faculty member at least 2 weeks prior to the presentation to review the case and the teaching points. Residents may select any

interesting case but it should be applicable to emergency medicine. The case should be presented as an unknown and the audience should attempt to derive the diagnosis. This presentation should be highly INTERACTIVE with audience.

Senior Grand Rounds

EM Senior Residents will have an hour to present a “State of the Art “Conference. The resident should select a relevant emergency medicine topic with a body of literature to review. Examples include shock, pediatric head trauma, acute coronary syndrome. The most important point will be to make the talk practical and interesting. Talks based on unique experiences (International EM, Disaster Relief) may also be appropriate. Faculty should be able to obtain new insight from the topic. Residents should also utilize recognized experts and complete an exhaustive literature search. Prepare early and practice. Review your topic choice with a faculty member. Choose topic June of year preceding. A comprehensive handout (not a copy of the slides) must be provided for distribution with a bibliography.

Chapter Review

Formal Chapter reviews with weekly quizzes have been fully integrated into the EM Didactic curriculum. Residents are required to read, present and summarize as asked in the pearls series.

Journal Club

Coordinators:

Caroline Molins and Katia Lugo

Introduction:

Journal Club is an integral part of residency training. We have developed a model of journal club based upon the principles of evidence-based medicine.

Goals:

- Improve resident and faculty participation
- Teach critical reviewing skills
- Validate and/or update clinical practice
- Integrate clinical and didactic teaching
- Reinforce research / statistics curriculum
- Practical experience in literature searches
- Encourage critical thinking in clinical arena
- Identify potential areas of future research

Choosing an Article:

- Articles will be chosen from the recent medical literature. Emergency Medicine articles will be featured, but other medical or surgical specialty journals may also be reviewed.

Possible Conclusions from Journal Club

- Question is answered, validating current practice or suggesting change
- Leads to further questions and journal club subjects
- No answer found in literature, possible future research topic

The schedule for Journal Club and resident presenters will be posted and distributed. Please contact the resident coordinators at least 1 month in advance for topic and article assignments.

EVIDENCE BASED MEDICINE CONFERENCE

Coordinator: Bethany Ballinger

Purpose:

- To address a focused clinical question that pertains to the every day practice of emergency medicine.
- To conduct a comprehensive literature search for all evidence that pertains to the question chosen
- To synthesize the data and formulate the most reasonable conclusion to the question asked based on the available evidence.
- To present the background, evidence, and conclusions in a concise and conclusive talk.

Format:

- 2 separate EBM topics will be presented during the one-hour lecture block.
- Residents may design their own clinical question or select one from the list provided. Topics must be approved by the conference supervising attending, Dr. Ballinger.
- The speaker should first address why the clinical question was chosen and how it affects our clinical practice.
- The discussion should include a brief- no more than 5 minute- review of the issue including background on the topic.
- The bulk of the discussion should focus on a review of the evidence found.
- The speaker should present his or her own conclusions, leaving 5 minutes at the end for discussion with the audience.

- The talk should be no more than 20 minutes duration, and contain no more than 15-20 slides.
- Review the talk with Dr. Ballinger at least 2 weeks prior to presentation.

Evaluations Process:

ACGME Core Competencies:

Accreditation of the residency program is predicated on adherence in training to the ACGME-defined Core Competencies in six areas. All residents will be continually evaluated based on the following six competencies.

1. **Patient Care:** Residents must be able to provide patient care that is compassionate, appropriate, and effective for the treatment of health problems and promotion of health. Among other things, residents are expected to:
 - Gather accurate information in a timely manner.
 - Generate an appropriate differential diagnosis...
 - Implement an effective patient management plan.
 - Competently perform the diagnosis 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.
2. **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.
3. **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.
4. **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.
5. **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:
- 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.
6. **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.

- Advocate for and facilitates patients' advancement through the health care system.

Resident Performance:

Residents will be evaluated by the faculty/preceptor at the end of each rotation. Evaluations are based upon the six core competencies established by the ACGME:

1. Patient care
2. Medical knowledge
3. Practice based learning
4. Interpersonal and communication skills
5. Professionalism, and
6. System-based practice.

Evaluations will be reviewed periodically, by the faculty and Program Director meeting as a Resident Performance Evaluation Committee (RPEC). Faculty evaluations and written examinations will be utilized by the RPEC in determining the progress of the resident. The Program Director will meet with the resident at least biannually to review performance. Any necessary remediation or counseling will be determined by the Program Director and when indicated, individuals may be placed on probation or suspended. Evaluations will be kept on file in the resident's personnel file and will be accessible to the resident through the office of Emergency Medicine Education.

Faculty Teaching:

Residents will turn in written, anonymous evaluations of the program, rotations, and faculty on an on-going basis. The results of these evaluations will be reviewed by the Program Director and appropriate feedback will be given to individual faculty members. The information will also be used by the Core Curriculum Committee to revise and alter the educational content of the program and its rotations.

Other Evaluations of Residents:

Residents will be evaluated by means of a 360-degree approach which will include evaluations by peers (senior residents), nurses, and patients. The results of these evaluations will also be discussed with the resident during biannual meetings.

Confidentiality Process:

All evaluations, counseling and probationary actions involving a resident will be kept in a confidential fashion. Under no circumstances will such actions be discussed in a public forum. Additionally, all evaluations of faculty by residents will be treated as confidential by the Program Director.

Scholarly Activity Check List:

Shift Cards

6 to 8 shift cards must be completed per Emergency Medicine Block.

These can be completed on paper and dropped into box at end of the shift (will be scanned into New Innovations Portfolio section under Shift Cards) or can be completed electronically and will be held directly in Portfolios under Evaluations.

Follow up Log

Requirement is for 1 patient follow up per week of the Emergency Medicine Rotation.

For eg. If on the EM rotation for 4 weeks then 4 follow ups will be required. If on rotation for 3 weeks due to vacation then 3 follow up logs will be required.

Follow up logs are held in Scholarly Activities section of Portfolio under “Follow up”.

Journal Club and Critical Literature Review

The resident will give 1 Journal Club presentation per year for each of the 3 years, and critical literature reviews as assigned by Program Director.

This will be held on Scholarly Activities section of Portfolios under “Journal Club”.

Core Lectures

PG1 residents will be required to give 1 core lecture.

PG2 residents will be required to give 2 core lectures.

PG3 residents will be required to give 3 core lectures.

All residents will be required to participate in Pearls conference program and will upload their Pearls, as assigned.

A copy of these presentations will be kept in Scholarly Activities in Portfolio under “Presentations”.

Case Presentations

The resident will give 1 case presentation per year for each of the 3 years.

A copy of this presentation will be kept in Scholarly Activities in Portfolio under “Presentations”.

Trauma Presentations

The resident will give 1 trauma presentation per year for each of the 3 years.

A copy of this presentation will be kept in Scholarly Activities in Portfolio under “Presentations”.

Morbidity and Mortality Presentations

PG3 residents will be required to give 1 M&M presentation during the 3rd year.

A copy of this presentation will be kept in Scholarly Activities in Portfolio under “Presentations”.

Log and Learn/ PBLI project

Residents will be required to complete 4 “Log and Learn” activities per year for each of the 3 years.

These will be kept in Scholarly Activities in Portfolio under “Log and Learn”.

Supervision Policy:

Every resident is assigned to a designated service block rotation. The attending physician is ultimately responsible for the overall care of each individual patient being treated during that shift as well as for the supervision of the resident(s) assigned to the patient. It is the responsibility of the resident(s) to make sure the attending is aware of the history and physical presentation of the patient as well as their plan for treatment. The attending will approve or revise the treatment plan. There is a clear chain of command centered on graded authority and clinical responsibility.

Emergency Medicine residents can function in two capacities: indirectly supervised or directly supervised. The resident can evaluate patients, write prescriptions, write orders and progress notes, and otherwise complete medical records. Residents **cannot perform** invasive procedures (e.g., chest tube, arterial line, central line, and endotracheal intubation) without direct supervision until they have completed an ACLS course. Residents cannot function without direct or indirect supervision by an attending physician who has privileges at Florida Hospital for patient care and to perform indicated procedures.

The attending physician is expected to:

- Confirm (or change) the diagnosis
- Approve procedures and timing
- Be available or physically present (as dictated by his/her judgment) during any procedures and assure that they are properly carried out
- Supervise post-procedural care

The resident will keep the attending fully informed and document patient care with written notes.

Residents have graded and progressively increasing responsibilities during their Emergency Medicine training as evidenced by the following: (taken directly from the PIF, pg. 71)

PGY-1:

- Rotate in the main Emergency Department and present to PGY-3 residents or attending
- Rotate in Urgent Care area and present cases to PGY-2 residents or attending
- Attend didactic lecture series and present case conferences, MultiTrauma case Conferences, Core Lectures, and Journal Club as assigned

PGY-2:

- Manage Urgent and Emergency cases in the main Emergency Department
- Perform many technical procedures
- Directly participate in major resuscitations
- Supervise and run the Urgent Care area and teach medical students and PGY-1 residents on minor care. This supervision creates an environment for increased responsibility
- Attend didactic lecture series and present case conferences, MultiTrauma case Conferences, Core Lectures, and Journal Club as assigned

PGY-3:

- Supervise over-all Emergency Department patient flow
- Provide clinical teaching and supervision to medical students, PGY-1 and PGY-2 residents with faculty oversight
- Direct cardiac and trauma resuscitations
- Handle incoming patient telephone calls and rescue squad reports
- Maintain a high autonomy in providing patient care and running the department
- Attend didactic lecture series and present case conferences, MultiTrauma case Conferences, Core Lectures, Senior Grand Rounds, and Journal Club as assigned

Chief Resident Duties:

The Chief Resident has administrative duties for which s/he is responsible to the Program Director and Associate Program Director. Besides the clinical responsibilities of a senior resident, the Chief Resident's responsibilities also include the following:

1. Ensure that the residents on their team adhere to the mandated duty hour restriction.
2. Ensure that all residents have at least an average of one day off in seven.
3. Monitor all residents on their team for signs of fatigue or other possible impairment.
4. Ensure that all patients are staffed with the proper attending physicians.
5. Notify the proper attending staff member of any change in patient condition.
6. Ensure attendance of their team members at educational conferences.
7. Supervise and educate medical students.
8. Monitor the interaction of junior residents with hospital staff, patients and families.
9. Notify the Program Director of any problems related to the previously described responsibilities.
10. Responsible to serve as liaison between faculty and residents.
11. Responsible for setting up and acquiring audiovisual equipment, keys, cords for conferences.

Chief Resident Responsibilities

1. Scheduling
 - a. Assist with
 - i. Year long schedule
 - ii. Monthly schedule
2. Administrative
 - a. Assist in organization of Residency
 - i. Assist the Residency Coordinator
 - ii. Assist the Residency leadership
 - b. Applicant interviews
 - i. Assist in interviewing
 - ii. Assist in applicant tours
3. Clinical
 - a.

4. Resident related
 - a. Beeper coverage
 - b. Discipline
 - i. Identify potential problems
 - ii. Assist in monitoring trends of concern (e.g. recurrent lateness / absences)
 - iii. Keeping a log of absences / lateness
 - iv. Keeping a log of how various interactions have been handled
 1. Individual resident schedule changes or adjustments
 2. Multi-party shift switches
 3. Scheduling disputes
 4. Must cc the PD / APD for these
 - c. Resident representation at Faculty meetings
 - d. Incoming Intern orientation and education
5. Teaching
 - a. Assist in organization of residency lectures
 - i. Journal Clubs
 - ii. EBM forums
 - b. Assist in Medical Student teaching
 - c. Assist in Simulation sessions
6. Research
 - a. Assist in ascertaining compliance with progress
 - b. Assist in IRB process
 - c. Monitor resident participation with Dr. Adewale
7. Miscellaneous
 - a. Attendance at Chief Resident Forum at SAEM Scientific Assembly
 - i. Takes place late May or early June yearly
 - b. Emergency Medicine Chief Resident Survival Guide
 - i. EMRA bookstore
 - c. Resources – CORD listing

Patient Charting Responsibilities:

Charting:

The Emergency Department uses an electronic medical record (EMR) system and template paper documentation system. Residents are encouraged to learn to chart concurrently with patient care. Ordering labs, x-rays and medications during the visit is mandatory. Charts are expected to be completed during the visit. This includes electronic signature on any outstanding orders in the EMR.

Delinquent Charts:

Prompt and timely completion of charts is expected and is a professional responsibility.

Accumulation of charts longer than one (1) week will result in issuance of a notification.

Failure to complete charts within 2 weeks will result in an additional shift in the ED at a time scheduled by the chief resident.

Medical Records:

- Health care providers must maintain adequate medical records to:
 - Afford continuity of patient care
 - Document that quality care has been rendered
 - Justify payment for services rendered
 - Serve a defense against malpractice claims
 - Function as a basis for submitting required reports to appropriate governmental agencies
- All patient reports should be completed at the time of service. They should contain sufficient information concerning the reason for presenting and the diagnosis and treatment methods. Correct terminology and diagnosis codes are essential.
- Keep in mind that a patient's records could become a legal document, which you may be asked to interpret and defend in a court of law many years from now. It, therefore, should not be treated as a forum for unproven opinions, personality comments, assumptions, or derogatory statements to consultants, patients, peers, etc.: record the facts/omit opinions, judgments and assumptions. Never EVER alter a medical record after a query regarding the care of a patient.
- Death Certificates must be completed within 72 hours of the patient's death.
- Medico-legal issues, such as adverse events, angry patients or family members, etc. should be relayed to the Program Director and Faculty immediately. A lack of timely intervention frequently exacerbates problems.
- Delinquency in record completion may result in loss of vacation time in order to correct deficiencies.

Confidentiality:

Compliance with HIPPA regulations is mandatory. All information presented to you by a patient, by a doctor about a patient, by a patient's family about a patient, with few exceptions, is CONFIDENTIAL.

- Do not discuss patients with others while walking in the halls, in the elevator, in the cafeteria, or while in any public areas.
- During Grand Rounds and conferences, patients are never to be presented by their names.
- Copies of discharge summaries, operative reports, and other medical data are confidential and must be disposed of by acceptable legal means when no longer needed.

- Confidential, locked shred bins are provided in the Emergency Department as well as on the units. Do not place any confidential information in waste baskets or other receptacles that eventually end up in a commercial or city dump.
- In all instances, patients are to be treated with the same respect and confidentiality that you would afford your own family members.

Faculty Mentors:

Each resident will be assigned a faculty mentor at the beginning of residency training. The faculty member will be considered a mentor of the resident and will be expected to meet with the resident at a minimum on a biannual basis. These meetings will be arranged by the advisors throughout the year. However, all of our faculty members are eager to be of assistance to residents, and you should feel free to discuss problems, situations, ideas, etc. with the faculty at any time.

Residency Performance Evaluation Committee:

Academic Advancement

The Program Director, upon the recommendation of the Emergency Medicine Core Clinical Faculty, has the authority to advance a resident from one year to the next. The criterion for advancement follows the guidelines set forth within the Florida Hospital Graduate Medical Education Manual. This includes direct observation of the resident, rotation evaluations, correspondence between departments and written examinations (e.g. Core content tests, Inservice). It is expected that the residents participate in all aspects of the curriculum, as well as in the periodic evaluation of educational experiences and teachers. It is further expected that residents complete all administrative responsibilities of a resident (e.g. licensing, credentialing, etc.) in a timely fashion. The resident must have medical records that are thorough, comprehensive and completed in a manner consistent with Florida Hospital Medical Staff requirements. All evaluations (rotation requirements, preceptor and resident evaluation) must be documented prior to the resident semi-annual evaluation.

The criteria for advancement shall be based on six competencies set forth by the ACGME , all of which need to be evaluated as competent for the appropriate level of advancement. These parameters are:

1. Medical Knowledge – fund of knowledge, clinical performance rotation evaluation, clinical judgment, understanding and appropriate use of evidence-based medicine. PGY I residents must have successfully passed USLME III to be advanced to the second year.
2. Patient Care – ability to provide effective care of patients in both outpatient and inpatient settings; establish an appropriate doctor-patient relationship; application of knowledge to individual patient needs; effective gathering of patient information; procedural competence and experience.
3. Practice-Based Learning and Improvement -- able to analyze practice experience,

recognize limitations and make systematic improvements; ability to locate, appraise and assimilate evidence from scientific studies; use of information technology to manage information, access on-line medical information and support own education.

4. Professionalism– positive working relationship with others; acceptance of responsibility; punctuality; reliability; respect; compassion; ethical principles; cultural sensitivity; integrity ; responsiveness to the needs of patients and society that supersedes self-interest. There must be an absence of impaired function due to mental or emotional illness, personality disorder, substance abuse and other adjustment disorders. All residents, at every level, are expected to teach and supervise more junior residents and medical students.
5. Interpersonal and Communication Skills – effective information exchange with patients, their patient’s families and professional associates; work effectively with others as a member or leader of health care team.
6. Systems-based Practice – awareness of and responsiveness to the larger context and system of health care; ability to effectively call on system resources to provide care that is of optimal value; practice cost-effective health care and resource allocation that does not compromise quality of care.

There are three steps that shall be evaluated: the PGY1 to PGY2, the PGY2 to PGY3, and PGY3 to graduation. At each level, acceptable progress in the six competencies will need to be documented. Additionally, the PGY2 and PGY3 resident must be judged competent to act with limited independence. Before graduation, the resident must be judged competent to act independently.

PGY1-PGY2

- USMLE III complete
- All post tests complete
- Patient logs and procedures logged into New Innovations
- Medical Records up to date
- Satisfactory completion of rotations Blocks 1-13 (post-tests, assignments and evaluations)
- PGY1 research requirements complete
- In-Training Exam scores above 50th percentile (for their respective year of training) or Residency Performance Evaluation Committee Individual Education Plan requirements complete.

PGY2-PGY3

- Licensure application complete
- Medical Records up to date
- Patient logs and procedures logged into New Innovations

- Satisfactory progress of ultrasound procedures logged into New Innovations
- Satisfactory progress of critical care resuscitations logged into New Innovations
- PGY2 research requirements complete
- Satisfactory completion of rotations Blocks 1-13 (post-tests, assignments and evaluations)
- In-Training Exam scores above 50th percentile (for their respective year of training) or Competency Committee Individual Education Plan requirements complete.

PGY3-Graduation

- Satisfactory completion of rotations Blocks 1-13 (post-tests, assignments, and evaluations)
- Completed Research/Scholarly Activity project presented
- All evaluations of rotations completed (faculty of resident and resident of faculty)
- All post tests and faculty-assigned projects complete
- All EM-required procedures logged in to New Innovations (Satisfactory progress must have been demonstrated by March of predicted graduation date).
- All minimum number of procedures completed and logged into New Innovations (e.g. OB, Orthopedics, etc.)

Academic Probation

Additionally, in the course of residency training certain individuals may need special attention addressing specific needs. Among these are issues related to academic remediation / probation plans as well as disciplinary concerns. For this reason a Residency Performance Evaluation Committee will be charged with supervising such concerns. This committee exists as an ad hoc committee made up of at least three of the clinical faculty with Dr. Nazario serving as chair. The Residency Performance Evaluation Committee will assist the Program Director by developing an appropriate course of action.

For instance in developing a Remediation Plan, the Residency Performance Evaluation Committee will convene to develop an assessment of the resident's progress and their recommendation towards a resident's developing cognitive, clinical, psychomotor and behavioral skills. This meeting is to be attended by the resident, the Program Director and any other residency faculty deemed necessary. At its discretion the committee may use various factors in reaching their conclusions. These may include, and are not limited to:

Inservice results
 Semi-annual reviews
 Psychometric testing
 Referral to Physician Support Services
 Intense periodic evaluations – Daily shift Cards, Formative evaluations by selected faculty,
 Patient logs, etc.
 Referral to a Board review course

Failure to show progress in any of the areas detailed above may result in an administrative recommendation or action. This may include the requirement of remedial work, limitation of

moonlighting, extension of the training period, denial of promotion, termination of the Agreement, or denial of the certificate of completion. A resident who fails ANY rotation in a year may be denied promotion. The failure of a rotation is determined by a failed rotation evaluation and/or core content test.

Chain of Command Issues

If a resident experiences a difficulty with a decision from the Chief Residents, they should attempt to resolve the issue with the Chiefs. If the Chiefs cannot resolve the impasse, then the issue is brought to either the Associate PD or the Assistant PD (APD). They will serve as the final arbitrator for the great majority of these discussions. There should be exceedingly few dilemmas that cannot be resolved in this manner. Then, and only then, should the Program Director be contacted by either one of the APDs regarding said issue.

As a matter of professionalism, the chain of command assures that appropriate channels have been approached in a timely manner. This sets the stage for expectations in one's future employment and work in the field of medicine. Failure to comply with this may be considered as a breach of professionalism and will be referred to the Residency Performance Evaluation Committee.

Dismissal, Non-Renewal & Grievance:

Dismissal or non-renewal may occur because of failure of the resident to comply with his/her responsibilities or failure to demonstrate appropriate medical knowledge or skill as determined by the program's supervising faculty. Dismissal may also occur where there is misconduct. Examples of misconduct include but are not limited to: being under the influence of intoxicants or drugs; disorderly conduct, harassment of other employees (including sexual harassment); the use of abusive language, fighting or encouraging a fight; threatening, attempting, or causing injury to another person while on the premises. Please refer to the GME Policy Manual for specific policies.

A resident is usually not dismissed without a warning period, except in instances of flagrant misconduct. In other circumstances, it is the responsibility of the residency program director to document a warning period prior to dismissal or failure to reappoint a house officer and to demonstrate efforts for the provision of opportunities for remediation if needed. Such opportunities must be provided and documented and placed in the resident's training file. The resident is entitled to a copy of the documentation upon request.

In the event that a resident is to be dismissed or his/her contract not renewed, s/he may initiate a formal grievance procedure. Grievance procedures will follow the policy stated in the GME Policy Manual.

Professional Relationships:

Patient Care:

- Team: The team (attending physician, chief resident, intern/resident, nurse, and student) is responsible for each patient's care. Quality care for the individual patient is the ultimate goal of each team member.
- PGY-1 resident: The PGY-1 resident rotates in the Emergency Department and in Urgent Care. In the Emergency Department setting, s/he should evaluate the patient and present findings to the PGY-3 resident and attending. In the Urgent Care setting, the resident evaluates the patient and presents the findings to the PGY-2 resident and attending.
- PGY-2 resident: The PGY-2 resident manages both the urgent and emergent cases in the main Emergency Department. S/he performs many technical procedures and directly participates in major resuscitations. S/he supervises and runs the Urgent care area and teaches medical students and PGY-1 residents in minor care procedure.
- PGY-3 senior resident staff: The senior resident supervises over-all emergency department patient flow and provides clinical teaching and supervision to medical students and PGY-1 and PGY-2 residents with faculty oversight. The PGY-3 resident directs cardiac and trauma resuscitations. S/he also handles incoming patient telephone calls and rescue squad reports.
- Attending Physician: The attending physician holds ultimate responsibility for every aspect of patient care. S/he is also actively engaged in teaching and is responsible for providing guidance and experience in all facets of the patient's care.

Nursing Staff:

- The nursing staff is an integral part of the health-care team. Personal and professional courtesy will be extended to the nursing staff at all times. The nursing staff will be included in the patient's course of care at all times and should be advised of any changes in treatment/diagnostic plans, special requests, or anticipated problems.
- Residents are responsible for a significant contribution to the education of the nursing staff. Such information is vital to assist them in taking better care of the patients. Explanation and thoughtfulness will yield manifold results.
- Simple "pick-up-after-yourself" and care in performance of procedures will allow the nursing staff more time with your patients.

Pharmacy Staff:

- The pharmacist is another vital member of the health-care team. S/he is responsible for all medications dispensed in the hospital.
- S/he is also a ready source of information on the various therapeutic agents, their dosages, compatibilities, toxicities, administration forms, and combinations.
- It is the pharmacist's legal and professional responsibility to ensure that the intent of your order is fulfilled. When the pharmacist questions an order, s/he is doing so to ensure that the patient receives the appropriate medication in the appropriate dosage.
- If you are paged by the pharmacist, it is your duty to respond quickly and courteously.

Resident Interaction with Medical Students:

All residents will be expected to participate in the education and mentoring of medical students. This will enhance their training and will include:

- Teaching requisite patient care procedures
- Instructing in the development of logical approaches to clinical problems
- Encouraging reading in Emergency Medicine texts and journals, providing the student with select review articles on topics concerning their patients
- Instructing and assisting in the development of good patient care and treatment
- Reviewing each student's "work-ups" and providing constructive criticism
- Treating the medical student in a professional and courteous manner
- Assigning cases and patients
- Enforcing reading and preparation for specific cases that they will observe in the Emergency Department.

Continuity of Care/Night Call Activities:

Continuity:

Continuity of care is an important facet of residency training. There are multiple ways of obtaining this training. One method is follow-up of interesting/complicated patients after their transfer from the Emergency Department; another is the night-call experience.

Emergency Medicine residents are expected to follow-up on interesting/complicated patients that they saw in the Emergency Department. This can easily be accomplished by adding the patient to the sign-on list in the hospital computer system which enables the resident to receive daily follow-up, including operative reports, autopsy reports, discharge summaries, etc. Residents may also track who is currently caring for their patients in the event that they would like verbal follow-up to discuss the progress of these patients with the admitting service. Residents must be able to provide examples of this tracking to their attending.

Call Duties:

Night Call:

Another means of continuity in training is the call experience. The purpose of night call is to provide residents with patient care experiences throughout a 24 hour period. There are specific guidelines that provide for this experience while still maintaining adherence to duty hours policy:

- In-house call must occur no more frequently than every third night, averaged over a four-week period

- Continuous on-site duty, including in-house call, must not exceed 24 consecutive hours. Residents may remain on duty for up to 6 additional hours to participate in didactic activities, maintain continuity of medical and surgical care, transfer care of patients, or conduct outpatient continuity clinics.
- No new patients may be accepted after 24 hours of continuous duty, except in outpatient continuity clinics. A new patient is defined as any patient for whom the resident has not previously provided care.

In the first and second years of training, residents will have an average of 1.9 days per week of call, and in the third year of training, the amount of call will reduce to an average of 1 day per week.

On-Call duties for EM residents:

In order to provide full coverage in the Emergency Department during most of the week, residents will be placed on-call for a block at a time in the event that a resident who is scheduled to work is absent. The on-call resident must be in the city of Orlando and available when called to cover the absent resident. The resident who is on-call is excused from his activities on the rotation that he/she is on for that day. For those residents covering 7am-7pm shift, he/she is excused that day from his/her activities in whichever outside rotation the resident is on, and for those residents covering 7pm-7am shift, he/she is excused from his/her activities on the rotation he/she is on the following day. The Chief residents are responsible for notifying the preceptor that the on-call resident is covering a shift.

The resident that is scheduled to work and is absent will be sanctioned as per the rules set in the disciplinary action section of the handbook.

The on-call duty schedule is as follows:

- PGY1 residents will cover shifts when another PGY1 is absent.
- PGY2 residents and PGY3 residents will cover either one. PGY3 from July to December and PGY2 from January to July.

The rotations that will be used to assign the on-call residents are as follows:

- PGY1 resident during his/her EMS/ID rotation and another block assigned by the Chief Resident
- PGY2 resident will be on call in a block assigned by the Chief Resident
- PGY3 resident during his/her PM/Research rotation

Pager Call:

At-home call (pager call) is defined as call taken from outside the assigned institution.

- The frequency of pager call is not subject to the every third night limitation. However, pager call must not be so frequent as to preclude rest and reasonable personal time for each resident.

- Residents taking pager call must be provided with one day in seven completely free from all educational and clinical responsibilities, averaged over a four-week period.
- When the resident is called to the hospital from home, the hours spent in house will be counted toward the 80-hour limit.
- The program director and faculty must monitor the demands of pager call in their programs and make scheduling adjustments as necessary to mitigate excessive service demands and/or fatigue.
- In case of critical overload of sick patients, on call residents will aide in patient care.

On-Call Guidelines:

- The GMEC adheres to ACGME guidelines regarding the frequency of call. The policy may be found in the GME manual.
- Responsibilities while on call shall include responding to all calls in a prompt and courteous manner, either by phone or by personal evaluation of the patient, as appropriate. Additionally, any significant changes in patient coordination will be communicated to a senior resident and the responsible attending physician.

Duty Hours:

Duty hours are defined as all clinical and academic activities related to residency training, 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. The ACGME sets forth the following guidelines for training of residents in Emergency Medicine.

Duty Hours -- Emergency Medicine rotations:

- As a minimum, residents shall be allowed an average of 1 full day in 7 days away from the institution and free of any clinical or academic responsibilities, including planned educational experiences.
- While on duty in the emergency department, residents may not work longer than 12 continuous scheduled hours. Residents must have at minimum eight (8) hours off between shifts and, if possible, should have ten (10) hours off (as specified in ACGME VI.G.5.b)). The scheduled clinical shift is the basis for the required time off and allows the other clinical time (finishing documentation, handing off, etc.) to count towards the total duty hours average.
- A resident should not work more than 60 scheduled hours per week seeing patients in the ED and no more than 72 duty hours per week.

Duty Hours -- Non-Emergency Department Rotations:

- Duty hours must be limited to 80 hours per week, averaged over a four-week period, inclusive of all in-house call activities.
- Residents must be provided with 1 day in 7 free from all educational and clinical responsibilities, averaged over a 4-week period, inclusive of call. 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 time period provided between all daily duty periods and after in-house call.

Emergency Medicine residents at all levels of training shall be allowed an average of one day in seven (averaged over a four-week period) free of clinical responsibilities (see above).

Residents will be relieved of their clinical duties no later than 1:00 pm the day following in-house night call (a maximum of 6 hours post call).

Lack of compliance by any resident will result in the “Emergency Duty Hour Call Plan”: The residents who don’t come in will have to come in late that night.

Other Policies:

Disaster Plan (Hurricane):

At the issue of a Hurricane **WATCH** by State and/or local governments for Brevard, Volusia, Seminole, or Orange counties, faculty, residents, students, and staff will follow *initial preparations* guidelines.

At the issue of a Hurricane **WARNING** by State and/or local governments for Brevard, Volusia, Seminole, or Orange counties, faculty, residents, and students will activate for first 24 hour shift including overnight at the hospital in anticipation or preparation for the disaster. This is to ensure coverage in the event roads are not passable after the initial stages of the disaster. The second team will report to the hospital at 7:00 am the next day or as soon as physically possible to travel on the roads to relieve the first team that stayed overnight at the hospital. (See attached Team Assignments.) All Team Members should contact Medical Education to advise of status, location, and current phone numbers.

Initial Preparations:

At the issue of a Hurricane Watch, Team 1 should begin emergency preparations. Check pagers and have a fresh battery. Externs are to come to Medical Education and provide current phone number.

Notification of Disaster (Hurricane) Warning:

Teams will be activated. Normal rotations will be suspended until recovery is complete at a time determined by the DME.

All residents are to:

1. Report to the command center.
2. Support resident service areas if needed and available.
3. Keep attendings, Chiefs, and Command Center apprised of location and availability.
4. Both teams may be called in initially and the shifts worked out according to workload demands.

Teams will thereafter go to twelve-hour shifts with a twelve-hour recovery shift, or other shifts as assigned, before returning to normal rotations. Normal dress code regulations will be suspended for the duration of the emergency. Scrubs may be worn.

Medical Education office will be closed at the discretion of the DME.

All faculty, residents, externs, and other personnel are to wear name badges at all times while in the hospital. If name badge is missing, employee is to go to the command center check-in and be arm banded.

Faculty will release employees after discussion with the DME and not without Command Center notification and agreement. All employees will be available when in the hospital to provide whatever services Command Center may need. All employees are to be present at assigned location. Failure to appear will result in a review and possible disciplinary action up to and including termination.

Employees may bring immediate family members with them when they report to work. All family members are to bring three-day kits and bedding. Each person is to check in and be arm banded before taking them to their assigned location. Pets are not allowed.

All activities are to be coordinated with the Command Center.

After the Disaster (Hurricane)

The DME will meet with the Command Staff for debriefing. Disaster (Hurricane) Report will be provided to Administration.

Command Center:

The Command Center will begin functioning at the determination of the Hospital Administrator and will be located in the Emergency Department Conference Room. The DME or DME representative will attend all scheduled Command Center meetings prior to, during, and after disaster to assist with coordination.

Phone Numbers:

Special Needs Patients (Orange County) 836-7115
Medical Education FHEO 303-8683
Command Center Extensions at FHEO
6842, 6843, 6844, 6845, 6846, 6847, 6848, 6849, 6850, 6851
Cell phone number: 342-8232

Team Assignments:

Florida Hospital East Orlando – Department of Medical Education Team Assignments

<u>Team 1</u>	<u>Team 2</u>
Megan Leonard	Kevin Steinwachs
Lauren Py	Paul Passafiume
Jill Ward	Marshall Naquin
Breckon Pav	Vu Nguyen
Doran Heist	Javier Benitez
Hebron White	Troy Mostaan
Bret Sanders	David Holland
Frankie Mendiola	Jorge Insignares
Kristen VanderVelde	Zachary Wilson

Dress and Grooming:

All individuals on the Emergency Medicine service are expected to look and act as responsible physicians. Professional appearance and manners are to be exercised at all times in all environments, even though the work and conditions may be very stressful. Appropriate grooming and attire are always required. Good personal hygiene is mandatory. Use of deodorant is encouraged, and to be considerate of patients and fellow staff, residents should not wear strong fragrances.

The resident will be expected to follow the dress code as printed in the GMCEC manual. The policy on wearing scrubs is as follows: “Scrubs may be worn in the hospital when appropriate (ED, ICU, OB, Anesthesia, Surgery, Night rotations). Florida Hospital scrubs are not to be worn outside of the hospital. Athletic footwear may be worn in the hospital if the resident is wearing surgical scrubs. Physician white coats should be worn at all times if the resident is not wearing the approved scrubs or if scrubs do not have the residents name embroidered. When attending academic activities in hospital, residents are to dress in a professional attire and wear their physician white coat, as well. The use of torn or worn jeans, shorts, t-shirts, flip-flops or other inappropriate clothing is strictly prohibited.

Work Environment:

Providing a sound academic and clinical education must be balanced with concerns for patient safety and resident well-being. The program will ensure that the learning objectives of the program are not compromised by excessive reliance on residents to fulfill service obligations.

Didactic and clinical education must have priority in the allotment of residents' time and energies. Duty hour assignments must recognize that faculty and residents collectively have responsibility for the safety and welfare of our patients.

Leave:

The American Board of Emergency Medicine requirements for residency training in order to qualify for certification are specific regarding the amount of time that must be accomplished; the physician must successfully complete a minimum of thirty-six (36) months of post-medical school training under the control of an Emergency Medicine residency program accredited by the Accreditation Council for Graduate Medical Education (ACGME). The ABEM has adopted a policy regarding resident absence from a training program as it relates to the Board's credentialing requirements. The policy is as follows: "Leaves of absence, vacation time, sick time, etc., that exceed six weeks in an academic year require extension of the residency program. Such leave time cannot be accrued from year to year. Therefore, the Board defines an acceptable year of training as a minimum of 46 weeks." The program director is ultimately responsible for verifying successful completion of a resident's training time to fulfill the Board's minimum credential requirements. The ABEM further states that if a residency program already has a policy in effect for leave time that is less than six weeks, the program's policy may take precedent over the ABEM policy.

Further, it is the policy of Florida hospital that no time-off requests are permitted during the last two weeks of a resident's contract period. General guidelines for time away can be found in the GME manual.

Program-specific guidelines follow:

- Vacation/Sick Days/Holidays: Residents will be provided with 20 paid days off per year. This time includes vacation days, sick days, and holidays and is in addition to granted days for Board Examinations.
- Vacations may be requested in one-week blocks.
- No more than one week in a row/No more than one resident at a time/No vacation in ED blocks with only 2 residents assigned.
- No vacation time will be permitted during required planned educational conferences such as EKG and critical care conference, symposium on emergency medicine, ACLS, PALS, NRP and ATLS, along with the annual GME retreat. The program director will have to approve all vacations.
- Education: Florida Hospital provides the resident with an annual continuing education allowance and paid leave to attend educational activities that will contribute to the quality of their training.
- With the exception of the education leave allowance, leave may not be carried over from one appointment year to the next, and there is no payment for unused time.
- FMLA: Please refer to the GME Manual for specific policy on family and medical leave, extended sick leave, maternity leave, paternity leave, and adoption leave.

- Written request for time off is mandatory and must be submitted to the Program Director. Initial requests will be solicited prior to the start of the academic year while the annual schedule is being written. Requested vacation periods are not guaranteed. Requests for changes must be accompanied by prearrangement of who will cover the resident's absence on a service with mandatory coverage.
- **Unexcused absences:** If a resident does not show up for assigned hours, including night call, without notifying his Chief Resident or Program Director, the absence will be considered unexcused. Unexcused time will be taken from the resident's leave bank. If the unexcused absence is repeated, disciplinary action may be taken by the Program Director depending on the severity and frequency of the infraction. Arrangements for "payback" to the other residents who may be assigned to cover in the resident's absence will be made at the discretion of the Program Director. Unexcused absence will result in an additional shift and 30 minutes lecture on a Thursday that will be scheduled in advance. It is common courtesy to let your attending, chief resident or directors know that you are going to be late or not show up to your shift as early as possible.

Moonlighting:

Because residency is a full-time endeavor and duty-hours regulations must be adhered to, it is the policy of the Emergency Medicine Residency Program that moonlighting privilege will be merit based. It is contingent upon the resident meeting or exceeding all academic and scholarly activities requirements as defined by: In-service performance, clinical performance, research requirements, and cannot be in behavioral or academic remediation.

Stress, Fatigue and Impairment:

The Program Director and faculty realize that residency training is a time of high stress. They will make every effort to monitor residents on their rotations for signs of stress, fatigue, or impairment. The resident can assist on his/her own behalf by adhering to duty-hour mandates and by communicating problems with his/her preceptor, faculty advisor, or the Program Director. Signs and symptoms of fatigue, stress, or impairment include some of the following:

1. Recent changes in behavior, including irritability, mood swings, inappropriate behavior, a breakdown in logical thought, trembling, slurred speech
2. Irresponsibility, such as failure to respond to calls, late arrivals for shifts or call, neglect of patients, incomplete charting, unexplained absences
3. Inaccurate or inappropriate orders or prescriptions
4. Insistence on personally administering patients' analgesics or mood-altering medications rather than allowing nursing staff to carry out orders
5. Poor concentration or poor memory, such as failure to remember facts about individual patients
6. Depression
7. Evidence of use or possession of alcohol or other drugs while on duty; intoxication at social events

8. Anger, denial, or defensiveness when approached about an issue
9. Unkempt appearance and/or poor hygiene
10. Complaints by staff or patients
11. Unexplained accidents or injuries to self
12. Noticeable dependency on alcohol or drugs to relieve stress
13. Isolation from friends and peers
14. Financial or legal problems
15. Loss of interest in professional activities or social/community affairs

In situations of stress, fatigue, or impairment, the faculty or resident may approach the Program Director or the Program Director may call a meeting with the resident. The problem will be discussed and the Program Director will make recommendations for resolving the problem. Such recommendations may include use of services within Florida Hospital such as the Employee Assistance Program, Employee Health Services, Physician Support Service, or referral to a counselor or psychiatrist. For further information, please refer to the GMEC policy on Impairment found in the Graduate Medical Education Manual.

Impairment:

Florida Hospital, along with the medical staff and graduate medical education is committed to providing safe, effective, timely, and respectful medical care while fostering an environment that promotes practitioner health. We affirm that substance use disorders and other behavioral health disorders are treatable illnesses and after treatment, practitioners can return to the safe and effective practice of medicine with appropriate monitoring. Please refer to the GME Manual for specific policy on impairment.

Resources:

Employee Assistance Program (EAP): This program assists faculty, staff, and their families with the resources they need to resolve personal, family, or job-related problems. EAP offers a comprehensive worksite-based program to assist in the prevention, early intervention, and resolution of problems that may impact job performance. The EAP is staffed with well-trained, caring professionals who listen and offer support and guidance. EAP is confidential and voluntary. You can contact EAP at: (407) 303-3690 (or tie: 844-3690).

Employee Health Clinic: The employee health clinic handles pre-employment physicals, performs annual physical assessments and PPD tests, and administers vaccinations. It also provides triage and evaluation for work-related injuries during normal business hours and does educational promotions, blood-borne pathogen counseling and treatment, and follows up on TB and other infectious disease exposures. The employee clinic can be reached at: (407) 303-1535 (or tie: 844-1535). Residents may opt to go to the Family Health Clinic for a charge of \$10.00 per visit.

Physician Support Service: This service is available to medical staff and residents. The service may be utilized by contacting Dr. Paolini's office at: (407) 691-5476. Your residency coordinator will have pamphlets and business cards for your use if you have questions about this service.

Faculty psychologists: The psychologists on staff as part of the staff in Graduate Medical Education are also available to the residents and their families as a resource in times of stress.

General Information:

Ink Stamps:

At the beginning of training, each resident will be issued a small pre-inked rubber stamp with his/her name. This stamp is to be used on all official documents, including, but not limited to: medical records, patient notes, and prescriptions in addition to the resident's signature. If the stamp is lost, it will be the resident's responsibility to notify the program coordinator and to pay for replacement when a new stamp is ordered.

Pagers:

Each resident will be assigned a pager which provides the primary method of communication while on duty. The pager should be turned on during all duty hours, and the battery should be checked frequently to assess signal strength. Damaged or lost pagers will be the responsibility of the resident. At any time on duty that you are unable to personally respond to pages (for example, in the OR) leave your pager with the desk in the OR.

Pagers can be accessed from hospital phones by dialing "87" or from outside the hospital by calling (407) 303-5599. Wait for the tone before inputting pager number and return number. Alternatively, text pagers can also be accessed for short text messages via "Wireless Office Messenger" from a Florida Hospital computer. A list of pager numbers will be made available to you for easy reference of the numbers frequently contacted.

Not answering pages during assigned duty hours will be considered grounds for disciplinary action and/or dismissal from the residency.

At the completion of residency training, the pager will be turned in for reassignment.

Resident File Access:

The GMEC requires that the resident's file is regarded as confidential, is maintained in a secure location, and is available only to the following:

1. Program Director
2. Residency Coordinator
3. Director of Academic Affairs
4. Administrator of Medical Education

5. Chair of Medical Education
6. Resident (under supervision)

The GMEC authorizes the Program Director, Director of Academic Affairs, Administrator of Medical Education, or the Chair of Medical Education to disclose the file or portions thereof to others whom they deem to have a legitimate need for the information or as authorized in writing by the resident. The GMEC policy requires that the exterior of each file will state: “Confidential Information – Access to this File and its Information is governed by the GME Manual on Resident File and Access.” Electronic files will have this statement on its opening or at a place within the file designated by the Program Director.

Resident Loan Deferment:

Loan deferment forms should be submitted to the residency coordinator. The department will certify the house officer’s current academic year of training and the anticipated graduation date.

Resident Workspace, Lockers & Mailboxes:

Office space is provided in the Emergency Department and lockers will be provided. A computer with inter- and intranet access will be available and access to EPIC Mailbox and EPIC for medical records and laboratory reports will be on this computer. Space will be provided, as well, for storage of personal items. Resident mailboxes for regular mail and schedules are also located in this space.

EM Resident Follow- Up Procedure

The Emergency Medicine Residency Review Committee requires EM Residents to obtain outcome or follow-up data on patients evaluated and treated on Emergency Department rotations. During EM month rotations, residents are required to complete four patient follow-ups per four week ED rotations. Residents are required to complete the Follow-up Template on the selected patients and place them in their portfolio in New Innovations and have a paper copy available on request from the department. The Follow-up template will be made available by both electronic and paper format.

Follow –up portfolio consists of three parts. First, select an interesting, complex or confusing case you saw. Secondly, seek information from a textbook, journal or other source (maybe several sources). Lastly, reflect on how your new knowledge would change your approach to this and future cases. This is the essence of practice-based learning.

Example:

1. Select one of your own cases that you felt required additional knowledge to treat comfortably. Patient had atypical pain but I was concerned because he had ECG changes and new dyspnea on exertion. He was young? Was this an MI or something else? If it was something else, could I have sent him home? How will I know next time?
2. Obtain a copy of the chart. You may keep one of the patient's labels then later print a copy of the scanned chart from FirstNet.
3. Obtain patient follow up information. Contact the admitting resident or access a discharge summary from the electronic medical record. IE the patient had pericarditis and was discharged home on NSAID's
4. Find the answers to the questions that arose as you managed the case using textbooks, articles, online sources, consulting experts or some other source. Summarize the things you learned and list the references.
5. Reflect on what you learned. How would you have managed this case differently i.e. how does this change your future practice? This reflection could be in the form of a letter or a concluding paragraph. I'll look for these EKG changes I missed the first time. Though he did not have all the typical features he had.....Keep all of these components and place in a folder for program director at end of four week EM period.

Florida Hospital Medical Center
Emergency Medicine Residency Program
R-1 Emergency Medicine Resident
RULES OF THE ROAD
2011-2012

Emergency Medicine Residents at the R-1 level for the 2011-2012 Academic Year are expected to:

General Requirements

1. Be aware that this EM Residency is three years in duration.
2. Attend EM Residency Orientation, including ACLS and ATLS courses (or provide documentation of current card from these courses), residency orientation, East Orlando Hospital orientation and Florida Hospital Orlando orientation.
3. Review educational goals and objectives for each R-1 rotation prior to starting the rotation. These goals and objectives will be given to each resident at the start of the R-1 year.
4. Review R-1 annual block schedule for the year, including assigned rotations and vacation blocks.
5. Behave in a highly professional manner, maintaining appropriate standards of conduct, dress, and hygiene. This also includes being on time to work, both on the EM rotations (shifts) and off-service rotations. Always treat patients as customers to whom a service is being provided.
6. Observe the norms of practice, call frequency, scheduling, and shift/call duration, as assigned on EM and off-service rotations.
7. Complete patient documentation and medical records in a timely manner as required by EM and off-service rotations.
8. Review rotation call/shift schedules in advance and deal with any scheduling conflicts in a timely manner.
9. Report absence from clinical responsibilities on a rotation for a break, lunch, etc. to the senior resident/faculty on that service.
10. Get prior approval from the administrative EM Chief Resident and the Residency Office for planned absences from EM and off-service rotations (e.g. vacation, USMLE exam, a day or more on off-service rotation, etc.). Also get prior approval by the involved off-service rotation Chief Resident or other appropriate personnel for planned absences (senior resident or Attending).
11. Discuss unanticipated absence due to illness as early as possible with the administrative EM Chief Resident and if rotating on off-service rotation, with Chief Resident for that service or other appropriate personnel. The R-1 resident will attempt to find coverage (e.g. shift change), and follow other standard procedures for the Residency. It is expected that the R-1 resident will make up the shift at a later date, preferably by covering a shift for the resident that covered the ill shift. When possible, permission will be given for unanticipated absence due to family emergency. The same rules as above apply to this situation.
12. Show up for all scheduled shifts or scheduled off-service rotation days. Failure to show up

for a scheduled shift or off-service rotation day that necessitates calling in a different resident will result in a need to pay back double the amount of time. For example, if a resident fails to show up for a shift and the on call resident covers the shift, then the resident who missed the shift owes 2 shifts to the on-call person who covered the shift. This occurs automatically whenever the on-call person arrives and starts to cover the shift or off-service day.

13. Unexcused absences: If a resident does not show up for assigned hours, including night call, without notifying his Chief Resident or Program Director, the absence will be considered unexcused. If the unexcused absence is repeated, disciplinary action may be taken by the Program Director depending on the severity and frequency of the infraction. Unexcused absence will result in an additional shift and 30 minutes lecture on a Thursday that will be scheduled in advance. It is common courtesy to let your attending, chief resident or directors know that you are going to be late or not show up to your shift as early as possible.
14. Arriving late to a shift. It is unacceptable to arrive late to your shift. Unexplained lateness meaning arrival greater than 15 minutes after the start of a shift is late. Late shifts will count as unexcused absence. Additionally the unexcused time will result in making the time up on an extra shift and plus a lecture. Showing up late more than 5 minutes on your shift twice in one block it will also be considered an unexcused absence and you will be required to make up an extra shift plus a lecture.
15. Work the full length of the shift or off-service duty period, unless intentionally released early by the supervising attending (EM blocks) or senior resident (off-service blocks). On the Pediatric EM service, this is done only with the permission of the Pediatric attending.
16. Comply with requests/deadlines from the Residency Office for information, documentation requests, etc. For example, selecting elective time by a certain date as requested.
17. Read emails in a timely manner, checking at least once a week. The Chief Residents or Residency Office can assist you with information on how to check emails when you are off-campus on off-service rotations or at home.
18. Notify Program Director of any malpractice claim, question of impropriety, or unexpected adverse outcome on the EM or off-service rotations.
19. Notify Program Director of any serious conflicts on the EM or off-service rotations
20. Notify Residency Office (Residency Coordinator) of changes of address, phone number or pager number.
21. Supply Residency Office (Residency Coordinator) with updated medical licenses, DEA and DPS certificates (if applicable), as well as copies of current ACLS, BLS, and ATLS cards showing successful completion of courses and expiration dates.

22. Complete daily shift cards for review and have supervising attending sign
23. Log all your duty hours on new innovations as this is the residents responsibility.

While on duty at Florida Hospital Orlando attend all Grand rounds that do not conflict with the EM Didactic series:

Here is a list of regularly scheduled Grand Rounds:

Medicine GR	12:00pm 1 st Wed of the month	Werner Auditorium
OB/GYN GR	7:30am 3 rd Thu of the month	doctor's lounge Orlando
Peds GR	7:00am 1 st Thu of the month	doctor's lounge Orlando
Cardiovascular GR	7:00am 4 th Wed of the month	Werner Auditorium
Digestive GR	7:00am 4 th Tue every OTHER month (May, July etc).	doctor's lounge Orlando

Academic Requirements

1. Complete and stay current on all academic requirements, including conference -attendance, EMS requirements, timely procedure log data entry, timely follow-up logs, examinations, and presentations at residency conference. There may be additional academic requirements as deemed necessary by the Program Director - the resident will receive written notice of any additional requirements. A review of current status of these academic requirements will be presented to the R-I resident.
2. Attend 100% of the Residency Conferences. Inform the Residency Leadership if you are having difficulties getting back for conferences. Residency conferences are mandatory scholarly activities. All are required to attend all conferences. This time is protected from any other activities for that purpose. Attendance to conferences will be considered as a regular shift and the same rules for unexcused absences will apply.
3. Complete EMS requirements as assigned to the R-I class for the academic year, including 4 hours of 911 Call station observation and 1 EMS ride-out. There is no helicopter ride-out requirement for the Residency. But if a resident chooses to ride with the helicopter, this will replace the one EMS ride-out requirement. The EMS ride-out can also be with a system Medical Director or a shift supervisor for the EMS service. The ride-out can be done with Orlando or suburban EMS services.
4. Complete procedure log data entry, paying special attention to recording resuscitations. Data should be entered when performing procedures. The procedure log provides important documentation of resident experience, and will be reviewed when the Program Director and the Promotion & Competency Committee evaluate resident clinical competency, and for recommendations as to hospital privilege credentialing and licensing. Some hospital credentialing committees are now requesting copies of your procedure log as an adjunct to documenting skill competencies. The recording of procedures at various hospitals is also of importance to us when we review the effectiveness of an off-service rotation such as the Florida Hospital Critical Care Rotation. Of critical importance is the documentation of resuscitations. The RRC-EM defines "resuscitation" as "patient care where prolonged physician attention is

needed, and interventions such as defibrillation, cardiac pacing, treatment of shock, intravenous use of drugs (e.g. thrombolytics, vasopressors, neuromuscular blocking agents), or invasive procedures (e.g. cutdowns, central Line insertion, tube thoracostomy, endotracheal intubation) are necessary for stabilization and treatment." The resuscitation should have "director" or "participant" listed as the role of the EM resident. Please also separate Pediatric and Adult medical and trauma resuscitations. Minimum numbers of resuscitations that must be documented prior to graduation include: 45 Adult Medical Resuscitations, 15 Pediatric Medical Resuscitations, 35 Adult Trauma Resuscitations, and 10 Pediatric Trauma Resuscitations. Residents should also be careful to document conscious sedation (minimum 15), ventilator management (minimum 20), intubations (minimum 35), chest tubes (minimum 10), lacerations, deliveries, lumbar punctures, and other procedure minimums as defined by the Program. As an informational item, the R-2 resident will be expected to have completed half the number of procedures listed above by the mid-point of the R-2 year. The Program Director and Promotion & Competency Committee will respond to small numbers of procedures and resuscitations with significant concern, and take appropriate action.

5. Turn in completed follow-up logs on 10 patients for blocks of adult and pediatric EM, 4 blocks total, by the end of the block following the EM block (4 weeks after completing the rotation). These logs will include both admitted and discharged patients.
6. Prepare campus case conferences, Rosen chapter reviews, Toxicology and procedural updates, along with critical literature updates as assigned. Actively participate in the conference pearls program. Presentation might include interesting X-rays, CT's, clinical findings, unusual presentations of disease, etc. The residents will be responsible to present different topics on conference day as per discussion with chief residents.
7. Prior to graduation, EM residents will complete a scholarly activity project. This project must be approved in advance through the Program leadership. The scholarly activity project will be of publishable quality and may be original research, review article, - case report, abstract, chapter, etc. The project may be done during any of the three years, but the resident is strongly urged to decide on a project and begin the project by the mid point of the R-2 year. Follow EM Research Curriculum Guideline.
8. Comply with residency for failure to complete academic requirements. Upon notification of being out of compliance, the resident will meet with the program director or designated faculty member to discuss the problem and develop an action plan. Thereafter the resident will meet every 4 weeks with the program director or designated faculty member to discuss progress in coming into compliance with the requirement. Upon notification of being out of compliance, the resident will have 28 days from notification or other time period as deemed necessary by program director or designated faculty member to come into compliance with the requirements. In addition the resident will have two 12- hour ED shifts added to the next block rotation schedules. If the resident is still out of compliance after the block, further actions including possible termination will be taken. Due process will be followed. Rotational hours will remain in compliance with RRC-EM.
9. Residents who are not current on the residency academic requirements will be counseled and other potential actions include academic probation. It should be noted that completion of all R-1

academic requirements is necessary for promotion to the R-2 level. The Department's Due Process Policy will be followed with regards to academic probation.

Examinations

1. Participate in the annual In-Training Examination administered by the American Board of Emergency Medicine.
2. Participate and successfully complete other written examinations as required by the Program.
3. The results of examinations may be used by the Promotion & Competency Committee and the Program Director to develop individual resident academic goals for the upcoming year, including but not limited to a special reading program. Low scores are of concern and the resident may have outside physician employment privileges limited or removed to encourage reading and academic endeavors to improve the resident's knowledge base.

Evaluations

1. Faculty and senior EM residents will evaluate performance for R-1 adult EM rotations. Composite evaluations for the EM and blocks as well as rotation evaluations for off-service rotations will be available in the Resident Portfolios. These evaluations will then be summarized in the two semiannual evaluations. Problem evaluations will be brought to the attention of the R-1 resident and an appropriate response developed.

Core Competencies

1. The residency is incorporating the new ACGME required core competencies in the education and evaluation process. All residents receive a copy of the competency-based form used for evaluation during the EM block rotations.
2. The template used for the residency curriculum is the Model Practice of Emergency Medicine that has been modified to include the core competencies.
3. The core competencies are an integral part of the overall resident evaluation process, including the rotation evaluations, the Evaluation by Direct Observation, and in the Nursing Evaluation of EM Residents.
4. Resident Portfolios are available to all EM residents in the Residency Office during office hours. Contents of the Portfolio include: annual block rotation schedules, follow-up logs, procedure log updates, evaluations (including exam results), scholarly activity, performance improvement project, Rules of the Road, EMS activities, Specific contents can be seen in the table of contents for each Portfolio. In addition to the above, there will be a section added for updates on conference attendance.

Outside Physician Employment

1. Adhere to the policy of no outside physician employment during the residency.

Other Requirements

1. Do not perform patient care or procedures that are beyond the scope/training of the R-1 resident, or for which the resident feels uncomfortable. For example, if the R-1 resident doesn't feel comfortable with a procedure, then assistance from a more senior resident or faculty should be sought.
2. Be aware that the Promotion and Competency Committee of the Department of Emergency Medicine will meet at least semi-annually to make recommendations to the Program Director on resident progression to the next year of training, and other matters related to the resident's clinical, professional, and academic performance.
3. Progress to the R-2 year only after successful completion of all R-1 clinical performance/competency requirements and the academic requirements.
4. Be aware that board-certified or board-prepared EM and Pediatric EM Faculty provide faculty supervision for all EM rotations.
5. Read the Education Goals and Objectives for the Residency Program document provided to all EM residents.
6. Read the Patient Care Responsibilities and Resident Supervision document provided to all EM residents.
7. Read the Resident Due Process document provided to all EM residents.
8. Be aware that the Program Director, Associate and Assistant Program Directors and Chief Residents are available 24 hours/day, 7 days/week to provide support, answer questions, and assist the R-1 resident. The Residency Coordinator, Education Assistant, and other Department personnel are also available to assist the R-1 resident.

I have read and acknowledge the 2011 – 2012 Rules of the Road.

R-1 Resident Signature and
Printed Name: _____
Date: _____

Dale S. Birenbaum, MD, Program Director

Date: _____

Florida Hospital Medical Center
Emergency Medicine Residency Program
R-2 Emergency Medicine Resident
RULES OF THE ROAD
2011-2012

Emergency Medicine Residents at the R-2 level for the 2011-2012 Academic Year are expected to:

General Requirements

1. Review educational goals and objectives for each R-2 rotation prior to starting the rotation. These goals and objectives were given to each resident at the start of the R-2 year.
2. Review R-2 annual block schedule for the year, including assigned rotations and vacation blocks.
3. Contact Rotation Directors/Coordinators for the R-2 off-service rotations at least 4 weeks in advance of the start of the rotation to discuss scheduling, rotation requirements, etc.
4. Behave in a highly professional manner, maintaining appropriate standards of conduct, dress, and hygiene. This also includes being on time to work, both on the EM rotations (shifts) and off-service rotations. Always treat patients as customers to whom a service is being provided.
5. Observe the norms of practice, call frequency, scheduling, and shift/call duration, as assigned on EM and off-service rotations.
6. Complete patient documentation and medical records in a timely manner as required by EM and off-service rotations.
7. Review rotation call/shift schedules in advance and deal with any scheduling conflicts in a timely manner.
8. Report absence from clinical responsibilities on a rotation for a break, lunch, etc. to the senior resident/faculty on that service.
9. Get prior approval from the administrative EM Chief Resident and the Residency Office for planned absences from EM and off-service rotations (e.g. vacation, USMLE exam, a day or more on off-service rotation, etc.). Also get prior approval by the involved off-service rotation Chief Resident or other appropriate personnel for planned absences (senior resident or Attending).
10. Discuss unanticipated absence due to illness as early as possible with the administrative EM Chief Resident and if rotating on off-service rotation, with Chief Resident for that service or other appropriate personnel. The R-2 resident will attempt to find coverage (e.g. shift change), and follow other standard procedures for the Residency. It is expected that the R-2 resident will make up the shift at a later date, preferably by covering a shift for the resident that covered the ill shift. When possible, permission will be given for *unanticipated absence due to family emergency*. The same rules as above apply to this situation.
11. Show up for all scheduled shifts or scheduled off-service rotation days. Failure to show up

for a scheduled shift or off-service rotation day that necessitates calling in a different resident will result in a need to pay back double the amount of time. For example, if a resident fails to show up for a shift and the on-call resident covers the shift, then the resident who missed the shift owes 2 shifts to the on-call person who covered the shift. This occurs automatically whenever the on-call person arrives and starts to cover the shift or off-service day.

12. Unexcused absences: If a resident does not show up for assigned hours, including night call, without notifying his Chief Resident or Program Director, the absence will be considered unexcused. If the unexcused absence is repeated, disciplinary action may be taken by the Program Director depending on the severity and frequency of the infraction. Unexcused absence will result in an additional shift and 30 minutes lecture on a Thursday that will be scheduled in advance. It is common courtesy to let your attending, chief resident or directors know that you are going to be late or not show up to your shift as early as possible.
13. Arriving late to a shift. It is unacceptable to arrive late to your shift. Unexplained lateness meaning arrival greater than 15 minutes after the start of a shift is late. Late shifts will count as unexcused absence. Additionally the unexcused time will result in making the time up on an extra shift and plus a lecture. Showing up late more than 5 minutes on your shift twice in one block it will also be considered an unexcused absence and you will be required to make up an extra shift plus a lecture.
14. Work the full length of the shift or off-service duty period, unless intentionally released early by the supervising attending (EM blocks) or senior resident (off-service blocks).
15. Comply with requests/deadlines from the Residency Office for information, documentation requests, etc. For example, selecting elective time by a certain date as requested.
16. Read emails in a timely manner, checking at least once a week. The Chief Residents or Residency Office can assist you with information on how to check emails when you are off-campus on off-service rotations or at home.
17. Notify Program Director of any malpractice claim, question of impropriety, or unexpected adverse outcome on the EM or off-service rotations.
18. Notify Program Director of any serious conflicts on the EM or off-service rotations.
19. Notify Residency Office (Residency Coordinator) of changes of address, phone number or pager number.
20. Supply Residency Office (Residency Coordinator) with updated medical licenses, DEA and DPS certificates (if applicable), as well as copies of current ACLS, BLS, and ATLS cards showing successful completion of courses and expiration dates.
21. Complete daily shift cards for review and have supervising attending sign.
22. Log all your duty hours on new innovations as this is a resident responsibility.

While on duty a Florida Hospital Orlando attend all Grand rounds that do not conflict with the EM Didactic series:

Here is a list of regularly scheduled Grand Rounds:

Medicine GR	12:00pm 1 st Wed of the month	Werner Auditorium
OB/GYN GR	7:30am 3 rd Thu of the month	doctor's lounge Orlando
Peds GR	7:00am 1 st Thu of the month	doctor's lounge Orlando
Cardiovascular GR	7:00am 4 th Wed of the month	Werner Auditorium
Digestive GR	7:00am 4 th Tue every OTHER month (May, July etc).	doctor's lounge Orlando

Academic Requirements

1. Complete and stay current on all academic requirements, including conference -attendance, EMS requirements, timely procedure log data entry, timely follow-up logs, examinations, and presentation of a literature review for residency conference. There may be additional academic requirements as deemed necessary by the Program Director - the resident will receive written notice of any additional requirements. A review of current status of these academic requirements will be presented quarterly to the R-2 resident.
2. Teach and evaluate R-1 EM residents, rotating residents, and medical/PA students.
3. Attend 100% of the Residency Conferences. Inform the Residency Leadership if you are having difficulties getting back for conferences. Residency conferences are mandatory scholarly activities. All are required to attend all conferences. This time is protected from any other activities for that purpose. Attendance to conferences will be considered as a regular shift and the same rules for unexcused absences will apply.
4. Complete procedure log data entry, paying special attention to recording resuscitations. Data should be entered when performing procedures. The procedure log provides important documentation of resident experience, and will be reviewed when the Program Director and the Promotion & Competency Committee evaluate resident clinical competency, and for recommendations as to hospital privilege credentialing and licensing. Some hospital credentialing committees are now requesting copies of your procedure log as an adjunct to documenting skill competencies. The recording of procedures at various hospitals is also of importance to us when we review the effectiveness of an off-service rotation such as the Florida Hospital Critical Care Rotation. Of critical importance is the documentation of resuscitations. The RRC-EM defines "resuscitation" as "patient care where prolonged physician attention is needed, and interventions such as defibrillation, cardiac pacing, treatment of shock, intravenous use of drugs (e.g. thrombolytics, vasopressors, neuromuscular blocking agents), or invasive procedures (e.g. cutdowns, central Line insertion, tube thoracostomy, endotracheal intubation) are necessary for stabilization and treatment." The resuscitation should have "director" or "participant" listed as the role of the EM resident. Please also separate Pediatric and Adult medical and trauma resuscitations. Minimum numbers of resuscitations that must be documented prior to graduation include: 100 Adult Medical Resuscitations, 25 Pediatric Medical Resuscitations, 75 Adult Trauma Resuscitations, and 15 Pediatric Trauma Resuscitations. Residents should also be careful to document conscious sedation (minimum 15), ventilator

management (minimum 20), intubations (minimum 35), chest tubes (minimum 10), lacerations, deliveries, sexual assault exams, and other procedure minimums as defined by the Program. As an informational item, the R-2 resident will be expected to have completed half the number of procedures listed above by the mid-point of the R-2 year. The Program Director and faculty will respond to small numbers of procedures and resuscitations with significant concern, and take appropriate action.

5. Turn in completed follow-up logs on 10 patients for each block of adult and pediatric EM, 4 blocks total, by the end of the block following the EM block (4 weeks after completing the rotation). These logs will include both admitted and discharged patients.
6. Prepare campus case conferences, Rosen chapter reviews, Toxicology and procedural updates, along with critical literature updates as assigned. Actively participate in the conference pearls program. Presentation might include interesting X-rays, CT's, clinical findings, unusual presentations of disease, etc. The residents will be responsible to present different topics on conference day as per discussion with chief residents.
7. Prior to graduation, EM residents will complete a scholarly activity project. This project must be approved in advance through the Program leadership. The scholarly activity project will be of publishable quality and may be original research, review article, - case report, abstract, chapter, etc. The project may be done during any of the three years, but the resident is strongly urged to decide on a project and begin the project by the mid point of the R-2 year.
8. Comply with residency for failure to complete academic requirements. Upon notification of being out of compliance, the resident will meet with the program director or designated faculty member to discuss the problem and develop an action plan. Thereafter the resident will meet every 4 weeks with the program director or designated faculty member to discuss progress in coming into compliance with the requirement. Upon notification of being out of compliance, the resident will have 28 days from notification or other time period as deemed necessary by program director or designated faculty member to come into compliance with the requirements. In addition the resident will have two 12- hour ED shifts added to the next block rotation schedules. If the resident is still out of compliance after the block, further actions including possible termination will be taken. Due process will be followed. Rotational hours will remain in compliance with RRC-EM.

Examinations

1. Participate in the annual In-Training Examination administered by the American Board of Emergency Medicine.
2. Participate and successfully complete other written examinations as required by the Program.
3. The results of examinations may be used by the faculty and the Program Director to develop individual resident academic goals for the upcoming year, including but not limited to a special reading program. Low scores are of concern and the resident may have outside physician

employment privileges limited or removed to encourage reading and academic endeavors to improve the resident's knowledge base.

Evaluations

1. Faculty and senior EM residents will evaluate performance for R-2 adult EM rotations. Composite evaluations for the EM and blocks as well as rotation evaluations for off-service rotations will be available in the Resident Portfolios. These evaluations will then be summarized in the two semiannual evaluations. Problem evaluations will be brought to the attention of the R-2 resident and an appropriate response developed.

Core Competencies

1. The residency uses the new ACGME required core competencies in the education and evaluation process. All residents receive a copy of the competency-based form used for evaluation during the EM block rotations.
2. The template used for the residency curriculum is the Model Practice of Emergency Medicine that has been modified to include the core competencies.
3. The core competencies are an integral part of the overall resident evaluation process, including the rotation evaluations, the Evaluation by Direct Observation, and in the Nursing Evaluation of EM Residents.
4. Resident Portfolios are available to all EM residents in the Residency Office during office hours. Contents of the Portfolio include: annual block rotation schedules, follow-up logs, procedure log updates, evaluations (including exam results), scholarly activity, performance improvement project, Rules of the Road, EMS activities, Specific contents can be seen in the table of contents for each Portfolio. In addition to the above, there will be a section added for updates on conference attendance.

Outside Physician Employment

1. Adhere to the policy of no outside physician employment during the residency.

Other Requirements

1. Do not perform patient care or procedures that are beyond the scope/training of the R-2

resident, or for which the resident feels uncomfortable. For example, if the R-2 resident doesn't feel comfortable with a procedure, then assistance from a more senior resident or faculty should be sought.

2. Progress to the R-3 year only after successful completion of all R-2 clinical performance/competency requirements and the academic requirements.
3. Be aware that board-certified or board-prepared EM and Pediatric EM Faculty provide faculty supervision for all EM rotations.
4. Read the Education Goals and Objectives for the Residency Program document provided to all EM residents.
5. Read the Patient Care Responsibilities and Resident Supervision document provided to all EM residents.
6. Read the Resident Due Process document provided to all EM residents.
7. Be aware that the Program Director, Associate and Assistant Program Directors and Chief Residents are available 24 hours/day, 7 days/week to provide support; answer questions, and assist the R-2 resident. The Residency Coordinator and other Department personnel are also available to assist the R-2 resident.

I have read and acknowledge the 2011-2012 Rules of the Road.

R-2 Resident Signature and
Printed Name: _____
Date: _____

Dale S. Birenbaum MD, Program Director
Date: _____

Florida Hospital Medical Center
Emergency Medicine Residency Program
R-3 Emergency Medicine Resident
RULES OF THE ROAD
2011-2012

Emergency Medicine Residents at the R-3 level for the 2011-2012 Academic Year are expected to:

General Requirements

1. Review educational goals and objectives for each R-3 rotation prior to starting the rotation. These goals and objectives were given to each resident at the start of the R-3 year.
2. Review R-3 annual block schedule for the year, including assigned rotations and vacation blocks.
3. Contact Rotation Directors/Coordinators for the R-3 off-service rotations at least 4 weeks in advance of the start of the rotation to discuss scheduling, rotation requirements, etc. For elective rotations, you will need approval from both the residency office as well as the elective rotation director to take the rotation. You will need to set up elective rotations a minimum of two blocks ahead of the rotation. If this is a new rotation, you will need 3 blocks advanced planning.
4. Behave in a highly professional manner, maintaining appropriate standards of conduct, dress, and hygiene. This also includes being on time to work, both on the EM rotations (shifts) and off-service rotations. Always treat patients as customers to whom a service is being provided.
5. Observe the norms of practice, call frequency, scheduling, and shift/call duration, as assigned on EM and off-service rotations.
6. Complete patient documentation and medical records in a timely manner as required by EM and off-service rotations.
7. Review rotation call/shift schedules in advance and deal with any scheduling conflicts in a timely manner.
8. Report absences from clinical responsibilities on a rotation for a break, lunch, etc. to the senior resident/faculty on that service.
9. Get prior approval from the administrative EM Chief Resident and the Residency Office for planned absences from EM and off-service rotations (e.g. vacation, USMLE exam, a day or more on off-service rotation, etc.). Also get prior approval by the involved off-service rotation Chief Resident or other appropriate personnel for planned absences (senior resident or Attending).
10. Discuss unanticipated absence due to illness as early as possible with the administrative EM Chief Resident. If rotating on off-service rotation, with Chief Resident for that service or other appropriate personnel. The R-3 resident will attempt to find coverage (e.g. shift change), and follow other standard procedures for the Residency. It is expected that the R-3 resident will make up the shift at a later date, preferably by covering a shift for the resident that covered the ill shift. When possible, permission will be given for unanticipated absence due to family emergency. The same rules as above apply to this situation.

11. Unexcused absences: If a resident does not show up for assigned hours, including night call, without notifying his Chief Resident or Program Director, the absence will be considered unexcused. If the unexcused absence is repeated, disciplinary action may be taken by the Program Director depending on the severity and frequency of the infraction. Unexcused absence will result in an additional shift and 30 minutes lecture on a Thursday that will be scheduled in advance. It is common courtesy to let your attending, chief resident or directors know that you are going to be late or not show up to your shift as early as possible.
12. Arriving late to a shift. It is unacceptable to arrive late to your shift. Unexplained lateness meaning arrival greater than 15 minutes after the start of a shift is late. Late shifts will count as unexcused absence. Additionally the unexcused time will result in making the time up on an extra shift and plus a lecture. Showing up late more than 5 minutes on your shift twice in one block it will also be considered an unexcused absence and you will be required to make up an extra shift plus a lecture.
13. Show up for all scheduled shifts or scheduled off-service rotation days. Failure to show up for a scheduled shift or off-service rotation day that necessitates calling in a different resident will result in a need to pay back double the amount of time. For example, if a resident fails to show up for a shift and the on call resident covers the shift, then the resident who missed the shift owes 2 shifts to the on-call person who covered the shift. This occurs automatically whenever the on-call person arrives and starts to cover the shift or off-service day.
14. Work the full length of the shift or off-service duty period, unless intentionally released early by the supervising attending (EM blocks) or senior resident (off-service blocks).
15. Comply with requests/deadlines from the Residency Office for information, documentation requests, etc. For example, selecting elective time by a certain date as requested.
16. Read emails in a timely manner, checking at least once a week. The Chief Residents or Residency Office can assist you with information on how to check emails when you are off-campus on off-service rotations or at home.
17. Notify Program Director of any malpractice claim, question of impropriety, or unexpected adverse outcome on the EM or off-service rotations.
18. Notify Program Director of any serious conflicts on the EM or off-service rotations.
19. Notify Residency Office (Residency Coordinator) of changes of address, phone number or pager number.
20. Supply Residency Office (Residency Coordinator) with updated medical licenses, DEA and DPS certificates (if applicable), as well as copies of current ACLS, BLS, and ATLS cards showing successful completion of courses and expiration dates.

Academic Requirements

1. Complete and stay current on all academic requirements, including conference -attendance, EMS requirements, timely procedure log data entry, timely follow-up logs, examinations, and presentation of a literature review for residency conference. There may be additional academic requirements as deemed necessary by the Program Director - the resident will receive written notice of any additional requirements. A review of current status of these academic requirements will be presented quarterly to the R-3 resident. There may be additional requirements as assigned by the Residency Director and you will receive prior written notice on this. All Academic requirements must be completed by the last week of May to graduate on time.
2. Teach and evaluate R-1 and R-2 EM residents, rotating residents, and medical/PA students
3. Attend 100% of the Residency Conferences. Inform the Residency Leadership if you are having difficulties getting back for conferences. Residency conferences are mandatory scholarly activities. All are required to attend all conferences. This time is protected from any other activities for that purpose. Attendance to conferences will be considered as a regular shift and the same rules for unexcused absences will apply.
4. Complete administrative rotation in the third year.
5. Complete procedure log data entry, paying special attention to recording resuscitations. Data should be entered when performing procedures. The procedure log provides important documentation of resident experience, and will be reviewed when the Program Director and the Promotion & Competency Committee evaluate resident clinical competency, and for recommendations as to hospital privilege credentialing and licensing. Some hospital credentialing committees are now requesting copies of your procedure log as an adjunct to documenting skill competencies. The recording of procedures at various hospitals is also of importance to us when we review the effectiveness of an off-service rotation such as the Florida Hospital Critical Care Rotation. Of critical importance is the documentation of resuscitations. The RRC-EM defines "resuscitation" as "patient care where prolonged physician attention is needed, and interventions such as defibrillation, cardiac pacing, treatment of shock, intravenous use of drugs (e.g. thrombolytics, vasopressors, neuromuscular blocking agents), or invasive procedures (e.g. cutdowns, central Line insertion, tube thoracostomy, endotracheal intubation) are necessary for stabilization and treatment." The resuscitation should have "director" or "participant" listed as the role of the EM resident. Please also separate Pediatric and Adult medical and trauma resuscitations. Minimum numbers of resuscitations that must be documented prior to graduation include: 100 Adult Medical Resuscitations, 25 Pediatric Medical Resuscitations, 75 Adult Trauma Resuscitations, and 15 Pediatric Trauma Resuscitations. Residents should also be careful to document conscious sedation (minimum 15), ventilator management (minimum 20), intubations (minimum 35), chest tubes (minimum 10), lacerations, deliveries, sexual assault exams, and other procedure minimums as defined by the Program. As an informational item, the R-2 resident will be expected to have completed half the number of procedures listed above by the mid-point of the R-2 year. The Program Director and faculty will respond to small numbers of procedures and resuscitations with significant concern, and take appropriate action.

6. Turn in completed follow-up logs on 10 patients for each block of adult and pediatric EM, 3 blocks total, by the end of the block following the EM block (4 weeks after completing the rotation). These logs will include both admitted and discharged patients. No logs for period 11, 12, 13 of PGY-3 year.
7. Prepare campus case conferences, Rosen chapter reviews, Toxicology and procedural updates, along with critical literature updates as assigned. Actively participate in the conference pearls program. Presentation might include interesting X-rays, CT's, clinical findings, unusual presentations of disease, etc. The residents will be responsible to present different topics on conference day as per discussion with chief residents.
8. Prior to graduation, EM residents will complete a scholarly activity project. This project must be approved in advance through the Program leadership. The scholarly activity project will be of publishable quality and may be original research, review article, case report, abstract, chapter, etc. The project may be done during any of the three years, but the resident is strongly urged to decide on a project and begin the project by the mid point of the R-2 year.
9. Comply with residency for failure to complete academic requirements. Upon notification of being out of compliance, the resident will meet with the program director or designated faculty member to discuss the problem and develop an action plan. Thereafter the resident will meet every 4 weeks with the program director or designated faculty member to discuss progress in coming into compliance with the requirement. Upon notification of being out of compliance, the resident will have 28 days from notification or other time period as deemed necessary by program director or designated faculty member to come into compliance with the requirements. In addition the resident will have two 12- hour ED shifts added to the next block rotation schedules. If the resident is still out of compliance after the block, further actions including possible termination will be taken. Due process will be followed. Rotational hours will remain in compliance with RRC-EM.

Examinations

1. Participate in the annual In-Training Examination administered by the American Board of Emergency Medicine.
2. Participate and successfully complete other written examinations as required by the Program.
3. The results of examinations may be used by the faculty and the Program Director to develop individual resident academic goals for the upcoming year, including but not limited to a special reading program. Low scores are of concern and the resident may have outside physician employment privileges limited or removed to encourage reading and academic endeavors to improve the resident's knowledge base.

Evaluations

1. Complete two Evaluations by Direct Observation experiences during the R-3 year. If a resident is not felt to meet all the competency requirements listed on the evaluation form for this experience, the Program Director will meet with the resident to respond to this. Likely responses

include 2 additional evaluations. These evaluations are included in the promotion decision process to the R-3 level, and meeting competency requirements is required to advance to the R-3 level.

2. Faculty and senior EM residents will evaluate performance for R-3 adult EM rotations. Composite evaluations for the EM and blocks as well as rotation evaluations for off-service rotations will be available in the Resident Portfolios. These evaluations will then be summarized in the two semiannual evaluations. Problem evaluations will be brought to the attention of the R-3 resident and an appropriate response developed.

Core Competencies

1. The residency uses the new ACGME required core competencies in the education and evaluation process. All residents receive a copy of the competency-based form used for evaluation during the EM block rotations.
2. The template used for the residency curriculum is the Model Practice of Emergency Medicine that has been modified to include the core competencies.
3. The core competencies are an integral part of the overall resident evaluation process, including the rotation evaluations, the Evaluation by Direct Observation, and in the Nursing Evaluation of EM Residents.
4. Resident Portfolios are available to all EM residents in the Residency Office during office hours. Contents of the Portfolio include: annual block rotation schedules, follow-up logs, procedure log updates, evaluations (including exam results), scholarly activity, performance improvement project, Rules of the Road, EMS activities, Specific contents can be seen in the table of contents for each Portfolio. In addition to the above, there will be a section added for updates on conference attendance.

Outside Physician Employment

1. Adhere to the policy of no outside physician employment during the residency.

Other Requirements

1. Do not perform patient care or procedures that are beyond the scope/training of the R-3 resident, or for which the resident feels uncomfortable. For example, if the R-3 resident doesn't feel comfortable with a procedure, then assistance from a more senior resident or faculty should be sought.
2. Be aware that graduation requirements for the R-3 resident include professional and clinical performance sufficient to allow the resident to practice independently and competently, as well as completion of all academic requirements of the residency. For residents who complete all requirements and graduate on time, the Verification of Training letter will be signed and returned to the American Board of Emergency Medicine in the usual manner, during the first week in July following graduation,

residents who are felt to be clinically competent but who have not completed all academic requirements will not graduate formally from the program until the requirements have been met. In addition, the training verification letter to ABEM will also include this information, and the resident will not be allowed to sit for the boards until the requirements have been met and ABEM is notified accordingly.

3. Graduation will occur only after successful completion of all R-3 clinical performance/competency requirements and the academic requirements.
4. Be aware that board-certified or board-prepared EM and Pediatric EM Faculty provide faculty supervision for all EM rotations.
5. Read the Education Goals and Objectives for the Residency Program document provided to all EM residents.
6. Read the Patient Care Responsibilities and Resident Supervision document provided to all EM residents.
7. Read the Resident Due Process document provided to all EM residents.
8. Be aware that the Program Director, Associate and Assistant Program Directors and Chief Residents are available 24 hours/day, 7 days/week to provide support, answer questions, and assist the R-3 resident. The Residency Coordinator, Education Assistant, and other Department personnel are also available to assist the R-3 resident
- 9.

I have read and acknowledge the 2011-2012 Rules of the Road.

R-3 Resident Signature and
Printed Name: _____
Date: _____

Dale S. Birenbaum MD, Program Director
Date: _____