

EDUCATIONAL DUTIES

Each resident has specific responsibilities to the residency program which will be outlined throughout this handbook under educational duties, clinical duties, and departmental regulations. The resident's contract addresses salary and fringe benefits and the guarantee of due process. Recognition and adherence to the duties outlined here do not require a written contract, and mutual agreement is implied by the resident's presence in the program beyond the first week of training. Each resident is expected to be familiar with these standards.

The goal of the Texas Tech Emergency Medicine Residency is to provide residents with an extensive experience in the art and science of medicine in order to achieve excellence in patient care. To achieve this goal the resident must commit to the following:

1. Under the supervision of the Residency Directors and faculty, assume responsibility for the safe, effective and compassionate care of patients, consistent with the resident's level of education and experience; and develop an understanding of ethical, socioeconomic & medical legal issues that affect the practice of medicine.
2. Participate fully in the educational and scholarly activities of the residency program and, as required, assume responsibility for teaching and supervising other residents and medical students.
3. Develop and participate in a personal program of self study and professional growth with guidance from the teaching staff.
4. Certain rotations call for the presentation of a didactic Conference. These include Research, Peds ED, Toxicology and Trauma.
5. Participate in institutional programs, committees, and activities involving the medical staff as assigned by the program director, and adhere to the established policies, procedures, and practices of the sponsoring organization and its affiliated institutions.
6. Apply cost containment measures in the provision of medical care.
7. Keep charts, records, and reports up to date and signed at all times.
8. Each Resident is expected to achieve ACLS Provider and Instructor, & ATLS Certification. APLS & PALS certification is encouraged. ACLS Instructor courses are held the 4th Thursday of February for PGY-I's, at no cost. In turn, they must teach an ACLS Provider course within 90 days. For recertification after the 90 days, registration fees will be deducted from bookfunds. PGY-III's who have never taken the Instructor course must pay the full fee of \$150.00.
9. Successful clinical and academic completion of rotations will be the primary, but not sole, criteria for promotion. Failure to demonstrate satisfactory academic and/or professional skill performance may constitute grounds for dismissal from the residency if an appropriate period of remediation is not successful.

CLINICAL DUTIES

The resident is expected to perform his/her duties with a mature and professional demeanor. The resident shall endeavor to establish and maintain intra- and inter-departmental rapport. While on duty, the resident should be responsive to guidance from both faculty and senior supervising residents. The resident may be assigned to give direction and instruction to residents, students, and nursing personnel working under his or her supervision. The resident should maintain a good attitude and cheerfully accept the duties and work schedules as published. Problems may be addressed to the Chief Residents or the Residency Director(s). The present Resident ED schedule is planned to maximize the time there are an EM-3, EM-2 and an EM-1 resident together in the ED.

Residents are expected to:

1. Arrive at work early enough to be ready to assume full duties at the designated shift start time. Being late to work and conferences reflects adversely on your professionalism and demonstrates disrespect for your peers and faculty. **Whenever conference is completed the ED residents for the day are expected to go to the ED promptly and check with the faculty before going to lunch.**
2. Manage patients in an appropriate and timely fashion. Insure a steady flow pattern, seeing non-urgent patients on a first-come, first-serve basis. Notify faculty of the presence of patients requiring enhanced documentation (Medicare & Medicaid pts). Special documentation & codes:

The following classes require faculty evaluation & a note documenting as follows:
“I saw and evaluated the pt. I agree with the findings & plan of care as documented by the resident.” or “I was present with resident during H & P. I discussed case with resident & agree with findings & plan as documented by resident.”

A-Medicare
G-Tricare/Champus

The following financial classes require a statement of supervision by faculty physician. (example: “I supervised pt. Care & agree/disagree with plan of care”) & check tethering block or statement.

U-Mcaid (Superior)	B-Medicaid
H-Out of state Mcaid(New Mex.)	O- Mcaid Eligible Vendor (pending Mcaid)
E/V-Chip	W-CIDC

Procedures require a teaching physician note.
Minor procedure <5 min. present during entire procedure
Major procedures > 5 min. present during key portion
(A statement of faculty presence can be appended to the procedure note.)

Only faculty time counts towards critical care. There must be a statement by faculty Of total time provided. (I provided 30 minutes of critical care...) this excludes time spent On procedures.

3. Assist the nursing staff with patient triage.
4. Follow the guidelines in the **Progression of Responsibility Policy**, which is located in the Department Policy section.
5. Assume complete charge of patient management (keep track of the status of your patients) until care is

physically transferred from the ED, your staff agrees, and the chart documentation is finished.

6. Manage any break periods for the benefit of all physicians, seeing that everyone is given appropriate consideration.
7. Manage any type of acute care situation decisions and seek specialty consultation at an appropriate interval.
8. After credentialing, Manage EMS Medical Control calls (EM-2 level.)
9. Complete all chart work and check out all patients to next on-duty Emergency Medicine resident prior to leaving work area. Check your ED box daily for charts returned for clarification by the faculty.
10. Dress appropriately as a physician. Either be clean-shaven or grow a beard. No "Miami Vice" dishevelment. You should wear shirt, tie and slacks (professional clothing for women) or TT EM department standard scrubs with a physician's white coat strongly suggested. No jeans or mix and match. You must wear socks with closed toe shoes of neutral colors and the shoes should be clean of blood or other debris. White shoes should be avoided. Black or ox-blood show stains the least or wear shoe covers. Nametags must be visible at all times and cannot be defaced. The patient has a right to know the name of the physician providing his or her care.
11. Document all charts on the "T-System" sheet. Wound check notes on the ED records. Use the personalized prescriptions and the name stamp for all documentation. If you have to make changes to a record use a single line through the incorrect text and initial the line out. Do not try to obliterate the prior text!
12. Maintain up-to-date medical record charting. When finishing the care of a patient be sure to write a diagnosis on the chart or "T-System" sheet. With the diagnosis write all procedures done for the patient, including suturing, use of restraints, use of conscious sedation, etc. **Have the faculty sign your chart before discharging the patient.**
13. **Maintain up-to-date & complete Procedure Logs using New Innovations.**
14. Remain alert and ready for all emergencies.
15. **Adhere to the published work schedules. Changes happen with some frequency. When a change involves you, an email will be sent to you and a phone call made. However, since stuff happens, when you leave the ED check the latest schedule to be sure when you are expected back at work.**
16. Follow guidelines, procedures and protocols established by faculty and administration as outlined in this Binder.

Important. At this level of professional training a physician is expected to seek out needed information about patient care responsibilities, work schedules, administrative requirements, etc. The use of "I didn't know" is not acceptable. Ask questions, and ensure matters are covered properly. If questions arise or there is a conflict in the advice given, do what is best for the patient and consult with the Attending Physician. Note that attendings may differ in their approach to the patients. This is good for your education. You may occasionally feel caught in the middle during sign-out but ultimately the faculty signing the chart of disposition must take responsibility for the care.

Risks to the EM Resident

There are certain risks inherent in the practice of Emergency Medicine. A partial list is included below. Any resident noting any of the following in self or others is expected to act in a professionally responsible fashion. Discussion with the Chief Resident or Residency Director is encouraged.

Risk of personal harm to the resident, either direct or indirect.

1. Avoid direct injury by not confronting dangerous patients alone or behind closed doors. With patients who seem paranoid or agitated, casually stay between them and the door to the room, so that you can escape if necessary.
2. Avoid indirect injury by observing universal precautions, & by obtaining all appropriate immunizations. Use the no touch suture trays for any patient with risk factors for Hep C or HIV. If you suffer a needle stick or other exposure OSHA regulations require that you notify faculty immediately, and the Texas Tech Occupational Health nurse (545-6501) by the next duty day.

Risk of stress injury, either physical or mental.

1. Do not single-handedly pick up heavy patients.
2. Spread your work hours appropriately. Use your vacations to relax, not just to moonlight.

Risk of substance abuse.

10% of Americans misuse drugs. Don't misuse alcohol, nicotine, or medications. Don't use illegal drugs. If you need a drink after work, talk to your peers or friends about the feelings. Physicians have a good rehabilitation rate, but problems are easier to treat early.

DEPARTMENT BENEFITS

1. Laboratory coats will be laundered at no charge by the Thomason laundry.
2. Picture IDs for TGH will allow free meals in the cafeteria if your medical records are up to date.
3. Parking at Thomason is in the staff garage in back of the hospital on Alberta, not in the front of the ED, or in the Alameda patient lot.
4. Dues for resident membership in ACEP, SAEM, and EMRA will be paid by the department. You will receive the Annals of EM and Academic EM.
5. A basic text in Emergency Medicine will be provided for each resident.
6. Each resident will receive \$100.00 per year for purchase of books and journals. More may be won in occasional quizzes that may be given.
7. All residents are encouraged to submit papers for presentation at major meetings. Expenses to major meetings for presentations will be paid by the Department. Time off and expenses for other types of conferences may or may not be allocated as deemed necessary by the Residency Director. After 18 months of residency each resident in good standing, and with adequate conference attendance, will be funded for one educational meeting from among the following: ACEP or AAEM Scientific Assembly, Winter Symposium, Clinical Forum, Research Forum, TCEP Annual Meeting or the SAEM Annual Meeting.
8. Support for research is available, and residents are expected to participate in clinical research. The Department will assist in procuring funding, equipment purchase, manuscript preparation and the like.
9. The Department maintains its own library with standard texts and reprint files for use by the residents. All books are available for check out for short periods (no more than 1 month). The resident should follow proper check out procedure. Each resident is responsible for return of all material and may have the residency certificate withheld until all books are returned and accounted for. In addition, the ED Computer is fully equipped with medical literature software.
10. A number of computer assets are available to the residents. Emergency Medicine tests, literature reviews and searches are all available. General computer programs are available.

RESIDENCY EXPECTATIONS

1. The term of residency will be three (3) years. Contracts are for one year and will be renewed based on acceptable progress.
2. The call schedules for off-service rotations shall be variable and be designed to meet both the resident and service requirement for the supervising department. Off-service rotation hours will be in compliance with the ACGME requirement.
3. The work schedule for the Emergency Department will be dependent on the graduate level of the resident. Generally, the EM-I resident can expect to work nineteen shifts per month (12 hours each) and have at least every fifth day off. Usually they will have every fourth day off. EM-2 residents work 18 shifts per month in the ED and EM-3 residents work 17 shifts. Residents will not trade shifts so they work more than 5 shifts straight without 24 continuous hours off. All simple trades must be approved > 72 hours in advance by the Chief Resident of Operations.
4. The resident can expect to have senior resident and/or staff assistance and supervision available to him at all times.
5. Work schedules will not be changed without prior approval of the residency director and will not be changed to accommodate out-of-department activities.

ORIENTATION TO THE ED

1. All patients presenting to the Emergency Department for care will be evaluated by a physician. Patients are classified as Class I - IV, I's being emergencies with immediate life threatening problems (multiple trauma, code arrests, etc.), II's being emergent care problems (asthma, chest pain, etc.) Class III patients are urgent (abdominal pain, stable fractures, and febrile illness). Class IV patients are stable and non-urgent.
2. The Emergency Medicine resident in charge (EM-II or III) or faculty will meet all ambulance arrivals for initial triage and consultation with EMS personnel. EMS medical control will be managed by the Emergency Medicine residents and staff. The resident in charge should assign a physician to the patient's care if he determines that the patient is presenting with an urgent condition.
3. The Emergency Department physician is responsible for all patients in the Emergency Room until the patient has been admitted, transferred, or discharged. The emergency physician's responsibility is shared with, but does not end when another service has been consulted.
4. **Procedures:** EM Residents and rotators working in the ED are supervised by faculty present. All procedures are therefore performed in the presence of the ED faculty. EM Residents on off-service rotations are supervised under the guidelines of that department. EM-1 residents beginning residency in July are required to complete the **Basic Skills Checklist (see attached)**, with faculty providing one-on-one documentation of the residents ability to safely perform the procedures noted. This checklist is to be returned to the Residency Coordinator.
5. **Histories, Physicals, Progress Notes & General Documentation:** Histories and physical exams are done with the supervising faculty present in the ED. Rotators and EM-1 residents are required to have the faculty at the bedside for the first five pelvic exams. All documentation of new patient encounters uses the T-Sheet System in the ED. The faculty will cosign these with independent or concurrent physical exam by the faculty on certain patients as required by federal guidelines.
6. If a physician has participated to any significant extent in the evaluation and care of a patient, i.e., history and physical, the physician should sign the chart. If the patient work-up is still in progress at the time of shift change, care will be turned over to the oncoming physician. This transition of care, and the time that the care was turned over, should be indicated on the chart. The accepting physician should also sign the chart if he makes a significant contribution to the evaluation and care of the patient, especially if he is involved with decision-making. The on-coming physician should not accept the patient if he does not know the patient well, is uncomfortable with the disposition previously arranged, or does not provide care for the patient.

If the physician has only participated in a preliminary manner with a patient's care, i.e. not seen the patient, but perhaps ordered an old chart, asked the nurses to move a patient to another room or undress a patient prior to examination or assigned a medical student to the case, the physician should not sign the chart. A Triage Physician may sign initial orders but not provide further care, nor sign the chart. As much as possible patients should not be turned over to another physician in the middle of a work-up, especially if the patient's case is quite complex, or hinges on an exam difficult to repeat, i.e. pelvic. If possible the initial physician should follow through, seeking consultation if necessary.
7. **Consultations:** Residents in the ED should discuss the case with the faculty before calling for consultation. **Under no circumstances will unwritten and informal opinions be sought or**

accepted from other services. Obtaining consultations from other services should not be delayed pending laboratory work that will not add materially to the patient's work-up. Such delays, while providing some convenience to the consulting physician, are not consistent with good medical care and have medico-legal implications. Complaints from other services about this policy should be referred to the faculty on duty who will handle the problem appropriately.

It is vitally important that the time of consultation be recorded both on the consultation form and on the ED record. Several other services have written guidelines about the performance of consults and we should help them with written data. The emergency physician has the option of agreeing or not agreeing with any consultation. If the patient is to be discharged home a reasonable compromise must be found. If agreement is not obtained then the faculty physician should be consulted.

- A. Surgery - For all surgical problems, including the surgical sub-specialties, with the exception of orthopedics, the surgical resident should be consulted. **For major trauma cases and any immediate life threatening surgical condition, i.e. ruptured abdominal aneurysm, the trauma team senior resident should be paged.** For routine surgical consultations the 1st call surgical resident should be called.
- B. Orthopedics - Orthopedics should be consulted on all major or complicated fractures and dislocations. Certain cases may be referred to clinic. A copy of a consult and any X-rays are placed in the appropriate consult box.
- C. Pediatrics - Should be consulted on children with significant problems (up to the age of 17), unless consultation from orthopedics or surgery is more appropriate. Pediatrics should be consulted on all cases of suspected child abuse/neglect.
- D. Obstetrics/Gynecology - Pregnant patients who are beyond the 20th week of pregnancy with a complaint referable to the pregnancy i.e. vaginal bleeding, abdominal pain, pre-eclampsia etc. should be referred to L&D for treatment. Others will be seen in the Emergency Department.
- E. Family Medicine - Family Medicine patients should be seen in follow-up by Family Practice. Emergent care should be delivered by the EM physicians.
- F. Internal Medicine - Medicine consultation is requested on all patients at the time of administration of thrombolytic therapy for myocardial infarction. The attending cardiologist on call should be consulted only by faculty. Do not delay indicated therapy in emergencies. The EM faculty will decide if admission to Internal Medicine is indicated.

8.. **Follow-up Appointments:**

- A. Texas Tech Clinics - For chronic problems and comprehensive evaluation of non-emergent conditions, and long term follow-up, the patient should be referred to the appropriate specialty clinic. **Current Primary Clinics Roster kept in ED**
- B. Orthopedics - Patients treated for fractures except nasal, skull, facial, or rib fractures should be referred to the Orthopedic Clinic for follow-up. Patients with minor sprains may be referred to a primary care provider. To enable a patient to be seen in the ortho clinic the protocol is as follows:
- Write a consult describing the injury, X-ray findings and treatment provided
 - Insure that this consult is stamped with a phone number for the patient (ask the patient if the phone number on the stamper card is accurate)
 - Place the consult & X-rays obtained in the box in the physician's area
 - Tell the patient to call after noon on the next weekday to obtain the appointment.
- Back pain without fracture, neurological findings or spondylolysis/spondylolisthesis can be referred to a PCP.
- C. Seizure clinic - Adult patients with seizure disorders should generally be referred to Seizure Clinic. They should have a primary care M.D. if they have any other problems.
- D. Surgical Clinics:
- Ophthalmology - An ophthalmologist is available. If the patient requires urgent, but not emergent consultation, contact the eye clinic during normal working hours.
- Urology- Complete a consultation Form with a time frame of consultation need. If unfunded, a copy goes to Medical Management.
- General Surgery- Busy, but able to see patients in an appropriate time frame as requested on a written consult.
- ENT - Consultation form with time frame of consultation needed.
- Oral Surgery- Private practitioners are on call.
- E. Medicine Clinic- In general the waiting time for medicine clinic follow up is long, 2-3 months, and more. Frequently, the clinic is closed to new patients. Patients must be seen in the general medicine clinic prior to referral to the specialty clinics.
- F. Community Clinics- If the patient has a personal physician please refer the patient to this individual. Patients wishing to transfer from outlying clinics to central TTUHSC clinics should expect a long wait. Primary care resources, most of which include IM, Peds and FP are indicated in the follow-up sections of the Logicare instructions under Primary Care – El Paso and Primary Care – New Mexico, respectively Juarez residents are referred to doctor of choice in Mexico, unless they have insurance.
- G. Access to care is very limited for many individuals seen in our ED. Patients requiring urgent follow-up should be discussed with faculty for options. Do your best to meet the patient's needs.

9. Transfers: Resident physicians should not accept patients in transfer from other hospitals. Transfers from other hospitals are the responsibility of the admitting service & also require approval of the hospital administration. Private physicians may give a call regarding patients they are sending from a private office. This does not require permission, however, a private M.D. should be notified if they are sending critically ill patients & we have no ICU beds.

10. MEDICOLEGAL

- A. Rape/Sexual Abuse: **NOTIFY FACULTY**. Do not begin an evaluation in any way on a stable patient before faculty is notified.
- B. Psychiatric Patients - Patients brought to the Emergency Department on a Police Custody Order (PCO) must be seen by a physician, but not necessarily a psychiatrist. A court ordered emergency detention Mental Illness Affidavit (MIA) is specifically for a psychiatric evaluation (see below). The emergency physician's primary duty is to evaluate the patient for the possibility for organically based alteration of mental function, and excluding that, to make a brief assessment of the patient's mental condition including suicidal and or homicidal risks. Patients with a need for Emergency Psychiatric care will generally need to be transferred to the El Paso Psychiatric Center through the Mental Health Authority Crisis Hot-Line. Faculty will assist in this. **Note that any licensed physician may perform a medical exam determining the presence of mental illness and risk of harm to self or others. The forms are available from the case workers and after notarizing are faxed to a Judge for an order of confinement to a mental health facility for treatment. This meets the requirements of the MIA and is recommended as a means to facilitate the transfer of the patient to EPPC or NCED without further need for evaluation by MHA.**
- C. Medical Examiner Cases: Patients expiring within 24 hours of hospital presentation must be referred to the county medical examiner's office. The admitting office will do this. You should cooperate with the Medical Examiner's assistants in evaluating the cause of death and allowing them to copy the chart. We recommend that you do not sign death certificates on patients in whom you are not sure of the cause of death. This is properly a job for a PCP with a good knowledge of the patient.
- D. Animal Bites: All animal bites occurring in the U.S. must be reported to Animal Control. In El Paso or Juarez, especially in areas near the Rio Grande, or with wild animal bites, prophylaxis against rabies should be considered. A form is available in the triage area to assist in this.
- E. Medical Records: Assessment and disposition should be appropriate for the subjective and objective findings. Records should stand up under close scrutiny of the faculty and any legal observers. Documentation should include all vital signs, treatment prior to admission, medications, tetanus status, allergy assessment, treatment, and response to treatment, instructions, follow-up arrangements, condition on discharge, dosage and amounts of prescribed medications, and signature with stamp of the physician's name.
- F. Faculty Supervision: The Emergency Medicine resident will have direct access to faculty for supervision and guidance at all times. When faculty is not physically present in the Emergency Department, the following guidelines shall be utilized:
1. The most senior Emergency Medicine resident in the department shall be in charge.

2. The faculty will inform this resident where on campus he can be found and will be available by phone or by pager.
3. The resident in charge should call the faculty physician for any problem for which the resident feels he needs advice or assistance.
4. The resident in charge should call the faculty physician anytime a patient arrives or is anticipated to arrive who is critically ill or in need of invasive procedures even if the resident feels capable of the requisite emergency care.

11. Wound Check Clinic

WCC is our ER follow-up for lacerations, wounds, I & D,s, eye injuries, cellulitis, and very minor burns. Surgery has its own clinic for their post-op patients, so send them there. Our WCC time is 7:00 - 7:30 am (no stragglers, they must register) every morning except Thursday (EM Conference).

This is a free follow-up for ER-surgical problems - no new problems or concerns to be seen. Patients may return as often as the physician deems necessary. Patients with medical problems that need one follow-up visit can be sent to Urgent Care Clinic (see Urgent Care Clinic paragraph)

Do not schedule wound check visits on Thursdays. The ED faculty will call you from conference to evaluate the patient yourself.

Basic Laceration Guidelines: 2 to 3 day follow-up is needed only in contaminated wounds or in those in whom flap viability is a concern. Facial lacerations: 3-5 days from placement; Scalp lacerations: 5-7 days. Extremity lacerations: 10-14 days (especially 14 days over a joint) Lacerations repaired with dermabond may or may not need follow-up.

When in doubt - err on the longer time for removal rather than earlier in our population. Have patient return then for suture removal at an assigned date. The patient does not need to follow up earlier unless there are signs of infection.

Suture Removal: - Remove sutures

- Steri-strip with Benzoin. If you have patients using Neosporin, they can discontinue after 24-48 hours.

Incision & Drainage: Follow-up 24 - 48 hours after incision and drainage. Remove packing (if placed) and clean. Repack lightly as needed or place wick. This must be done every day, so instruct the patient to do so or have daily wound check clinics until repacking is not indicated. For major incision and drainage, especially perianal abscesses or pilonidal cysts, they should also follow-up in the Surgery Clinic.

Burns & Road Rash: Superficial 1-2 degree burns - Neosporin to facial burns 1st and 2nd degree. Larger burns/road rashes in critical areas such as hands, joints need PT attention.

- A. Deep 2nd and 3rd degree burns - follow-up in the Surgery and/or Physical Therapy Clinic also. Consider burn center referral.
- B. Burns on hands - Consult Trauma or Ortho Hand Service

Clean burns in 1st and 2nd degree do not need constant attention. Dressing with adaptic (lightly impregnated Vaseline) gauze, with a regular gauze cover allows for changing the cover every

two to three days, while leaving the adaptic in place. Constant dressing changes debride the wound, but may slow healing by debriding the new epithelial cells as well. Judgment is needed.

Delayed Primary Closure: Many of our patients present delayed from injury for wound care. Discuss with faculty if you think the wound may be appropriate for DPC. Wounds with purulent drainage must heal by secondary intention. Err on the conservative side and return to wound clinic in 4 days for DPC.

Eye Injuries: Corneal abrasions need follow-up every morning until healed. Obtain a complete eye exam, visual acuities, slit lamp and staining. Follow-up every morning as needed until injury is resolved or until follow-up with ophthalmologist is indicated.

Cellulitis: Superficial cellulitis - check in UCC in 2 days to evaluate progress of infection. If antibiotics are used, warm compresses help. Follow-up p.r.n. in respective clinic. If cellulitis same - follow closely every day as needed. If worse, register patient for evaluation and admission.

Tetanus series - follow-up in UCC; RN to vaccinate

Rabies series - follow-up in UCC; RN to vaccinate The M.D. must sign an order for each injection.

Miscellaneous:

- A. Thursday morning conference attendance is mandatory while on all rotations in El Paso. This has been arranged with the clinical chiefs of the other services. You should be released from clinical duties that morning.
- B. All resident scheduling changes must be cleared through the chief resident and noted on posted schedules. The Residency Coordinator should be notified. Changes with fellow residents are voluntary on their part.
- C. Meal breaks should be held to 20 minute limit. All out-of-department business should be managed on your free days.

Urgent Care Clinic is staffed 9a-6p on Monday, and 10a-6p Tuesday – Saturday. Its primary function is first evaluation of patients with class 4 problems (non-urgent). It is available to meet your requirements for follow-up (special requirements IV.B.7). Use it to reevaluate patients with limited problems that you believe will require no more than 1 follow-up visit (i.e. community acquired pneumonia in an otherwise healthy patient). Be sure the discharge instructions reflect that the follow-up is to see you in Urgent Care on a date that you will be in the ED.

Dr. Palafox, who is the faculty member in charge of UCC, is also willing to see a limited number of follow-ups from the ED. Be sure you appoint to a day that he is scheduled and write a short consult telling him what you want him to do.

Some UCC shifts are available for internal moonlighting for approved PGY-2 & 3 residents.

EVALUATIONS

Criteria

Criteria for resident evaluation include knowledge base, technical skills, professional development, teaching abilities, interpersonal relationships, use of universal precautions, motivation, problem solving ability, written records, conference attendance, oral exams and annual In-Service exams.

Methods

- Each resident is evaluated by the Emergency Medicine faculty and by faculty from off-service rotations every month, utilizing a standard evaluation form (**see attached example**) and in the future be completed on-line.
- Observational evaluations will be performed by the Residency Directors. Each evaluation will consist of observation of a single patient visit in its entirety. In addition, a 360 degree evaluation will be performed by assisting nursing personnel and the patient to rate the resident. On most ED rotation months a resident will be rated one time by each of the Residency Directors.
- At least 3 times each year residents are scheduled for formal evaluation sessions. At this time they review their evaluations and are counseled by their advisor. The advisors use this time to discuss the residents progress, areas in need of improvement, and long/short-term goals.
- Residents are given tangible evidence of progress through an annual ABEM In-Training Exam & the use of MD Challenger educational tools.
- Oral Exams are conducted on a quarterly basis. These are formatted simulations of patient encounters. Residents are tested on a rotating basis and faculty critiques performance.
- Unsatisfactory performance will require formal counseling between resident & advisor to discuss the specific unsatisfactory performance areas & future performance expectations. The resident will be on "Observational" status until performance expectations are met.
- Failure to exhibit improvement of performance following counseling may constitute grounds for "Probation", failure to renew annual contract, dismissal, or failure to be recommended to ABEM as a suitable candidate.
- Written documentation, signed by resident and advisor, of all counseling sessions and remediation plan will be kept on file in the department.

Faculty/Rotation Evaluations

On a quarterly basis, residents are asked to complete evaluation forms on each faculty and rotation they have completed (**see attached examples**). Composites are typed from all these evaluations for anonymity purposes.

These composites of the faculty evaluations are given to the Chairman for the evaluation of faculty. The composites of the rotations are given to the Chairman, Program Director and Asst. Program Directors to ensure that rotations are up to standard.

Resident meetings are held two times each quarter. Rotations, conferences, staff, etc. are discussed. On the

basis of these forums, rotations and/or conferences may be changed to better meet the residents' needs.

On an annual basis, residents are asked to complete a "Program Evaluation Form" (see **attached example**). These composites are given to the Chairman.

ADVANCEMENT

Promotion of the resident and award of a residency certificate shall be based on evidence of satisfactory progressive scholarship and professional growth (see **Progression of Responsibility in Department Policies**), not just being present for 3 years. The trainee must demonstrate the ability to assume graded and increasing responsibility for patient care. Interpersonal skills are as important as professional skills in the practice of Emergency Medicine.

EM residents are expected to demonstrate progression in competence and skills. Progression is demonstrated in a variety of means:

- Observational Evaluations
- Rotation performance (Evaluation Forms)
- Written quiz scores
- In-service exam score
- Annual oral exam performance

As needed, the Promotions Committee will meet to formally discuss advancement of each resident to the next year level. The Promotions Committee members include the Program Director, Associate Program Director(s), and a Clinical Faculty member. The Residency Director makes **all** final decisions.

Failure to demonstrate adequate progression will be identified at an early stage, and will be handled with individual intervention and counseling. Persistent failure to progress may result in academic probation.

Criteria for Promotion: EM-1 to EM-2

1. Completed all rotations with acceptable evaluations.
2. Attended > 70% of residency conferences.
3. Completed all assigned readings as evidenced by a satisfactory quiz score average, which will normally be considered to be > 65%.
4. Satisfactorily accomplished EM-1 goals and objectives as determined by Program Director.
5. Adequate completion of admission/procedure/follow-up log, and other administrative responsibilities as determined by Program Director.
6. Satisfactorily completed assigned lectures, M & M conferences, and patient follow-up conferences as determined by Program Director.
7. Practices in a safe, expedient manner, well-versed in initial evaluations and common ED complaints.
8. Demonstrated level of confidence and clinical competence to progress to a less supervised role as determined by consensus of the promotions committee.
9. Satisfactory scores on observational evaluations and oral exams
10. Completion/passage of USMLE Step 2 within the required attempts (Housestaff P & P)

Criteria for Promotion : EM-2 to EM-3

1. Completed all rotations with acceptable evaluations.
2. Attended > 70% of residency conferences (cumulative for residency period.)
3. Completed all assigned readings as evidenced by a satisfactory quiz score average, which will normally be considered to be > 65%.
4. Satisfactorily accomplished EM-2 goals and objectives as determined by Program Director.
5. Adequate progress in research curriculum as determined by Research Director.
6. Adequate completion of admission/procedure/follow-up log, and other administrative responsibilities as determined by Program Director.
7. Satisfactorily completed assigned lectures, M & M conferences, and patient follow-up conferences as determined by Assistant Program Director.
8. Able to act independently with a wide variety of patients, with expeditious, directed evaluations and work-ups, as determined by the promotions committee.
9. Satisfactory scores on observational evaluations and oral exams
10. Satisfactory ability to manage patient flow in assigned areas of the ED as determined by the promotions committee.
11. Adequate progression on in-service exam scores and oral exam scores as determined by Program Director.
12. Completion and passage of USMLE/Comlex Step 3 within the required attempts.
13. **Has acquired a license allowing full independent practice in a State. Failure to obtain a license will result in extending your 2nd year, which in turn will delay graduation.**

Criteria for Graduation: EM-3

1. Completed all rotations with acceptable evaluations.
2. Attended > 70% of residency conferences (cumulative.)
3. Completed all assigned readings as evidenced by a satisfactory quiz score average, which will normally be considered to be > 65%.
4. Satisfactorily accomplished EM-3 goals and objectives as determined by Program Director.
5. Met research and performance improvement objectives.
6. Adequate completion of admission/procedure/follow-up log, and other administrative responsibilities as determined by Program Director.
7. Satisfactorily completed assigned lectures, M & M conferences, and patient follow-up conferences as determined by Assistant Program Director.
8. Proven capability to independently manage all aspects of the ED, including patient care, patient flow, teaching, and personnel management and supervision as determined by the promotions committee.
9. Competence in administrative and managerial aspects of Emergency Medicine as determined by Program Director.
10. Adequate progression on in-service exam scores and oral exams as determined by Program Director.

Changes in criteria for Promotion

New criteria for promotion and graduation may be added or modified from existing criteria. This will generally only be done upon mandate from the RRC or ACGME.

EMERGENCY MEDICINE CURRICULUM

The Texas Tech School of Medicine Emergency Medicine Residency Program consists of thirty-six months of post-graduate training in Emergency Medicine following graduation from an accredited medical school.

The training program consists of didactic instruction, supervised clinical experience, and structured administrative and laboratory experience designed around a core curriculum to prepare the graduate to be able to successfully challenge the examination for certification of the American Board of Emergency Medicine. The resident is evaluated formally by regular in-service examinations and supervising faculty to ensure the trainee's progress.

Didactic Instruction:

Formal instruction covering all the topics outlined in the Basic Lecture Curriculum (**see Model of Clinical Practice of EM**) is presented by the Emergency Medicine Faculty and selected affiliated faculty in a series of weekly lectures. Emphasis is placed on the acute aspects of the evaluation and management of the variety of medical conditions seen in the Emergency Department. Generally, five hours of weekly lectures are offered and attendance by residents is mandatory (**See Conference Attendance Policy in Department Policies**). In addition, the EM-1 physicians are given an introductory series of lectures for several hours daily during the month of July.

Case Review Conferences:

Case conference provides a review of patient management resulting in a complicated outcome or of interesting cases. It is conducted by Resident staff during weekly conferences. Emphasis is placed on identification of crucial diagnostic and management points to prevent patient morbidity and mortality. Cases are selected by the Resident presenting with review by the Chief Resident for Instruction. Residents are expected to present a case every quarter during year 1, every 2 months during year 2 and monthly during year 3.

Trauma Conference is presented twice monthly with participation specifically by the Surgery Trauma faculty and resident staff.

Post-graduate courses:

Standard courses of instruction in Advanced Cardiac Life Support, Advanced Pediatric Life Support and Advanced Trauma Life Support are required for each resident. These courses are provided through the joint efforts of qualified instructors in the Texas Tech-Thomason complex and affiliated institutions. The resident is expected to achieve provider certification. The Department will pay for one ACLS and one ATLS course per resident. PALS or APLS may be paid for by book fund money.

Laboratory Experience:

Structured instruction in the animal laboratory with "hands on" experience for the resident is provided on a recurring basis to insure that each resident is proficient in the application of procedural skills essential to emergency patient care. Cricothyrotomy, thoracotomy, thoracostomy, pericardiocentesis, peritoneal lavage, and cardiac pacing are included in this experience. An annual morning laboratory session for teaching indications, techniques, and complications of hemodynamic monitoring is offered.

Journal Club:

Residents meet with faculty for a monthly review of current pertinent literature. Emphasis is placed on evaluation of the literature in terms of study type, design, statistical analysis, accuracy of data, and appropriateness of author's data interpretation. (See **Research Evaluation Criteria sheet**)

Skills Practice Sessions :

Practice sessions for intubation, slit-lamp diagnosis, non-invasive vascular diagnosis are offered as needed. An advanced wound care course is included in the PGY I lecture series.

Radiology Reviews:

Serial review of radiologic diagnostic problems by anatomic system is carried out in coordination with the Radiology Staff.

ADMINISTRATIVE TRAINING

During progression through the program the resident is required to assume, with faculty supervision, increasing responsibility for the administrative aspects of emergency department management. The responsibilities include, but are not limited to, supervising patient flow through the Department, supervising junior residents and students, and participating in and contributing to the development of extra-mural activities of the Department.

Chief Resident

During the last year of training, selected resident(s) may serve as Chief Resident and would be responsible for some operations of the Department and coordination of Departmental activities for the residents. Among the responsibilities of the Chief Resident are arranging conference schedules and resident ED schedules, participating in the fiscal and personnel managerial aspects of the Department, participating in daily chart and medical care audits with the faculty.

Administrative Month

The Administrative Resident facilitates follow-up of patients through daily auditing of charts, Emergency Department log, EKG and x-ray interpretation and hospital discharge summaries. All unusual or complicated cases are reported back to the resident involved. Many of the cases are discussed in the weekly Case Conference. The Administrative Resident also makes ward and ICU rounds to gather feedback on patient outcome. On a monthly basis, interesting ICU cases are discussed in conference through "chart rounds." A daily E.D. Follow-up Clinic enables the resident to follow all wound care and other short-term minor problems. A performance improvement and planning project will be completed (Program Requirements IV.B.12.c)

Prehospital Care (EM-2 and 3s)

The resident provides medical supervision for the El Paso Emergency Medical Services System through radiotelemetry. He/she also participates in the Texas Tech-Thomason training program for paramedics. During a block EMS rotation each EM-II resident works in the pre-hospital setting and, participates in the auditing, planning, and administrative conferences of El Paso EMS.

Research

Each resident is required to meet the curriculum goals. There will be 2 tracks. The first track is primarily for those interested in clinical medicine. It involves independent study, demonstrating an understanding of basic literature search technique, demonstration of basic statistical analysis and an understanding of critical review of the literature. The Research Director will determine satisfactory completion of the curriculum. The second track is generally for those interested in research or academics. This second track consists of independent contribution concerning some aspects of Emergency Medicine.

CLINICAL EXPERIENCE

Each resident spends a minimum of eighteen months on rotation in the Emergency Department and up to eighteen months on out-of-department rotations during the three-year training program. Four to six months are spent in the Emergency Department during the EM-I year, and six or seven months during the EM-II and EM-III years. Residents with prior training will have some flexibility in designing a curriculum to best suit their individual needs.

Emergency Department Rotation - The resident is responsible, with faculty supervision, for the initial triage, evaluation, and management of all patients presenting to the Department. In addition, the resident is responsible for assisting the faculty in the supervision and instruction of medical, nursing, and allied health students and rotating residents in the Department. The responsibilities are graded, with the senior resident providing for most of the supervision and critical care patient decisions. While on rotation in the Department, the resident is responsible for follow-up of patients in the Emergency Department Follow-up Clinic.

Out-of-department Rotations (See page 21)

Rotation on a number of clinical specialty services outside the Emergency Department is required of all residents. The exact schedule and nature of these rotations is tailored to the individual resident's need, based in part on the resident's prior training and in part on need perceived by the resident and faculty. Since the resident's first postgraduate year may vary, a prescribed foundation of clinical experience must be supplemented within the available rotation months.

Selective Rotations- Residents are allowed to participate in a number of selected rotations outlined under Clinical Rotations after the required rotations are fulfilled. Requests for special rotations are considered and arranged on an individual basis. No more than one month per year may be arranged off campus.

Critical Care Rotations - Critical care experience is comprised of 6 required block rotations and additional selective time in the same rotations. The rotations include Medical Intensive Care (2), Trauma Intensive Care (2), Surgical ICU (1).

Evaluation of Rotations- Each resident is expected to maintain documentation of their experience on all clinical rotations which includes description of patient problems encountered, and manual skills utilized. This record is kept on file and reviewed by the Residency Director to insure that clinical rotations meet the objectives of the training program. Residents also participate in annual rotation evaluation sessions. On the basis of consensus and review of experience, the rotation schedule may be altered.

INCOMPLETE AND DELINQUENT MEDICAL RECORDS

- A. A complete account of incomplete and delinquent medical records is done every Friday. Each resident should visit Medical Records to complete charts weekly.

INCOMPLETE medical records are defined as those incomplete less than 15 days after discharge date.

DELINQUENT medical records are defined as those incomplete more than 15 days after discharge date.

- B. Each resident shall be notified of the total number of incomplete and delinquent medical records he has in each category.
- C. Failure to complete medical records within a few days may result in suspension of free meals privileges.

CLINICAL BLOCK ROTATIONS

The following are expected to be completed by the resident prior to completion of the residency. The resident will generally complete the following schedule, with individual modification as necessary to meet the trainee's and the program's goals, and considering any prior training.

EM-I: 4 months ED

- 1 month Ortho
- 1 month EMS/Research
- 2 months Internal Medicine (1 each ward and ICU)
- 1 month Surgery ICU
- 1 month OB-GYN
- 1 month Anesthesia
- Elective

EM-II: 7 months ED

- 2 months Trauma and Sexual Assault, Phoenix
- 1 month Peds ED (Phoenix Children's or Providence)
- 1 month Cardiology Consult Service
- 1 month MICU

EM-III: 7 month ED

- 1 or 2 months ED QI / Administrative
- 1 month Elective or Peds ICU (dependent on peds medical resuscitations documented)
- 1 month Toxicology
- 1 month elective

Elective Rotations: _____

- Dermatology
- Neurology
- Ophthalmology
- Radiology/Ultrasound
- Infectious Diseases
- Hyperbaric Medicine
- Medicine Sub-specialties
- Research

TEN COMMANDMENTS OF EMERGENCY MEDICINE

June 2, 1992

- I. Always be courteous. Always!
- II. Don't make patients wait unnecessarily. Check on them frequently. Talk to the family.
- III. Pay attention to what the patient is saying and how it is said. Establish eye contact. This ED visit may be the only chance you have in your life to really make a difference--Make the most of it.
- IV. Be a real person to the patient. Compliment them and acknowledge their compliments. If you own a coat just like theirs, tell them yourself.
- V. Make the patient's stay as comfortable as possible. Get the patient a drink of water or a blanket, and get it for them yourself.
- VI. Never be loud or boisterous where a patient or their family will observe or hear you.
- VII. Always safeguard the health and safety of your nursing staff and ancillary personnel. Never allow them to be physically assaulted or verbally abused by patients or other staff without defending them.
- VIII. Be friends and be friendly to the medical staff. Know their families. Ask their advice and share your knowledge when they ask for your help. Compliment them to their patients. Visit their offices and let them use yours. Remember--if you weren't lucky enough to be an EM physician, you would be in their shoes.
- IX. Tell the patient if you are not exactly certain what is causing their problem, but never admit that you don't have a clue. If nothing else tell them what you know they don't have.
- X. Never brag about a great diagnosis or gloat when another doctor makes a mistake. You might have sent that patient home yourself. Be proud of your work without being obnoxious.

Courtesy of John Carson, MD

EMERGENCY MEDICINE PEARLS

(of miscellaneous color.) June 2, 1992

1. TORQUEMADA'S LAW: When you are sure you are right, you have a duty to impose your will on others.
2. Virgilio's Law: Even a rock will urinate when given enough Lasix.
3. Slay's Aphorism: When a crisis occurs and all is in a state of confusion yell out "Airway!"
4. Every psychoneurotic patient ultimately dies of organic disease.
5. The prescribing of a medication never cured a patient. (Taking the medication occasionally cures a patient.)
6. Place your bets on uncommon manifestations of common conditions rather than on common manifestations of uncommon conditions.
7. No patient was ever cured by a laboratory result.
8. The newest and most expensive drug is commonly not the best.
9. All drugs are potentially toxic. The fewer prescribed, the lower the dose, and the shorter the treatment, the better the patient.
10. Over diagnosing and over treating are bad medicine.
11. A diagnosis may be based on reviewing the x-ray, but not necessarily on viewing the report.
12. Patients can get well without antibiotics.
13. The average case of viral bronchitis lasts three weeks, which is 10 days longer than the average American can go without seeing their doctor.
14. If you cannot figure out the patient's problem get a second opinion. If no diagnosis is then made the chances of making a diagnosis with a third or fourth opinion is vanishingly small.
15. You cannot diagnose a disease you never heard of.
16. The basic guideline is: Would I want to have this done to my wife or child in this circumstance?
17. "Tranquilizers" work best for the prescribing physician, not the patient.
18. The patient's intelligence has no bearing on his emotional understanding of your diagnosis. Assume nothing!
19. If the patient is loaded for bear, don't attack, get help.
20. Beware of ethanolic anesthesia. Examine the whole drunk repeatedly.
21. Remember, you're in a fishbowl. Close the curtains and lower your voice.
22. Before discharge try a test of function. If the patient can't make it to the bathroom and back, they probably can't go home.
23. An assessment spelled out in diagnostic terms stops all thought. Don't get trapped early. Not all vomiting is gastroenteritis!
24. If you haven't treated or commented on the chief complaint, you haven't treated the patient.