EMERGENCY MEDICINE PHYSICIAN ASSISTANT RESIDENCY
BROOKE ARMY MEDICAL CENTER
RESIDENCY GUIDE

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SECTION I INTRODUCTION

1. PURPOSE This residency guide prescribes policies and procedures for the administration of the Emergency Medicine Physician Assistant Residency**.**

2. SCOPE This publication applies to all personnel involved in this residency as staff or residents of the Emergency Medicine Physician Assistant Residency.

3. REFERENCES See Appendix 1

4. PROGRAM DESCRIPTION The U.S. Army Emergency Medicine Physician Assistant (EMPA) Residency is a 12 month program of clinical rotations, formal didactic instruction, and a research project. The residency prepares the EMPA to evaluate, diagnose, and stabilize those conditions which pose an immediate threat to life and limb. The EMPA will also be able to manage medical and surgical conditions encountered in an Emergency Department (MEDCEN's/MEDDAC's) or a deployable environment. The curriculum is modeled from the emergency medicine curriculum developed by the Society for Academic Emergency Medicine (SAEM), Council Of Emergency Medicine Residency Directors (CORD), and the American College of Emergency Physicians Core Content Task Force II. The guidelines for evaluating the EMPA resident is modeled from the Accreditation Council of Graduate Medical Education (ACGME) core competencies, and places emphasis on the skills required of the military Emergency Medicine Physician Assistants. The skills that distinguish the U.S. Army EMPA are; resuscitation, toxicology, EMS system design and supervision, disaster management, environmental emergencies, and operational military medicine. The EMPA Residency program maintains its membership with the Association of Postgraduate Physician Assistant Programs. The U.S. Army EMPA Residency is unique in that it exists within an established Emergency Medicine Residency (San Antonio Uniformed Services Health Education Consortium/SAUSHEC) enhancing educational and research opportunities. Another unique facet of the SAUSHEC EMPA residency is a specially designed orientation month introducing the resident to the basic concepts of evaluation and management of emergency patients. This comprehensive course consists of over 25 lectures, an advanced airway lab, animal procedure lab, suture lab and certification in BLS, ACLS and APLS. There is also a 3-day course of introduction to toxicology taught by an emergency medicine trained toxicologist.

A. The Didactic Phase (App 2) is conducted at BAMC and WHMC and will provide the technical foundation for further learning and development through emergency medicine lectures, conferences and presentations. The Didactic portion consists of the following:
1. A one-month introduction to emergency medicine consisting of lectures and ACLS/APLS certification, structured to allow each EMPA student to make a smooth transition into the program.
2. Grand rounds, morning reports, procedure lab, trauma/radiology/EKG/M&M conferences, and participation in emergency medicine research.
3. Academic clinical evaluation through monthly exams on required readings, midterm and final written/oral examinations, case presentations, and continuing evaluation of skills during each rotation.
4. Research paper suitable for publication.
5. Lectures to attendee's of the Emergency Medicine Basic Skills Course.

B. The Clinical Practicum (App. 3) is conducted at BAMC, University and Santa Rosa Hospitals and is designed to bridge the gap between theory and practice through one-on-one supervised hands-on training. To be effective, the Clinical Practicum must be conducted in a true patient care environment. The EMPA resident applies the principles and procedures he has learned during the didactic phase. It is imperative this hands-on experience be an integral part of the entire program rather than a separate, unrelated experience. Because the projected assignments for EMPA residents will be in the outpatient setting, emphasis is placed on emergency and ambulatory care. The Clinical curriculum consists of 13 blocks of 28 days with 7 blocks in an emergency department setting.

5. GOALS

A. Recognize, evaluate, and stabilize all patients with life or limb threatening conditions presenting to the ED.

B. Recognize, evaluate, and treat patients with medical and surgical conditions encountered in the emergency department. This includes the ability to simultaneously manage multiple patients.

C. Make a timely, appropriate disposition for all patients presenting to the ED. This includes the ability to effectively communicate and interact with patients, family members, hospital administrators, and health care providers.
D. Under the supervision of a physician, interact effectively with the pre-hospital care environment and function as a Base Station Emergency Medicine Physician Assistant.

E. Develop teaching and research skills suitable to disseminate information to all levels of health care providers.

F. Effectively perform administrative tasks necessary to assist in the management and development of an Emergency Department.

1. The Emergency Medicine Physician Assistant resident fulfills these goals through a comprehensive mixture of clinical exposure (both in and out of the ED) and didactic reading/lectures. Training is provided in the administration of Emergency Medicine Departments and Emergency Medicine Service Systems. Teaching and research skills are developed through case presentations, didactic lectures and participation in Morning Report. A minimum of one scientific paper of suitable quality for publication will be required for graduation.

6. MEDICAL REFERENCES

A) Rosen's Emergency Medicine: Concepts and Clinical Practice, 5th ed., 2002
(3 volume set), ISBN-0323011853.
B) Emergency Orthopedics, 4th ed., 2001, ISBN-0838522106.
C) Rapid Interpretation of EKG's, 6th ed., 2000, ISBN-0912912014.
D) Emergency Medicine: A Comprehensive Guide, 5th ed., 2000, ISBN-0070653518.
E) The Radiology of Emergency Medicine, 4th ed., 2000, ISBN-0683306790.
F) Grant's Atlas of Anatomy, 10th ed., 1999, ISBN-0781722608.
G) Goldfrank's Toxicologic Emergencies, 7th ed. ,2002, ISBN-0071360018.
H) Wounds and Lacerations: Emergency Care and Closure, 2nd ed., 1997, ISBN-0815188536.
I) Signs & Symptoms in Emergency Medicine, 1999, ISBN-0323002110.
J) The Wills Eye Manual, 3rd ed., 1999, ISBN-0781716020.
K) Clinical Procedures in Emergency Medicine, 3rd ed., 1998, ISBN-072166055X.
L) Just the Facts in Emergency Medicine, 2001, ISBN-0071345493.
M) Admission & Discharge Decisions in Emergency Medicine, 2002,ISBN-1560534125

7. DESCRIPTION OF TITLES The following are descriptions of the titles assigned to personnel who participate in the training of EMPA students.

A. Residency Director, EMPA Residency (62A9B) (needs to be ABEM certified): Title given to the EM Physician who has professional and academic responsibility for the Emergency Medicine Physician Assistant Residency.

B. Program Director, EMPA Residency Program (65DM2): A graduate EMPA appointed by the Chief, Physician Assistant Section, Army Medical Specialist Corps, to assist the Residency Director, with the management of the Didactic and Clinical Practicum, and directs the administrative and PA related aspects of the EMPA Residency.

C. Academic Advisor/Preceptor, (62A or 65DM2): Emergency medicine physician or emergency medicine Physician Assistant staff member who directly overseas the day-to-day training of the EMPA residents.

MISSION STATEMENT
BAMC

Serving with Pride, Competence and Character

Our Mission...

Our mission is to improve the health of our community while ensuring deployment readiness of Brooke Army Medical Center personnel. We do it by operating a customer-focused, quality integrated health care system and by conducting graduate medical education and clinical investigation.

Our Vision...

Our vision is to be the premier Department of Defense Center of Excellence in health care, education and training, and its research as a national asset crucial to the direct support of our Armed Forces' total readiness mission.

Our Goals …

Ensure medical readiness by maintaining a healthy force (including BAMC staff), training personnel for the medical mission, and preparing for contingencies.

Guarantee a "We Care" patient-focused health care delivery system by improving community health through health promotion and disease management, practicing hospitality (patient and staff focused), and ensuring patient-friendly access for active duty and Prime enrollees to primary and specialty care.

Continually improve staff education, graduate medical education, and research to maximize health care and readiness missions.

Our Army Values...

Loyalty
Duty
Respect
Selfless Service
Honor
Integrity
Personal Courage

9. EMERGENCY MEDICINE HISTORICAL BACKGROUND AND DEFINITION

In the late 1960's and early 1970's there developed an increasing awareness of the need to deliver high quality medical care to the patients, both in transit and during the first hour in the hospital. Pre-hospital care matured from a delivery mechanism to a fairly sophisticated and appropriate transport, linked to hospitals by radio and telemetry communications. At the same time a fairly small group of physicians recognized the need for formal training in Emergency Medicine and was willing to pursue that goal prior to formal acceptance by the medical community. The first residency in Emergency Medicine opened its doors to applicants in 1972, seven years before the specialty was officially recognized.

In 1975, the House of Delegates of the American Medical Association defined the Emergency Physician as a physician trained to engage in:

1. The immediate initial recognition, evaluation, care and disposition of patients with acute illness and injury.
2. The administration, research, and teaching of all aspects of emergency medical care.
3. The direction of the patient to resources of follow-up care, in or out of the hospital as may be required
4. The provision when requested of emergency, but not continuing, care to inpatient hospital patients.
5. The management of the emergency medical system for the provision of pre-hospital emergency care.

In 1979, the American Board of Medical Specialties formally accepted Emergency Medicine as its newest specialty two years later, as part of a "Definition of Emergency Medicine" developed by the American College of Emergency Physicians and endorsed by three other organizations representing residents in training and academic emergency physicians, a paragraph was published that summarized the practice of the specialty:

Emergency Medicine encompasses the immediate decision making and action necessary to prevent death or any further disability for patients in health crisis. Emergency Medicine is practiced as a patient-demanded and continuously accessible care. It is the time-dependent process of initial recognition, stabilization, evaluation, treatment, and disposition. The patient population is unrestricted and presents with a full spectrum of episodic, undifferentiated physical and behavioral conditions. Emergency medicine is primarily hospital-based, but with extensive pre-hospital responsibilities.[1]

[1]Emergency Medicine, An approach to clinical problem solving, Sanders. 1991

10. EMERGENCY MEDICINE: A PERSPECTIVE

Emergency Medicine is a unique medical specialty with knowledge, skills, and expertise demonstrated through clinical practice, professional literature, and specialty board recognition. Emergency Medicine practitioners possess, by training and practice, special skills in areas such as resuscitation, environmental medicine, pre-hospital care systems, disaster medicine, and toxicology. Though we in medicine are often criticized for our inability to change our way of thinking, this is less true in Emergency Medicine. As a new specialty we tend to be dynamic, often approaching problems with new perspectives and challenging unproved, if perhaps, traditional concepts. As Emergency providers we must be well rounded, constantly learning and developing a broad based find of knowledge. Our specialty is made up of the health care team, and involves interaction with almost every other medical specialty. We must be dynamic and flexible yet firm in our decisions concerning our patients' best interest… we are Patient Advocates! We are a service profession that assists its 'patients; its' customers. We care for patients without regard to age, gender, religion, creed, social status, anatomical region or time of day.

Emergency Medicine has extended the delivery of care where disease and injury is first perceived e.g., EMS responders, Emergency disaster teams, HAZMA T and others. We are ready to serve the patient twenty-four hours a day. We are accessible! In many communities the Emergency Department is the principle access into the medical system.

The patients initiate the first contact and they define their emergency. It is up to us in Emergency Medicine to decide how much of an emergency exists and what care is immediately needed. In seeing a wide variety of patients with many problems, it is wise to remember that not all patients are as sick as they appear nor are they as well as we think. There are false positives in patients' emergencies, i.e., hysteria. There are also false negatives, i.e., denial.

Retrospective judgment is easy. Prospective judgment is difficult. Making on the spot judgments wad decisions is what we do... with enthusiasm. Emergency providers must be able to recognize and efficiently deal with difficult medical realities, and excel in the art as well as the science of medicine. Our specialty brings a sense of urgency and prioritization to the management of emergent patient needs. We must quickly define and understand the pathophysiology of any acute decompensation and orchestrate a team response that can intervene to stabilize and resuscitate the patient. Ours is a practice requiring reaction to situations, often in the absence of an ideal data base. At times we remove the threat. At times we only stabilize until definitive intervention is available. At times we attempt to restore the homeopathic state. At times we change the primary focus to the relief of suffering while the patient completes the act of dying.

11. EMERGENCY MEDICINE TRAINING FOR U.S. ARMY PHYSICIAN ASSISTANTS: HISTORICAL BACKGROUND

History: In 1981 the Army initiated training in Emergency Medicine for Physician Assistants. The training was in response to an Army wide EM physician shortage. PAs were trained to augment physician staff in the ever busy emergency departments. Most assignments were to understaffed MEDDAC 's located throughout CONUS.

Selected PAs were enrolled in a training program at Darnall Army Community Hospital, Ft. Hood Texas, which already had an existing emergency medicine physician residency. The program of study was twelve months long and paralleled the second post graduate year training for emergency physicians. However, suffering a severe PA shortage in line units and PA retention dropping, the Army reduced or stopped most post-graduate training for PAs in 1986. A total of twelve EMPAs were trained during those five years.

In 1989. the American College of Emergency Physicians published a position paper in the Annals of Emergency Medicine on the utilization of PAs in military emergency medicine.[1] While there was some division among physicians as to the practicality of utilizing PAs in emergency medicine, the authors made the important point that the training of PAs in this field prepared them for the type of trauma that could be anticipated in combat.[2] The authors stress that PAs should be used as physician extenders and not as a physician substitute. The article maintained that EMPAs could be a valuable asset to a military emergency department.

The college advocated that all EMPAs should receive a formal course of training in either a fellowship or residency program for at least twelve months and that the training should be conducted at an already approved emergency medicine physician residency program.

In 1991, the Army Surgeon General approved a plan for a revised program. The first EMPA training began at Brooke Army Medical Center, Ft. Sam Houston, Texas on

1 July 1991. In 1992 a second program was established at Madigan Army Medical Center, Tacoma, Washington. A third program began in 1995 at Darnall Army Community Hospital, Ft.Hood Texas and closed the following year, after graduating one class, in 1996. All three training sites have active emergency medicine physician residencies. Upon successful completion and graduation from EMPA training the graduates are awarded the M2 identifier (65DM2).

[1]American College of Emergency Physicians. Task Force on Military Emergency Medicine. Military emergency medicine systems. Ann Emerge Med. 1989;18:2 16

[2]The US Army Emergency Medicine Physician Assistant Program, MM Peter A. Forsberg, PA-C, MSC, Fed. Prac;03,1996

12. GUIDELINES ON THE ROLES OF PHYSICIAN ASSISTANTS IN THE EMERGENCY DEPARTMENT

Approved by the ACEP Board of Directors February 2002
Approved by the ACEP Board of Directors May 2001
Replaces previous statements titled "Guidelines on the Role of Physician Assistants in Emergency Departments" approved by the ACEP Board of Directors September 1996 and April 1995
Physician assistants (PAs) provide services in various roles in emergency departments (EDs), including out-of-hospital patient care, patient triage, patient care in the ED, and selective administrative functions. The American College of Emergency Physicians (ACEP) endorses the following guidelines for EDs that use PAs.

1. PAs working in EDs should have or should acquire specific experience or specialty training in emergency care, should participate in a supervised orientation program, and should receive appropriate training and continuing education in providing emergency care. They should possess knowledge of specific ED policies and procedures. PAs must be aware of and participate in the performance improvement activities of the ED.

2. PAs may be placed in clinical and administrative situations in which they will supplement and assist emergency physicians. PAs do not replace the medical expertise and patient care provided by emergency physicians.

3. PAs work clinically with the supervision of an emergency physician. The physician evaluates the care that each patient receives and assumes ultimate responsibility for the patient. The supervising physician for each PA encounter should be specifically identified. ED medical directors should define the number of PAs whose clinical work can be simultaneously supervised by one emergency physician.

4. The medical director of the ED or a designee has the responsibility of providing the overall direction of activities of the PA in the ED.

5. The PA's scope of practice must be clearly delineated and must be consistent with state PA regulations. This delineation should include a list of symptom complexes that may be evaluated and initially addressed by PAs. The delineation also should include a list of the medical procedures that PAs may perform:
a)before consultation with the emergency physician.
b)only after consultation with supervising emergency physicians.
c)only under the direct supervision of an emergency physician.

6. Credentialing procedures must be specifically stated and be similar to those required of other mid-level providers. PAs working in the ED must meet the requirements of the state or federal jurisdiction in which they practice and should be appropriately certified.

SECTION II DIDACTIC AND CLINICAL PRACTICUM

1. INTRODUCTION: Emergency Medicine (EM) is a distinct specialty which focuses upon the initial evaluation, diagnosis and stabilization of patient with acute illnesses or injuries. In addition, the Emergency Medicine Physician Assistant (EMPA), working under the supervision of an Emergency Physician, initiates treatment, involves consultants, makes disposition decisions and makes appropriate follow-up arrangements for the patient discharged from the Emergency Department (ED).

A. Proper administration of the didactic and clinical practicum is of the utmost importance to the EMPA and to the EMPA Residency. Although the overall responsibility of administration lies with the Residency and Program Director, it is vital that the emergency medicine staff members conduct the didactic and clinical practicum in a uniform manner**.**

2. LEAVE

A. Leave: The EMPA resident is allotted two weeks of leave during the 12 month residency and it is encouraged that this leave is granted during the two week Christmas holiday period. Ordinary leave is not permitted during off-service rotations. This is to encourage maximum participation in the disciplines associated with Emergency Medicine. Emergency leaves may be granted at any time through the coordination with the Company Commander. It may be necessary, however, to extend the residents' training to make up lost time incurred from emergency leave.

B. Additional Training: In lieu of taking leave, the resident may utilize this time period for an additional training rotation or as a study period.

3. RESPONSIBILITIES

A. Commander, BAMC is responsible for:
1. The overall EMPA Residency Program provided at his facility.
2. Monitoring and coordinating the EMPA Residency with the Residency Director, EMPA Residency

B. Residency Director, EMPA Residency:
1. Residency Director, EMPA Residency is responsible for the EMPA Residency under the direction of the Commander, BAMC.
2. Maintains knowledge of the contents of this guide.
3. Monitors the quality of instruction provided to the EMPA residents.
4. Provides an initial briefing and orientation for the EMPA residents. This should be accomplished during the first week of the training program.
5. Ensures weekly resident meetings are conducted.
6. Initiates and/or reviews all evaluation and grading reports.
7. Supervises maintenance of Resident Counseling File.
8. Supervises timely submission of final reports to the Chief, Physician Assistant Section, Army Medical Specialist Corps and the Physician Assistant Branch Manager, PERSCOM.
9. Completes or reviews and submits an Officer Evaluation Report (OER) on each resident at the completion of the residency.
10. Assigns oral examination board members to administer and evaluate the EMPA resident at the midterm and end of the residency.
11. Ensures monthly counseling for each resident. All counseling sessions are recorded on the Record of Student Counseling.

C. Program Director, EMPA Residency:
1. Primary responsibility for day-to-day and long range operation of the EMPA residency.
2. Maintains knowledge of the content of this guide.
3. Directs the training of the EMPA residents. Prevents or corrects problems and informs the Residency Director of existing or potential problems.
4. Maintains and updates the curriculum and Residency Guide under the supervision of the Residency Director.
5. Functions as a liaison between the Chief, Physician Assistant Section, Army Medical Specialist Corps and the Residency Director and EMPA residents.
6. Provides continuing academic/professional supervision of EMPA residents. Maintains a resident personnel/counseling file on each EMPA resident.
7. Makes himself available to the EMPA residents on an as-needed basis in order to detect and solve problems.
8. Monitors all Evaluation and Grading Reports. Discrepancies existing between a resident's grade and his actual performance has to be brought to the attention of the Preceptor and the Residency Director for clarification or correction.

9. Monitors residents weigh-in and semi-annual ARPT
10. Administers the midterm and final written comprehensive examination.
11. Secures the oral examination board cases and coordinates their administration. The Program Director, EMPA Residency will function as a member of the oral board.
12. Provides the newly assigned EMPA resident with an orientation and tour of the training facility. This includes an introduction to all staff members on the emergency medicine service.
13. Maintains liaison with other EMPA training residencies.
14. Maintains the permanent academic records of all residents enrolled in the EMPA Residency.

D. Academic Advisor/Preceptor:
1. Provides continuing academic/professional mentorship of assigned EMPA residents.
2. Maintains knowledge of the contents of this guide.
3. Provides technical education to the EMPA resident to include, but not limited to, exposure to all areas of emergency medicine.
4. Assists in completing the Evaluation and Grading Report(App 5) upon the EMPA's completion of the clinical rotation.
5. Reviews the Procedural Evaluation Checklist on a weekly basis for tasks completed (App 9).
6. Assists in counseling each individual EMPA resident concerning his progress (or lack there of) on a weekly basis to provide feedback concerning his strong and/or weak points. This feedback must be provided no later than the last three days of each clinical rotation at an absolute minimum. The Evaluation and Grading Report must be utilized (App 5).
7. Keeps the Residency and Program Director informed on a timely basis about any student who is having difficulty and/or who may be a hazard to himself or patients.
8. Administers block/rotation examinations.

E. EMPA Resident: The points listed below will be explained to each resident before starting the EMPA residency.
1. Learns by all means and methods available.
2. Meets with the Academic Advisor/Preceptor or his designated representative on weekly basis.
3. Accomplishes the task on the Procedural Evaluation Checklist as a minimum (App 9).
4. Reports promptly for duty, emergency medicine lectures, conferences and off-service rotations.
Many duties and responsibilities are generic to the program. Compliance with these is necessary by all EMPA residents.
5. Complies with all DEM administrative requirements and guidelines.
6. Submits of patient log sheets and procedure skill assessment sheets to Program Director at the end of each block rotation.
7. Ensures ED Service and off-service evaluations are completed by preceptor 3 days prior to end of rotation and submitted to Program Director.
8. Provides an OER Support Form (DA Form 67-9-1) to the Program Director during the first month of training.
9. Supports clinical research protocols being conducted in the ED through appropriate enrollment and data gathering.
10. Is responsible for all assigned didactic readings, lectures, case presentations, and research project.

4. GENERAL ASPECTS OF EMPA RESIDENCY

A. Admissions
1. EMPA residents will present any patient felt to require admission to either the Senior Resident or a staff EM physician. If it is determined the patient requires admission, the EMPA resident is responsible for coordinating with the on-call physician of the particular admitting service for patient movement to the ward. The consulting service must provide a written consultation when they disagree with the requirements for admission.
2 The staff emergency medicine physician on duty will be notified about any disagreement between the EMPA resident and the admitting consulting physician before the patient is considered for discharge.

B. Conferences
1 Formal didactics Grand Rounds will be held on Fridays from 0700-1200 hours. The lectures will be presented by ED staff, guest speakers and occasionally , ED and EMPA residents. The lecture series is designed to cover the major topics in the "model of the clinical practice of emergency medicine". The Residency Director is primarily responsible for arranging/assigning speakers. Ground Rounds are mandatory every Friday. There will be EMPA Ground Rounds every Friday from 1300-1600 when Grand Rounds are at BAMC. All EMPA residents must wear the appropriate duty uniform for didactics.
2 Morning Report (App. 24) will be held each morning Monday through Friday. Its primary emphasis is on clinical decision-making, and will generally take the form of case presentations followed by interactive discussions. In addition, Morning Report provides an opportunity for review of administrative matters and information dissemination. All EMPA residents finishing a night shift or starting a day shift are required to attend. Attendance by EMPA residents scheduled for a swing shift or a day off are encouraged to attend, but attendance is not mandatory. The staff EM physician/Senior Resident will be responsible for content and direction of Morning Report.

3. Journal Club will be held during each block. It is designed to provide a concise review of literature pertinent to emergency medicine. The topic and format will be coordinated by the Chief Resident and an assigned staff member.
4. Morbidity and Mortality (M&M) Conference will be incorporated into the didactic schedule every other block. An assigned staff member and the Chief Residents will be responsible for assuring that appropriate cases are presented.
5. There will also be mandatory attendance for; Trauma, Radiology, and EKG Conferences. Procedural Skills Lab will be scheduled throughout the year.

C. ED Duty
1 The EMPA resident schedule should be completed two weeks prior to an ED block. The EMPA Program Director is to ensure timely completion. The number of hours worked by EMPA residents, must meet the guidelines suggested by the Resident Review Committee (RRC), for EM (physician) residents. In general, no shift will involve greater that 12 hours of clinical duty. No more than six consecutive day or evening shifts will be worked, although an EMPA resident may request up to seven consecutive night shifts. Shift hours in the BAMC ED will be; 0700-1600hrs, 1500-2400hrs, and 2300-0800hrs, a minimum of 16 shifts per BAMC ED block will be scheduled. Off-service rotation duty hours and number of shifts will be determined by the prospective service Chief/Program Director.
2 Requests for specific days off during an ED block must be submitted in writing to EMPA Program Director NLT four weeks prior to the start of that block. They will be honored as permitted by the scheduling requirements. After a schedule is completed and distributed, each resident is responsible for his/her assigned shifts. EMPA residents may trade shifts subject to approval from the EMPA Program Director. After changes are made and approved, the affected EMPA residents must update the duty roster in the ED and department office. The responsibility of coverage will remain with the originally assigned EMPA resident.
3 Supervision of the ED requires the presence of a responsible emergency medicine physician. The responsible physicians in the ED are the EM staff physician and EM Chief Resident. An attempt will be made to assign EMPA residents to separate ED shifts. Individual situations that require the EMPA resident to be absent from the ED should be worked out with the Program Director.
4. Duty IS NOT complete until all patients currently in the ED, including those being evaluated by residents, EMPA residents, interns, students, have been checked out to the incoming residents. The incoming EMPA resident should arrive at least 15 minutes prior to the schedule shift change in order to facilitate patient transfer and other duty requirements. The outgoing resident should physically introduce the incoming EMPA or physician resident to all patients for which they will be responsible (the senior resident will need to meet all patients currently in his area). In addition, patients pending arrival to the ED and administrative matters ie., chemistry lab malfunction should be relayed at this time.
A written annotation indicating to whom and at what time the patients' care responsibilities were transferred should be made in the patient's ED record.
5. All patients evaluated by an EMPA resident will be presented to an emergency medicine housestaff or the Senior Resident prior to the patient leaving the ED. All EMPA resident charts must be co-signed by the supervising Senior Resident(if patient was presented to Senior Resident) and the emergency medicine housestaff prior to the patient's release from the ED.
6. During the year if you are ill, injuried, or require medical attention it is your responsibility to ensure the Program or Associate Program Director is/are notified immediately. During your off-service rotations ensure the rotation preceptor is also notified of your potential absence.

D. EMPA Resident Rotations
1. Goals, objectives, and reading assignments for each rotation as well as points of contact will be furnished 2 weeks prior to the start of each rotation. The EMPA resident should read these goals so that he/she can direct his/her efforts during the rotation. On off-service rotations, it is mandatory for the EMPA resident to communicate with the designated point of contact well in advance to firm up details and coordinate schedules. Each EMPA resident is responsible for obtaining, taking and turning in the post-rotation test on the last Friday of the rotation block.

E. The Academic Program
1. The 12-month EMPA Core Curriculum has been divided into 7 ED rotations (BAMC, University and Santa Rosa Hospitals) and 6 off-service rotations.
2. Off-service rotations will constitute an average of 25% of the 12 month residency and are intended to provide further training in areas of potential weakness or interest, as well as an opportunity to maximize exposure to certain patient sub-populations.
3. Specific didactic and procedure goals have been developed for each of the rotations and are modeled after the Model Curriculum and the Model of the Clinical Practice of Emergency Medicine (App. 27). A required reading list has been generated for each rotation and the information tested upon completion of the rotation.

F. Case Studies
1 The EMPA resident will complete two case studies during the academic year. The case study should provide a brief preview of the presentation, discussion and clinical course of a patient evaluated during a rotation. An extensive literature review (10 years) should accompany each case study for subsequent filing in the Resident Article File.

2. Format for case studies will include the following:
a) A clear, concise description of the case to include chief complaint, history, PE, procedures, diagnostic tests and hospital (or ED) course.
b) A brief discussion of the value of the case to the EM resident. The discussion should demonstrate an understanding of the disease process by the EMPA resident.
3. One case study is due prior to the mid-year. The other must be completed no later than three weeks before graduation.
4. The goals of the case studies include an opportunity to become more familiar with a topic of interest, gain experience in conducting a literature search, gain an understanding of changing trends in management of disease and finally to improve on written and oral presentation skills.

G. Research Requirement/Publication Requirement
1 The production of original research is important for the advancement of Emergency Medicine and our EMPA residency. In addition, involvement in a research project allows one to develop the skills necessary for critical review of published literature. It is recognized however, that bench research doses not appeal to everyone.
2. One original article must be written and submitted to one of the current EM or PA journals two months prior to graduation. This article may be written by an individual EMPA resident or in association with another EMPA resident or EM staff physician, or EM resident. This article does not have to be published prior to graduation, only submitted.

H. Electives
1. Electives are designed to:
a) Pursue an EMPA resident's interest in an area of medicine applicable to the practice of emergency medicine.
b) Further an EMPA resident's fundamental knowledge and clinical skills in an area not fully mastered through the designed exposure in the model curriculum.
c) Goals and objectives, procedure check lists, and reading assignments are developed for each elective by the EMPA resident in coordination with the Program Director to maximize the learning experience for the individual EMPA resident. Electives will be approved only if they meet academic needs of the individual EMPA resident

I. Procedural Skill Lab
1. The goals are to gain competency in procedures often needed in providing resuscitation/advanced life support. Emphasis is on development of skills, although indications/contraindications will be discussed. The laboratory environment is utilized to provide an educational opportunity without stress. The procedures, however, should be performed as if involving a seriously ill patient. Procedural Skill Lab will be scheduled every month. Each EMPA resident will participate in the monthly Procedural Skill Labs and be responsible for completing a Procedural Skill Assessment sheet (App. 10) on procedures attempted. Procedures include:

a) Venous cut down
b) Diagnostic Peritoneal Lavage
c) Transvenous cardiac pacing techniques
d) Tube thoracostomy
f) Needle pericardiocentesis
g) Thoracotomy
h) Pericardiotomy
i) Aorta Compression/occlusion
j) Heart puncture wound repair
k) Defibrillation
l) Cricothyroidotomy
m) Central line placement

J. Graduation
1. To graduate from the Emergency Medicine Physician Assistant Residency, the resident must demonstrate successful completion of the following:
a) Demonstrate competency in the Seven Crucial Objectives of the EMPA Residency
b) Completion of a research project suitable for publication
c) Maintain an overall clinical and academic average of 80% (see **8. Evaluation Procedures**, paragraph C 6a-h)
d) Present two case presentations
e) Be in compliance with Army weight regulations and pass the APFT.

K. EMPA Faculty
1.The successful operation of an EMPA residency is predicated upon the involvement of graduate EMPAs within the program. One or more graduate EMPAs may be assigned to the program to provide academic and clinical guidance in areas of emergency and operational medicine, and to manage or assist in the administration of the EMPA residency. EMPA faculty

will supervise EMPA residents in the ED and assist in the procedural skill labs, give didactic instruction, counsel EMPA residents, administer examinations, attend Grand Rounds, Morning Reports, M&M/Trauma/EKG/Radiology conferences, and participate in all decision making processes affecting the EMPA residency.
L. Professional Activities
1. The EMPA faculty must serve as role models for the EMPA residents. In addition to the clinical and interpersonal aspects, the EMPA faculty must represent and understand the forces which shape the discipline of the military EMPA.
2. The EMPA staff will maintain NCCPA certification and AAPA membership.
3. EMPA faculty will participate in the faculty development program and maintain appropriate CME as outlined by the NCCPA.
4. EMPA faculty are to take an active role in the establishment of greater involvement for EMPAs in organizations such as AAPA, TAPA, SEMPA, SAEM and ACEP.
5. EMPA faculty will maintain contact with other EMPA programs in order to share ideas for continued program improvement.

5. PERSONAL CONDUCT

A. Any resident whose personal conduct and or behavior constitutes a disciplinary problem may be considered for termination from training and/or disciplinary action under the Uniform Code of Military Justice (UCMJ).
1. Examples of personal conduct that might justify relief and or disciplinary action include but are not limited to the following:
a) Cheating, e.g. copying the answers of another, unauthorized use of notes or other references, knowingly permitting another to copy answers from one's examination paper orally or otherwise giving examination answers to another in an unauthorized manner.
b) Unauthorized absence from assigned place of duty or training.
c) Use of obscene, profane or abusive language.
d) Repeated tardiness or absence.
e) Failure to maintain proper military appearance.
f) Lack of military and/or common courtesy.
g) Disruptive behavior.
h) Alcohol and or drug abuse.
i) A general lack of interest or application in meeting and maintaining physical fitness and weight standards IAW AR 600-9.
j) Any conduct not in keeping with the moral or ethical standards of an Army Officer and a healthcare professional IAW AR 351-3, AR 40-48, AR 40-68, and AR 600-20.

B. The EMPA resident is being prepared to function as an Emergency Medicine Physician Assistant. Only those residents who demonstrate initiative, responsibility, good judgment, self-confidence, self-control, honesty, leadership abilities and continually strive for improvement will be allowed to graduate from the EMPA residency. Residents who demonstrate deficiencies in one or more of these areas will be recommended for probation, extension of training, or termination from training from the EMPA residency.

6. PHYSICAL FITNESS

A Each EMPA resident will take the Army Physical Fitness Test (APFT) every six months. The results will be forwarded to the Residency Director. In order to graduate from the EMPA residency, each EMPA resident must obtain a passing score on the APFT as well meet weight standards IAW 600-9 within 6 months prior to the graduation date.

B. Any resident who does not meet these requirements will be directed to the Dean, SAUSHEC for administrative action.

7. UNIFORM

A. The duty uniform may be BDU, Class B uniform, or authorized scrub suit during ED rotations and other duties.

B. The appropriate duty uniform for other rotations will be specified by the Clinic, Department or Service Chief of all other rotations. Appropriate civilian attire must be worn when rotating in a non-military hospital.

8. EVALUATION PROCEDURES

A. Purpose: The evaluation process of the EMPA Residency is designed to,
1. Evaluate the resident's progress throughout the program.
2. Determine levels of resident's academic accomplishment in order to submit grades to the Chief, Physician Assistant Section, Army Medical Specialist Corps.

3. Determine if the resident is adequately prepared to graduate from the EMPA Residency.
4. Ensure each resident is capable of performing the crucial objectives of the EMPA residency upon completion of the program.
5. Ensure each graduate EMPA resident can perform the duties of an Emergency Medicine Physician Assistant as a staff member on an Emergency Medicine Service.
6. EMPA resident critiques and evaluations of the clinical rotations are vital to the continued viability of the EMPA residency program. Every EMPA resident will be responsible for completion of an Evaluation of Rotation Form within 3 working days after completion of a rotation and will likewise receive an Evaluation and Grading Report. In addition, the ED staff will be evaluated by the EMPA Resident on an Evaluation of Staff Form, twice during the academic year.

B. Crucial Objectives, EMPA Residency (Performance Objectives)
1. EMPA residents must accomplish each of the 7 crucial objectives listed in Appendix 4 and demonstrate the attitude and behavior consistent with an Emergency Medicine Physician Assistant in order to graduate from the EMPA Residency.
2. Residents who fail one or more of the crucial objectives must be evaluated and recommended for probation, extension of training, or termination from training.

C. Evaluation Procedures
1. Performance criteria: The responsibility for evaluating the performance of the EMPA resident must reside in the professional judgment of the preceptors who directly observe the EMPA students during the didactic and clinical practicum.
2. Only those EMPA residents who demonstrate the required knowledge, skill, attitude, and the motivation to satisfactorily function as an Emergency Medicine Physician Assistant should be awarded passing grades.
3. Grading standards have been established to cover the minimum points in the performance evaluations of the EMPA residents during the didactic and clinical practicum. It is essential these standards be strictly applied so each EMPA resident is evaluated uniformly.
4. Numerical Grades: When assigning numerical grades to EMPA residents, it is important to remember most of the EMPA residents are average and should receive numerical ratings between 70 and 100 percent. Few EMPA students, only those who are truly exceptional, deserve ratings of 100 percent. EMPA residents who do not perform satisfactorily on a clinical rotation should receive a failing grade (a numerical rating between 0 and 69 percent). A rating below 70 percent places the EMPA resident on a probationary status.
5. Quizzes/Tests: EMPA residents will have assigned readings during each ED and off-service rotation. The readings are designed to cover the majority of Tintinalli A Comprehensive Study Guide and Rosen's Emergency Medicine Concepts and Clinical Practice during the residency. Failure (less than 80%) on two consecutive tests, or greater than 2/3 of the total test scores or a combined average test score of less than 80%, will result in the EMPA resident being counseled and placed on a probationary status.
6. Essentials for Graduation: No resident can graduate from the EMPA residency without demonstrating an acceptable level of performance in each area essential for effective job performance throughout the didactic and clinical practicum. In order to graduate, the EMPA resident must:
a) Achieve a final average grade of at least 80 percent.
b) Achieve a grade of at least 80 percent on the mid term and final examinations.
c) Achieve a grade of at least 80 percent on the mid-term and final oral boards.
d) Achieve a grade of at least 80 percent on all clinical rotations (Preceptor evaluation and written examination).
e) Pass all 7 Crucial Objectives of the EMPA residency.
f) Successfully pass the APFT within six months prior to graduation.
g) Be within the Army's standards for acceptable weight set forth in AR 600-9.
h) Consistently demonstrate acceptable personal conduct and behavior IAW AR 40-48 and AR 600-20.

NOTE: Failure to accomplish any of the above requirements will require the resident to be placed on a probationary status, processed for extension of training, or termination from training.

7. Evaluation and Grading Reports: The Evaluation and Grading Reports provide a means of measuring the resident's progress as he/she moves from one rotation to another and as he/she learns new techniques and improves upon those he/she has previously performed. The preceptor is responsible for initiating and completing the Evaluation and Grading Report. When evaluating an EMPA resident, the preceptor must take into consideration the number of weeks the EMPA resident has been in the didactic and clinical practicum. The grade should reflect what the resident can reasonably be expected to have achieved at the time he/she is being evaluated. A copy of the Evaluation and Grading Sheet is to be included in the ED resident's counseling file.
8. Mid Term and Final Written Comprehensive Examination: The mid term and final written comprehensive examination will be given by the Program Director, EMPA Residency. Each exam consists of 100 questions with a 4 hour time limit. The examinations will be given approximately 4 weeks before completion of the first six months of the training, and the end of the residency.

a) Should the resident fail the mid term or the final examination, a retest for either the mid term or final examination will be given. The retest can be oral, written, or practical.
9. Oral Examination Boards: two oral examination boards will be conducted, approximately 2 weeks prior to the midterm and graduation date.
a) The Oral Examination Board will be composed of three members. The Residency Director , the EMPA Program Director and the third member appointed by the Residency Director.
b) Oral examination board will be one hour in duration.
c) Should the resident fail the mid term or the final oral board, a retest will be given. The retest can be oral, written, or practical.
10. Program Points and Grades
a) A numerical grade average will be reported to the Chief, Physician Assistant, Army Medical Specialist Corps for each resident completing the EMPA Residency.
11.Core Competencies: To continue to validate and assess competency skills, the Accreditation Council for Graduate Medical Education (ACGME) Joint Initiative core competencies will be utilized. The areas that will be evaluated to assess competency include; patient care, medical knowledge, communication skills, professionalism, practice based learning, and system based practice.
a) The evaluation methods are developed into a grid located in Appendix 26. These evaluation methods are supported by ; Evaluation and Grading Reports of each rotation, rotation specific written examinations, mid/final term written and oral examinations, quarterly professional and academic counseling, Officer Evaluation Reports, record reviews, 360 degree surveys, patient surveys, case studies and presenting these as lectures, research and QI projects, procedural labs, patient and procedure skill assessment sheets, morning reports, board rounds, and clinical evaluation exercise (similar to an objective structured clinical examination/OSCE/App 8).

9. PROCEDURAL EVALUATION CHECKLIST

A. Purpose: The Procedural Evaluation Checklist (App. 9) is a collection of procedures the resident accomplishes during the clinical practicum. It also provides the Program Director with a guide to each resident's weak and strong points. The training can therefore be tailored or concentrated in areas where the student needs the most help.
1. The Procedural Evaluation Checklist will be utilized as a summary of procedures attempted/accomplished. This information will be derived from the Procedural Skills Assessment sheets (App. 10).
2. The Procedural Skills Assessment sheets used during each procedure and will be maintained as part of a packet for the Procedural Evaluation Checklist.

B. The procedures and work-ups in the Procedural Evaluation Checklist may be checked off at any time during the didactic or clinical practicum.

C. The best way EMPA residents can learn the procedures and tasks listed in the Procedural Evaluation Checklist is to perform the tasks and procedures under supervision of their preceptors. Therefore, preceptors must be thoroughly familiar with the contents of the Procedural Evaluation Checklist and, most importantly, frequently observe each EMPA resident.

D. The preceptor or his representative should monitor the resident's checklist at least weekly to ensure the checklist is being properly maintained.

E. Changes in the Procedural Evaluation Checklist are NOT authorized without prior approval from the Residency Director.

F. At the completion of the didactic and clinical practicum, a copy of the completed Procedural Evaluation Checklist and supporting Procedural Skills Assessment forms must be retained in the residents counseling file. The originals are retained by the resident for future credentialing purposes.

10. RESIDENT COUNSELING

A. Academic Counseling
1. An academic advisor/preceptor will be assigned as the primary academic counselor. Additional counseling should be provided by the Residency Director and/or the Program Director as indicated.
2. The resident is counseled concerning his progress in the program, paying particular attention to actual or potential problem areas. Counseling and or corrective action should be done before problems result in academic difficulty.
3. EMPA residents are to be individually counseled at least monthly. Weekly counseling is strongly recommended in the first two ED rotations. Residents having difficulties must be counseled more often. The academic counselor should be available on an as-needed basis to avert or solve problems in a timely manner. This is in addition to the predetermined, scheduled counseling session.

B. End of Rotation Counseling
1. Each resident is to be kept informed by the preceptor about his performance while in each rotation.
2. Each EMPA resident is to be counseled by the academic advisor/preceptor during the last three days of the rotation, utilizing the corresponding narrative summary in Part I & IV of the Evaluation and Grading Report(App 5).
3. At the conclusion of the counseling session, both the preceptor and the resident will sign the appropriate areas of the Evaluation and Grading Report (App 5).
4. Residents experiencing difficulty in a clinical rotation will receive more intensive counseling by the preceptor. A Developmental Counseling Form (DA Form 4865) will be prepared, endorsed by the resident, and copies forwarded to the Residency Director.

C. An OER (DA Form 67-9) will be written for each EMPA resident at the end of the academic year and as required. Quarterly counseling will be conducted by the Program Director.
1. REQUIREMENT (AR 623-105)
a) Each EMPA resident will have an OER support Form (DA Form 67-9-1) completed upon entry into the EMPA residency.
b) An Officer Evaluation Report (OER) (DA Form 67-9) will be completed for each EMPA resident upon completion of the EMPA residency.
2. PROCEDURE
a) The OER will be completed IAW AR 623-105.
b) The Program Director will be the EMPA resident's rater.
c) The Residency Director or Chief/Asst. Chief EM Department will be the EMPA resident's senior rater.

11. RESIDENT COUNSELING FILE

A. A counseling file will be maintained by the Program Director on each EMPA resident. This file will include the following:
1. Block/Service/Resident (of rotation) Evaluations
2. Written and Oral examination test/results
3. Patient and Procedure logs
4. Resident Lectures (case studies) and Research Paper
5. Administrative file (counseling forms, military, and personnel data)

B. A copy of the Counseling file will be provided to the EMPA resident upon graduation and then maintained within the EMPA's archive files.

12. RESIDENT PROBATION

A. As part of the San Antonio Uniformed Services Health Education Consortium (SAUSHEC) under the Allied Health grid, the EMPA Resident's Due Process is located in Appendix 17. The following is an outline for probationary status.

B. Grounds for probation, extension of training, or termination from training include but are not limited to the following:
1. Failure to achieve a final average of at least 80 percent as outlined in the EVALUATION PROCEDURES of this residency guide.
2. Failure to achieve a grade of at least 80 percent on the mid term and final examinations.
3. Failure to achieve a grade of at least 80 percent on the mid term and final oral boards.
4. Failure to pass all 7 Crucial Objectives of the EMPA residency.
5. Failure to successfully pass the APFT within six months prior to graduation.
6. Failure to be within the Army's standards for acceptable weight set forth in AR 600-9.
7. Failure to consistently demonstrate personal conduct and behavior IAW AR 351-3, AR 40-48, AR 40-68, AR 600-50, and UCMJ regulations.

C. Program Level Remediation can be considered for correction of deficiencies without formal probation.
1. When the Program Director identifies a resident with a deficiency or deficiencies that have not been amenable to informal counseling and redirection, or identifies a deficiency of significant magnitude to be addressed now, the resident may be placed on program-level remediation.
2.Program-level remediation is a program tool to focus the energies and effort of the resident to improve performance in one or several areas. It requires formal counseling, identification of the deficiencies, a remediation plan and an evaluation plan. It is not normally longer than 60 days and should not be extended.
3. Program-level remediation is not an adverse action for purposes of National Practitioner Data Bank or licensure reporting. It is, however, reported to the Associate Dean, SAUSHEC for tracking.

D. Administrative remediation should be considered for minor offenses, which are administrative in nature and are not sufficiently serious to warrant extension of training or termination from training action.

E. Probation will remain in effect for at least 30 days and no more than 90 days. Extension of the probationary period can be granted for no more than an additional 90 day period. EMPA Residents who fail to demonstrate adequate improvement after two consecutive periods of probation/administrative remediation generally will be recommended for an extension of training or termination from training.
1. A resident will be placed on probation when adequate progress is not being made in program-level remediation. Additionally, a resident may be placed on probation directly if there is gross negligence or willful misconduct.
2. Probation normally is considered an adverse action for purposes of National Practitioner Data Bank or licensure reporting. It is processed through the SAUSHEC Graduate Medical Education Committee.
3. A resident whose progress continues to be substandard after appropriate probation, counseling and remedial action may have probation extended, training length extended, or may be removed from the training program.

F. A resident placed on probation will be notified, in writing, and will acknowledge receipt of notification by endorsement, and will be counseled within two working days of such notification (App 18).The resident will have 5 working days to provide a written rebuttal.

G. After the Faculty Board's decision, a resident may appeal its decision and request an appearance before the faculty board (App. 20).

H. Records of all residents on probation will be reviewed regularly by the Residency Director.

13. RESIDENT EXTENSION OF TRAINING AND TERMINATION FROM TRAINING

A. As part of the San Antonio Uniformed Services Health Education Consortium (SAUSHEC) under the Allied Health grid, the EMPA Resident's Due Process is located in Appendix 17.
1. The training time for a resident may be extended for a period not to exceed 90 days for administrative reasons. A resident who fails one clinical area or who experiences difficulty in a clinical area but displays a strong desire to improve, may be granted an extension . The extension is granted only if there are strong indications the resident will successfully complete the EMPA residency. All extensions in the clinical practicum must be requested through the Residency Director to the Dean, SAUSHEC not later than 30 days prior to the scheduled graduation date. The extension also needs the approval of the Chief, Physician Assistant Section, Army Medical Speciality Corps.
2. An EMPA resident who requires more than 90 days to complete the clinical practicum may be recycled to another class. Recycling of a resident from one class to another should be considered only when such recycling will greatly increase the chance of the student's successful completion of the EMPA residency. Request for recycling must be submitted through the Residency Director to, Chief, Physician Assistant Section, Army Medical Specialist Corps.
3. Residents who demonstrate deficiencies in academic, leadership, personal conduct, or those who are otherwise unsuitable for the duties of an EMPA should be terminated from the EMPA residency. The nature of the graduate EMPA's duties and responsibilities should be considered in the elimination process.
4. In lieu of extension or termination actions, the resident may submit a letter of resignation to the Chief, Physician Assistant Section, Army Medical Specialist Corps, through the Program Director and the Residency Director. The resignation letter will be forwarded to the Dean, SAUSHEC.

B. Extension Procedures: The following is an outline of the procedures to be followed for extending an EMPA resident:
1. After consultation with the Residency Director and the Chief, Physician Assistant Section, Army Medical Specialist Corps, the Program Director will prepare a letter (App 19) recommending extension of training. The Program Director must indicate the basis for the request.
2. The Program Director will prepare an Memorandum for Record (MFR) detailing the reasons for the recommendation, any remedial training the resident has received, the specifics of the previous resident counseling, and any other information deemed pertinent.
If the basis of the recommendation is the inability of the resident to pass one or more of the 7 Crucial Objects, the specific objective (s) must be stated in the MFR.
3. The Program Director will notify the resident in writing of his intention to extend the EMPA resident and inform the resident of the reason for the academic, or administrative action (App 19).
4. Upon receipt of the notification, the resident will reply by endorsement (App 19).
5. The Program Director will forward the following to the Residency Director:
a) Letter to Residency Director
b) Memorandum (s) for Record
c) Notification of recommendation for extension (App 19) with the residents endorsement.
d) All Records of Resident Counseling

e) Copies of the residents probation notices (App 18)
f) Copies of additional documents considered pertinent.

C. Termination Procedures: The following outline is to be used when processing EMPA residents for termination from training.
1. The Program Director will forward the following to the Residency Director:
a) Letter to Residency Director
b) Memorandum (s) for Record
c) Notification of recommendation for termination from training (App 19) with the resident's endorsement.
d) All Records of Resident Counseling
e) Copies of the resident's probation notices (App 18)
f) Copies of additional documents considered pertinent.
2. The Residency Director will notify the resident in writing he/she is to be processed for termination from the EMPA residency (App 19). The EMPA resident must be advised if he is terminated from the EMPA residency, he will be reassigned to a non-EMPA position.
3. Upon receipt of the notification, the resident will reply by endorsement (App. 19).
4. If an alternative action is not warranted, the resident must be notified of the reason (s) for the decision to terminate him/her (App. 22) from the EMPA residency. The resident may, within 5 working days, submit a written rebuttal and request an appeal of the Faculty Board's decision (App 20).
5. If termination from the EMPA residency is appropriate, the Residency Director will forward the following documents to the Chief, Physician Assistant, Army Medical Specialist Corps:
a) Letter to the Chief, Physician Assistant, Army Medical Specialist Corps.
b) Memorandum (s) for Records
c) Notification of recommendation for termination with resident's endorsement (App 19)
d) Summary of the formal hearing.
e) Resident's written rebuttal
f) Copies of all records of Resident Counseling
g) Copies of all Resident Probation Notices (s) (App 18)
7. The EMPA resident is to remain in training during the entire proceedings. In cases where the resident must be removed from training, the Residency Director will consult with the Chief, Physician Assistant Section, Army Medical Specialist Corps, prior to the removing of the resident from training unless there is an actual or potential threat to patients or to the resident.

SECTION III APPENDIXES

APPENDIX 1 REFERENCES

A. EMPA Residency Guide
B. AR 351-3 Professional Education and Training Programs of the Army Medical Department
C. AR 40-48 Non-Physician Health Care Providers
D. AR 40-66 Medical Record Administration
E. AR 40-68 Quality Assurance Administration
F. AR 600-9 The Army Weight Control Program
G. AR 600-20 Conduct
H. AR 623-105 Officer Evaluation Reporting System
I. Uniformed Code of Military Justice

APPENDIX 2 DIDACTIC AND CLINICAL PRACTICUM SITES

A. The below listed sites are potential sites for didactic and clinical training.
1. Brooke Army Medical Center (BAMC), Fort Sam Houston, Texas
2. Wilford Hall Medical Center (WHMC), Lackland AFB, Texas
3. University Hospital, San Antonio, Texas
4. Santa Rosa Hospital, San Antonio, Texas

APPENDIX 3 MASTER ROTATION SCHEDULE

EM 500	Introduction to Emergency Medicine	4 weeks
EM 501	General Medicine and Surgery	4 weeks
EM 502	Environmental Illness/Geriatrics/Psychiatry	4 weeks
EM 503	Emergency Medicine Resuscitation	4 weeks
EM 504	Trauma Surgery	4 weeks
EM 505	Emergency Medicine & Toxicology	4 weeks
EM 506	Pediatrics	4 weeks
EM 507	Neurology/Urology	2 weeks
EM 508	OB/GYN	2 weeks
EM 509	Orthopedics	2 weeks
EM 510	OMF/Otolaryngology/Ophthalmology	2 weeks
EM 511	SICU/CCU	4 weeks
EM 512	Radiology	2 weeks
EM 513	Elective/Leave/Clearing	4 weeks

APPENDIX 4 SEVEN CRUCIAL OBJECTIVES OF THE EMPA RESIDENCY

A. Demonstrate the ability to obtain a proper medical history and perform a complete physical examination on an emergency department patient including the ability to manage multiple emergency medicine patients.
B. Demonstrate a satisfactory knowledge of disease and trauma and pathophysiology and the ability to manage and direct the management of an emergency department. Included in this objective is the demonstrated ability to perform such critical Emergency Medicine Physician Assistant skills as naso/endotracheal intubation, advance cardiac life support, advanced trauma life support, procedural sedation and analgesia, peripheral and central venous access, thoracostomy.
C. Demonstrate the ability to properly document the delivery of emergency medical care.
D. Maintain an acceptable level of personal and professional conduct in accordance with the Physician Assistant Oath and military regulations.
E. Establish and maintain credibility as competent provider of emergency medical care with both patient and staff.
F. Demonstrate the ability to present emergency department patients in a professional manner and to communicate effectively with patients, all members of the emergency department and consulting services.
G. Be recommended for graduation by a simple majority of the staff physicians of the BAMC Department of Emergency Medicine.

APPENDIX 5 EVALUATION AND GRADING REPORTS

A. Purpose: EMPA residents are assigned to BAMC to attend the one year Emergency Medicine Physician Assistant Residency.

B. Format: Based on consideration of the function of the EMPA, seven crucial objectives have been defined (App 4). EMPA residents cannot graduate from the EMPA residency if they fail one or more of these crucial objectives. The Evaluation and Grading Report form is used to evaluate the EMPA resident. This form allows for grading both medical proficiency and personal attributes.

C. Procedure: The following procedure is to be followed for completing the Evaluation and Grading Report

1. The preceptor is the rating officer. He evaluates the EMPA resident in each section of Part I of the Evaluation and Grading Report. Assigning a numerical grade from 0 to 100 for each section. The preceptor should refer to the Narrative Descriptions of Numerical Grades in order to arrive at the appropriate grade. He also includes a comment on the EMPA residents strengths and or weaknesses in the space provided. Residents must be formally counseled concerning their performance on the clinical rotation during the last three days of each rotation. Every Evaluation and Grading Report must be signed by both the preceptor and the EMPA resident being evaluated.

2. The Program Director is to endorse the evaluation.

D. The Program Director is responsible for the following:

1. Ensuring each EMPA resident is formally counseled during the last 3 days of the clinical rotation.

2. Ensuring all Evaluation and Grading Reports are complete to include the residents name, SSN, numerical scores, and inclusive dates of the rotation.

3. Upon receipt of the Evaluation and Grading Report the Program Director will compute the residents overall grade for the clinical rotation. At the conclusion of the course the numerical grades will be submitted to the Chief, Physician Assistant Section, Army Medical Specialist Corps.

4. Ensure a copy of the Evaluation and Grading Report is maintained in the EMPA residents file.

E. The Residency Director is responsible for the following:

1. Receiving and reviewing the Evaluation and Grading Report

2. Endorsing the form.

F. In lieu of the Evaluation and Grading Report (App. 5), the Off Service Evaluation and Grading Report (App.6) can be used by the preceptor for the rotation evaluation.

1. The information from the Off Service Evaluation and Grading Report (App. 6) will be transcribed to the Evaluation and Grading Report (App 5) and become part of the permanent/archive resident counseling file.

G. The Weekly/Daily Counseling Form (App. 7) is to be used when rotating through the BAMC ED in lieu of the Evaluation and Grading Report (App. 5).

1. The information from the Weekly/Daily Counseling Report (App. 7) will be transcribed to the Evaluation and Grading Report (App. 5) and become part of the permanent/archive resident counseling file.

2. This form (App. 7) can also be used during any rotation when more intense counseling is required ie., probationary status.

APPENDIX 5

EVALUATION AND GRADING REPORT
PHYSICIAN ASSISTANT EMERGENCY MEDICINE PROGRAM

Name/Grade: _____ SSN:_____

Block/Course #: _____ Block/Course Title: _____

Block/Course Dates:_____ to_____ Student #: _____ Class # _____

Section I Preceptor Evaluation (Grade from 0-100) (Minimum passing grade is 70)

1. __ Ability to obtain a complete and problem oriented patient history and physical examination
2. __ Ability to order and interpret Lab, X-ray, EKG and other tests
3. __ Ability to develop a differential diagnosis
4. __ Ability to perform medical and surgical procedures
5. __ Knowledge of medications
6. __ Charting abilities
7. __ Ability to present and consult on patients
8. __ Ability to make appropriate dispositions
9. __ General emergency medicine related knowledge
10. __ Over all thoroughness and ability to manage patients in a timely manner

__ Average performance grade

Section II Written examination

__ Score (Minimum passing score is 80)

Section III Final Course/Block Grade (Minimum passing score is 80)

__ (Composite average of performance and written examination grades)

Section IV Comments (Strengths and weaknesses)

_____ _____
Preceptor Signature **Date**

_____ _____
EMPA Resident Signature **Date**

_____ _____
Program Director Signature **Date**

_____ _____
Residency Director Signature **Date**

APPENDIX 6

OFF SERVICE EVALUATION AND GRADING REPORT
PHYSICIAN ASSISTANT EMERGENCY MEDICINE PROGRAM

Name/Grade: _____ SSN:_____

Block/Course #: _____ Block/Course Title: _____

Block/Course Dates:_____ to_____ Student #: _____ Class # _____

Section I Preceptor Evaluation (Grade from 0-100) (Minimum passing grade is 70)

1. __ Ability to obtain a complete and problem oriented patient history and physical examination
2. __ Ability to order and interpret Lab, X-ray, EKG and other tests
3. __ Ability to develop a differential diagnosis
4. __ Ability to perform medical and surgical procedures
5. __ Knowledge of medications
6. __ Charting abilities
7. __ Ability to present and consult on patients
8. __ Ability to make appropriate dispositions
9. __ General emergency medicine related knowledge
10. __ Over all thoroughness and ability to manage patients in a timely manner

__ Average performance grade

Section II Comments (Strengths and weaknesses)

_____ _____
Preceptor Signature **Date**

_____ _____
EMPA Resident Signature **Date**

APPENDIX 6a

OFF SERVICE EVALUATION AND GRADING REPORT
PHYSICIAN ASSISTANT EMERGENCY MEDICINE PROGRAM/RADIOLOGY

Name/Grade: _____ SSN:_____

Block/Course #: _____ Block/Course Title: _____

Block/Course Dates:_____ to_____ Student #: _____ Class # _____

Section I Preceptor Evaluation (Grade from 0-100) (Minimum passing grade is 70)

1. __ Ability to order and interpret radiological studies
2. __ Ability to develop a differential diagnosis
3. __ Ability to perform radiological procedures
4. __ Charting abilities (as appropriate)
5. __ Ability to present and consult on patients
6. __ Ability to make appropriate dispositions
7. __ General emergency medicine related knowledge

__ Average performance grade

Section II Comments (Strengths and weaknesses)

_____ _____
Preceptor Signature **Date**

_____ _____
EMPA Resident Signature **Date**

APPENDIX 7

WEEKLY/DAILY COUNSELING REPORT
PHYSICIAN ASSISTANT EMERGENCY MEDICINE PROGRAM

Name/Grade: _____ SSN:_____

Block/Course #: _____ Block/Course Title: _____

Block/Course Dates:_____ to_____ Student #: _____ Class # _____

Section I Preceptor Evaluation (Grade from 0-100) (Minimum passing grade is 70)

1. __ Ability to obtain a complete and problem oriented patient history and physical examination
2. __ Ability to order and interpret Lab, X-ray, EKG and other tests
3. __ Ability to develop a differential diagnosis
4. __ Ability to perform medical and surgical procedures
5. __ Knowledge of medications
6. __ Charting abilities
7. __ Ability to present and consult on patients
8. __ Ability to make appropriate dispositions
9. __ General emergency medicine related knowledge
10. __ Over all thoroughness and ability to manage patients in a timely manner

__ Average performance grade

Section II Comments (Strengths and weaknesses)

_____ _____
Preceptor Signature **Date**

_____ _____
EMPA Resident Signature **Date**

APPENDIX 8

CLINICAL EVALUATION EXERCISE(OBSERVED STRUCTURED CLINICAL EXAMINATION/OSCE)

EMPA'S NAME_____

EVALUATOR'S NAME_____

DATE OF EVALUATION_____

A staff Physician Assistant/Physician will observe the EMPA resident interview a patient and perform a physical examination, followed by a presentation by the EMPA resident, presenting the history and physical examination away from the patient. The EMPA resident will give the initial diagnostic impression, and state initial plans for the diagnostic and medical care. The EMPA resident will present the pathological findings and physiology of the disease and treatment of the disease.

I. Data Gathering-History

1. Demonstrates consideration for the patient during the interview.
2. Recognizes and interprets non-verbal clues.
3. Allows the patient adequate time to tell about the illness in his own words, yet directs questions effectively to obtain the necessary information.
4. Develops in chronological sequence an accurate description of pertinent symptoms and events in the present illness.
5. Obtains appropriately complete information in past medical history, family history, and social history.

COMMENTS: Describe major strengths and weaknesses observed (i.e. give positive and negative critical incidents)

RATE: Superior_____
Satisfactory_____
Unsatisfactory_____

II. Data Gathering-Physical Examination

1. Demonstrates concern for the patient's comfort and modesty
2. Enlists the patients cooperation
3. Positions properly and applies skillfully the fundamental techniques of the examination to each region
4. Follows a logical sequence of examination from one region to another, emphasizing those areas of importance suggested by the interview
5. Applies special techniques to help gather complete information about an abnormality
6. Modifies the examination to adapt to patient limitations imposed by illness.

COMMENTS: Describe major strengths and weaknesses observed (i.e. give positive and negative critical incidents)

RATE: Superior_____
Satisfactory_____
Unsatisfactory_____

III. Case Presentation

1. Spends an amount of time that is appropriate for the complexity of the problem. Uses terminology that is meaningful and unambiguous. Presents information concisely in logical sequence. Reports accurately the information related by the patient and the observations made during the physical examination. Relates information about major problems in adequate detail without significant omissions or digressions, selectively highlighting less important problems.

COMMENTS: Describe major strengths and weaknesses observed (i.e. give positive and negative critical incidents)

RATE: Superior_____
Satisfactory_____
Unsatisfactory_____

IV. Diagnosis and Plan for Diagnostic Studies and Medical Care

1. Understands in physiologic terms and meaning of the patient's abnormal findings and interrelates them to explain logically the patient's illness. Is able to develop a differential diagnosis with an appreciation for priorities in each diagnoses considered. Identifies all of the patient's major problems.
2. Uses a logical sequence in planning diagnostic tests and procedures. Integrates diagnostic studies with the diagnostic impression, proceeding from the more simple and encompassing tests to the more complex tests.
3. Selects the most effective care with the least risk to the patient. Plans treatment to deal with all of the patient's major problems.

COMMENTS:Describe major strengths and weaknesses observed (i.e. give positive and negative critical incidents.)

RATE: Superior_____
Satisfactory_____
Unsatisfactory_____

V. OVERALL CLINICAL COMPETENCE

Circle the number which best describes overall clinical competence.

Superior	Satisfactory	Unsatisfactory
10 9 8	7 6 5 4	3 2 1

COMMENTS:

Evaluator's Signature_____

EMPA's Signature_____

DATE_____

APPENDIX 9 PROCEDURAL EVALUATION CHECKLIST

A. Purpose
B. Procedures
C. Instructions
D. Procedural Evaluation Checklist
E. Certification by Program and Residency Directors

A. PURPOSE: The purpose of the Procedural Evaluation Checklist is to:
1. Provide a repository for all procedures performed by the EMPA resident during the practicum of the EMPA residency.
2. Provide the academic advisor/preceptor with a guide to each residents weak and strong points. Training may then be tailored or concentrated in the areas where the student needs the most help.
3. Provide guidelines on direct supervision by the preceptors: The best way a resident can learn to do the case procedures listed in the Procedural Evaluation Checklist is to perform them under the direct supervision of their preceptors. Preceptors must be thoroughly familiar with the contents of this document and, most importantly, observe each EMPA student in action on a frequent basis.
4. Be utilized for credentialing of the EMPA graduate.
B. PROCEDURE:
1. The following elements are to be included when performing procedures,
a) Eliciting an appropriate history.
b) Performing an appropriate physical examination.
c) Order and interpret appropriate x-ray and laboratory procedures.
d) Formulating a working and or differential diagnosis.
e) Developing an appropriate plan for action (management).
f) Presenting the case to the preceptor in a clear, complete and concise manner.
g) All of the six major elements listed above must be used when assigning credit for the work-up. The emphasis must remain on the mechanics of the work-up as listed above.
2. The procedures in the Procedural Evaluation Checklist may be accomplished at any time during the clinical practicum.
3. Some EMPA residents may not be exposed to all the procedures listed in the Procedural Evaluation Checklist. The academic advisor/preceptor must notify the Program Director of circumstances which may prevent the completion of the checklist.
4. All attempted procedures are documented on a Procedural Skill Assessment sheet. At the end of the academic year, the number of procedures attempted is documented on the Procedural Evaluation Checklist.
5. A copy of the Procedural Evaluation Checklist must be certified by the Program and Residency Directors as a true copy. This is accomplished at the end of the academic year. Each resident is to retain the original completed checklist for future credentialing purposes.
C. INSTRUCTIONS:
EMPA Resident is responsible for:
1. Maintaining this checklist.
2. It is the residents responsibility to ensure each task and procedure performed is checked off and signed by the preceptor.
3. Upon graduation, retain the original checklist.
Academic advisors/preceptors are responsible for:
1. This checklist is an official document.
2. It is a record for future hospital credentialing and must be document as such.
3. Complying all Procedural Skill Assessment sheets and annotating on the Procedural Evaluation Checklist the amount of procedures attempted, your name,date, and signature.

9. (D) PROCEDURAL EVALUATION CHECKLIST

PROCEDURE	NUMBER	PRECEPTOR'S NAME, DATE AND SIGNATURE
1. Arterial Line Placement	_____	_____
2. Bag Valve Mask Ventilation	_____	_____
3. Central Venous Access	_____	_____
4. Cricothyrotomy	_____	_____
5. Cardioversion/Defibrillation	_____	_____
6. ED Resuscitative Thoracotomy	_____	_____
7. Internal Cardiac Massage	_____	_____
8. Lumbar Puncture	_____	_____
9. Naso/Endotracheal Intubation	_____	_____
10. Pericardocentesis	_____	_____
11. Peritoneal Lavage	_____	_____
12. Rapid Sequence Induction/Intubation	_____	_____
13. Tube Thoracotomy	_____	_____
14. Venous Cutdown	_____	_____
15. Wound Care	_____	_____
16. Trauma Resuscitation	_____	_____
17. Ultrasound		
a. FAST exam	_____	_____
b. Intravaginal exam	_____	_____
18. Successful passing of:		
a. BCLS	(Date) _____	_____
b. ACLS	(Date) _____	_____
c. APLS	(Date) _____	_____

E. STATEMENT

I Certify this is a true and accurate record of the case work-ups and procedures performed by:

NAME_____SSN_____
during the Clinical Practicum of the Emergency Medicine Residency. Further, all signatures contained herein are official from duly appointed Preceptors.

EMPA RESIDENT_____DATE_____
signature

PROGRAM DIRECTOR _____DATE_____
signature

MEDICAL DIRECTOR_____DATE_____
signature

APPENDIX 10

SAUSHEC EMERGENCY MEDICINE RESIDENCY
OPERATIVE/INVASIVE PROCEDURE SKILLS ASSESSMENT

Patient Number:_____ **Staff Physician: _____**
Diagnosis: _____ **Resident: _____**
Procedure: ARTERIAL LINE PLACEMENT **Date of Procedure: _____**

A. Demonstrates knowledge of Indications: Does Meet/Does Not Meet Standards (Circle One)
1. Blood gas sampling
2. Continuous pressure monitoring
3. Frequent blood sampling
4. Other (specify):

B. Demonstrates knowledge of Contraindications: Does Meet/Does Not Meet Standards (Circle One)
1. Previous surgery in the area (esp cutdown)
2. Anticoagulation
3. Coagulopathy
4. Skin infection/bum at site
5. Atherosclerosis
6. Decreased collateral flow

C. Properly prepares the patient: **Does Meet/Does Not Meet Standards (Circle One)**
1. Consent obtained yes/ no/ NA
2. Allen test performed & normal yes/ no/ NA

D. Demonstrates knowledge of procedure and skills to successfully complete procedure: Does Meet/Does Not Meet Standards (Circle One)
1. Site identified yes/ no
2. Sterile prep and drape yes/ no
3. Artery cannulated yes/ no
4. Catheter advanced without difficulty yes/ no
5. Catheter secured in place yes/ no
6. Sterile dressing applied yes/ no
7. Arterial waveform identified yes/ no

E. Postprocedure Care: Does Meet/Does Not Meet Standards (Circle One)
1. Adequate procedure note yes/ no

F. Complications: (Circle all which occurred)
1 .Hematoma
2 .Exsanguination
3. Infection
4 .Thrombosis
5. Arterial spasm
6. Catheter embolization
7. Skin necrosis
8. Other (specify):

G. Overall Assessment: Resident does/does not (circle one) demonstrate the knowledge of the indications and contraindications of this procedure and possesses the skills required to successfully complete the procedure.

Staff Signature **Date** **Staff Provider Stamp**

SAUSHEC EMERGENCY MEDICINE RESIDENCY
OPERATIVE/INVASIVE PROCEDURE SKILLS ASSESSMENT

Patient Number:_____ Staff Physician: _____
Diagnosis: _____ Resident: _____
Procedure: Bag Valve Mask Ventilation Date of Procedure: _____

A. Demonstrates knowledge of Indications: Does Meet/Does Not Meet Standards (Circle One)
1. Need for supported respiration with inadequate prep for anesthesia/intubation

B. Demonstrates knowledge of Contraindications: Does Meet/Does Not Meet Standards (Circle One)
1. Stable spontaneously breathing patient with nasotracheal or more controlled O.R. Airway placement available.

C. **Properly prepares the patient**: **Does Meet/Does Not Meet Standards (Circle One)**

1.	Correct Bag/Mask Size selected	yes	no	NA
2.	Bag connected to oxygen and on high flow rate	yes	no	NA
3.	Position Patient	yes	no	NA
4.	Suction available	yes	no	NA
5.	2 people utilized when possible	yes	no	NA

D. Demonstrates knowledge of procedure and skills to successfully complete procedure: Does Meet/Does Not Meet Standards (Circle One).

1.	Adequate mask seal	yes	no	NA
2.	Adequate Tidal Volume	yes	no	NA
3.	Sellick maneuver	yes	no	NA
4.	Maintains vigilance for aspiration	yes	no	NA

E. Postprocedure Care: Does Meet/Does Not Meet Standards (Circle One)
1. Adequate procedure note yes no

F. Complications: (Circle all which occurred)
1. Aspiration
2. Inadequate oxygenation
3. Other (specify):

G. Overall Assessment: Resident does/does not (circle one) demonstrate the knowledge of the indications and contraindications of this procedure and possesses the skills required to successfully complete the procedure.

Staff Signature **Date** **Staff Provider Stamp**

SAUSHEC EMERGENCY MEDICINE RESIDENCY
OPERATIVE/INVASIVE PROCEDURE SKILLS ASSESSMENT

Patient Number:_____ **Staff Physician: _____**
Diagnosis: _____ **Resident: _____**
Procedure: CENTRAL VENOUS ACCESS **Date of Procedure: _____**

A. Demonstrates knowledge of Indications: Does Meet/Does Not Meet Standards (Circle One)

1. Central venous pressure monitoring
2. Volume resuscitation
3. Emergency venous access
4. Inadequate peripheral IV sites
5. Infusion of concentrated solutions
6. Transvenous pacing

B. Demonstrates knowledge of Relative Contraindications: Does Meet/Does Not Meet Standards (Circle One)

1. General
   a. Distorted local anatomy (use contralateral side)
   b. Extremes of weight
   c. Vasculitis
   d. Prior long-term venous cannulation
   e. Prior injection of sclerosing agents
   f. Suspected proximal vascular injury
   g. Previous radiation therapy
   h. Bleeding disorders
   i. Anticoagulation or thrombolytic therapy
   j. Combative patient
2. Subclavian vein
   a. Chest wall deformity
   b. PTX (use ipsilateral side)
   c. COPD
3. Jugular vein
   a. IVDA via jugular system
4. Femoral vein
   a. Need for patient mobility

C. Properly prepares the patient: **Does Meet/Does Not Meet Standards (Circle One)**

1. Patient allergies confirmed	yes/	no/	NA
2. Consent signed and dated	yes/	no/	NA
3. Local anesthesia	yes/	no	NA

D. Demonstrates knowledge of procedure and skills to successfully complete procedure: Does Meet/Does Not Meet Standards (Circle One)

1. Approach identified	yes	no	
2. Sterile prep/drape	yes	no	
3. Patient properly positioned	yes	no	NA
4. Catheter easily passed	yes	no	
5. Appropriate line placement	yes	no	
6. Line secured	yes	no	NA
7. Sterile dressing applied	yes	no	NA

E. Postprocedure Care: Does Meet/Does Not Meet Standards (Circle One)

1. Confirmation of tube placement	yes	no
2. Procedure note complete	yes	no

F. Complications: (Circle all which occurred)

1. Pneumothorax
2. Hemothorax
3. Hydrothorax
4. Air embolism
5. Catheter embolization
6. Catheter kinking
7. Local hematoma
8. Adjacent arterial puncture
9. Other (specify)

G. Overall Assessment: Resident does/does not (circle one) demonstrate the knowledge of the indications and contraindications of this procedure and possesses the skills required to successfully complete the procedure.

Staff Signature **Date** **Staff Provider**

SAUSHEC EMERGENCY MEDICINE RESIDENCY
OPERATIVE/INVASIVE PROCEDURE SKILLS ASSESSMENT

Patient Number:_____ **Staff Physician: _____**
Diagnosis: _____ **Resident: _____**
Procedure: CRICOTHYROTOMY **Date of Procedure: _____**

A. Demonstrates knowledge of Indications: Does Meet/Does Not Meet Standards (Circle One)
1. Failure of oral, nasal, or pharyngeal hemorrhage
2. Upper airway obstruction, either partial or complete
3. Traumatic injuries making oral or nasal endotracheal intubation difficult or potentially hazardous

B. Demonstrates knowledge of Relative Contraindications: Does Meet/Does Not Meet Standards (Circle One)
1. Absolute contraindications
   a. Endotracheal intubation possible
   b. Transaction of trachea with retraction of distal end
   c. Fractured larynx or damaged cricoid cartilage
2. Relative contraindications
   a. Infant or young child
   b. Bleeding diathesis
   c. Massive neck edema
   d. Acute pharyngeal disease

C. Properly prepares the patient: **Does Meet/Does Not Meet Standards (Circle One)**
1. Basic airway management/supplemental oxygen employed prior to completion yes/no/NA
2. Instruments and needed equipment available yes/no/NA
3. Patient preparation/positioning adequate yes/no/NA
3. Sterile prep/drape yes/no/NA
4. Local anesthesia yes/no/NA

D. Demonstrates knowledge of procedure and skills to successfully complete procedure: Does Meet/Does Not Meet Standards (Circle One)
1. Employs monitoring techniques appropriate to patient condition yes/no
2. Appropriate landmarks identified yes/no
3. Maintains cervical spine precautions yes/no/NA
4. Appropriate incision site yes/no
5. Appropriate tube insertion yes/no
6. Adequate ventilation confirmed yes/no
7. Tube secured yes/no

E. Postprocedure Care: Does Meet/Does Not Meet Standards (Circle One)
1. Confirmation of tube placement yes/no
2. Procedure note complete yes/no

F. Complications: (Circle all which occurred)
1. Bleeding
2. Incorrect/unsuccessful tube placement
3. Prolonged procedure time
4. Subcutaneous emphysema
5. Laryngeal fracture or disruption
6. Pneumothorax, pneumomediastinum
7. Aspiration
8. Other (specify)_____

G. Overall Assessment: Resident does/does not (circle one) demonstrate the knowledge of the indications and contraindications of this procedure and possesses the skills required to successfully complete the procedure.

Staff Signature **Date** **Staff Provider Stamp**

SAUSHEC EMERGENCY MEDICINE RESIDENCY
OPERATIVE/INVASIVE PROCEDURE SKILLS ASSESSMENT

Patient Number:_____Staff Physician_____
Diagnosis: _____Resident_____
Procedure: Cardioversion/Defibrillation Date of Procedure: _____

A Demonstrates knowledge of Indications: Does Meet/Does Not Meet Standards (Circle One)

1. V. Fibrillation
2. Unstable V. Tach

B. Properly prepares the patient: **Does Meet/Does Not Meet Standards (Circle One)**

1. Confirmes rhythm with monitor or with paddles

C. Demonstrates knowledge of procedure and skills to successfully complete procedure: Does Meet/Does Not Meet Standards (Circle One)

2. Recognizes rhythm requiring defibrillation yes/no
3. Informs team of intentions yes/no
4. Applies gell to paddles or defib pads on patient in proper position yes/no
5. Charges paddles to appropriate energy level yes/no
6. Assures that team is clear of patient prior to defibrillation yes/no
7. Checks rhythm after defibrillation, if changed, checks pulse, if not repeats yes/no

D. Postprocedure Care: Does Meet/Does Not Meet Standards (Circle One)

1. Adequate sedation (cardioversion) yes/no/NA
2. Procedure note completed yes/no

E. Complications: (Circle all which occurred)

1. Hypoxia
3. Cardiac decompensation
4. Vomiting/aspiration
5. Asystole
6. Other (specify)_____

F. Overall Assessment: Resident does/does not (circle one) demonstrate the knowledge of the indications and contraindications of this procedure and possesses the skills required to successfully complete the procedure.

Staff Signature **Staff Provider Stamp**

Date

SAUSHEC EMERGENCY MEDICINE RESIDENCY
OPERATIVE/INVASIVE PROCEDURE SKILLS ASSESSMENT

Patient Number:_____ Staff Physician_____
Diagnosis: _____ Resident: _____
Procedure: ED RESUSCITATIVE THORACOTOMY Date of Procedure: _____

A. Demonstrates knowledge of Indications: Does Meet/Does Not Meet Standards (Circle One)

1. Penetrating trauma
   a. Loss of vital signs in the emergency department
   b. Loss of vital signs during transport
   c. No signs of life at the scene, but suspected cardiac tampanade or isolated extremity injury
2. Blunt trauma
   a. Loss of vital signs in the emergency department
   b. Arrive to emergency department with agonal signs of life

B. Demonstrates knowledge of Contraindications: Does Meet/Does Not Meet Standards (Circle One)

1. Blunt trauma without vital signs at the scene
2. Blunt trauma with no signs of life upon arrival to emergency department
3. Surgical consultants not available (situations outside of trauma center)
4. Patient not intubated, CPR over five minutes prior to arrival (relative contraindication)
5. Patient intubated, CPR over nine minutes prior to arrival (relative contraindication)

C. Properly prepares the patient: **Does Meet/Does Not Meet Standards (Circle One)**

1. Definitive airway obtained yes/no/NA
2. Equipment availability insured yes/no/NA
3. Un-cross matched blood, cell saver available yes/no/NA
4. Patient preparation/positioning adequate yes/no/NA
5. Sterile prep/drape yes/no/NA
6. Surgical consultants present or notified yes/no/NA

E. Demonstrates knowledge of procedure and skills to successfully complete procedure: Does Meet/Does Not Meet Standards (Circle One)

1. Ensures adequate ventilation/volume resuscitation during procedure yes/no
2. Chooses appropriate incision site and incision length yes/no
3. Obtains adequate exposure to heart yes/no
4. Inspects for tamponade and opens pericardial sac yes/no
5. Controls hemorrhage from heart and as otherwise indicated yes/no
6. Performs internal cardiac compression for asystole yes/no/NA
7. Performs aortic cross clamping yes/no/NA

E. Post-procedure Care: Does Meet/Does Not Meet Standards (Circle One)

1. Immediate transport to operating suite yes/no/NA
2. Procedure note complete yes/no

F. Complications: (Circle all which occurred)

1. Pulmonary laceration
2. Phrenic nerve injury
3. Coronary vessel injury
4. Esophageal injury
5. Other (specify)_____

F. Overall Assessment: Resident does/does not (circle one) demonstrate the knowledge of the indications and contraindications of this procedure and possesses the skills required to successfully complete the procedure.

Staff Signature **Staff Provider Stamp** **Date**

SAUSHEC EMERGENCY MEDICINE RESIDENCY
OPERATIVE/INVASIVE PROCEDURE SKILLS ASSESSMENT

Patient Number:_____Staff Physician: _____
Diagnosis: _____Resident: _____
Procedure: OPEN CARDIAC MASSAGE Date of Procedure: _____

A. Demonstrates knowledge of procedure and skills to successfully complete procedure: Does Meet/Does Not Meet Standards (Circle One)

1. Demonstrates understanding of all techniques yes/no
   a. One handed technique (thumb over left ventricle, finger over right, apex in palm)
   b. One handed with sternal compression (fingers flat over L ventricle, compress heart against sternum)
   c. Bimanual technique –PREFERRED (L hand cupped over R venticle, R hand flat against L ventricle)
2. Performs technique appropriately yes/no
   a. Force of technique perpendicular to plane of the septum
   b. Avoids finger tip pressure
   c. Coronary arteries not occluded by fingertips
   d. Anatomic position maintained to avoid obstruction of venous return
   e. Compression rate of 60-90 per minute

B. Post-procedure Care: Does Meet/Does Not Meet Standards (Circle One)

1. Immediate transport to operating suite yes/no/NA
2. Procedure note complete yes/no

C. Complications: (Circle all which occurred)

1. Cardiac/coronary artery injury
2. Injury to great vessels or other structures
3. Ineffective compressions
4. Other (specify)_____

D. Overall Assessment: Resident does/does not (circle one) demonstrate the knowledge of this procedure and possesses the skills required to successfully perform room the procedure.

Staff Signature **Staff Provider Stamp**

Date

SAUSHEC EMERGENCY MEDICINE RESIDENCY
OPERATIVE/INVASIVE PROCEDURE SKILLS ASSESSMENT

Patient Number:_____ **Staff Physician: _____**

Diagnosis: _____ **Resident: _____**

Procedure: Lumbar Puncture **Date of Procedure: _____**

A. Demonstrates knowledge of Indications: Does Meet/Does Not Meet Standards (Circle One)

1. R/O SAH
2. R/O Meningitis
3. Other (i.e., Pressure relief for chronic pseudotumor cerebri patient)

B. Properly prepares patient: Does Meet/Does Not Meet Standards (Circle One)

2. Obtains informed consent	yes	no	NA
3. Explains adequately the procedure	yes	no	NA
4. Positions the patient correctly	yes	no	NA
5. Sterilely preps and drapes the patient	yes	no	NA
6. Has all proper equipment and staff assistance	yes	no	NA

C. Demonstrates knowledge and skills to successfully complete procedures: Does Meet/Does Not Meet Standards (Circle One)

1. Able to detect physical landmarks	yes	no	NA
2. Anesthetizes the area	yes	no	NA
3. Holds and inserts the needle at correct location and angle	yes	no	NA
4. Corrects self as needed (i.e., position, angle, anesthesia)	yes	no	NA
5. Measures pressure	yes	no	NA
6. Collects CSF	yes	no	NA

D. Post-Procedure Care: Does Meet/Does Not Meet Standards (Circle One)

1. Clean site of Betadine	yes	no	
2. Have patient lie down for specified time	yes	no	NA
3. Sends appropriate tests of CSF	yes	no	NA
4. Gives antibiotics if indicated (purulent CSF)	yes	no	NA
5. Writes a procedure note	yes	no	NA

Complications: (Circle all that occurred)

1. Vagal syncope
2. Hypotension
3. Cardiac arrest
4. Nerve injury
5. Herniation
6. Other: (Specify) _____

Overall Assessment: Resident does/does not (circle one) demonstrate the knowledge of the indications and contra-indications of this procedure and possesses the skills required to successfully complete the procedure.

Staff Signature _____ Date _____Staff Provider Stamp_____

SAUSHEC EMERGENCY MEDICINE RESIDENCY
OPERATIVE/INVASIVE PROCEDURE SKILLS ASSESSMENT

Patient Number:_____ Staff Physician: _____
Diagnosis: _____ Resident: _____
Procedure: NASO/ENDOTRACHEAL INTUBATION Date of Procedure: _____

A Demonstrates knowledge of Indications: Does Meet/Does Not Meet Standards (Circle One)

1. Cardiac arrest
2. Airway compromise in infection
3. Airway compromise in trauma
4. Airway obstruction
5. Ventilatory compromise
6. Hypoxia
7. Cerebral resuscitation
8. Pt unable to maintain patent airway secondary to AMS, lack of gag reflex
9. Combative trauma victim not able to cooperate with necessary evaluation

B. Properly prepares the patient: **Does Meet/Does Not Meet Standards (Circle One)**

1. Patient allergies confirmed yes/no/NA
2. Consent signed and dated yes/no/NA
3. Assesses airway for potential complicating factors yes/no
3. Adequate pre-oxygenation yes/no/NA
4. Suction available yes/no
5. Adequate/appropriate pre-medication/RSI drugs yes/no/NA
6. In-line cervical immobilization yes/no/NA
7. Cricoid pressure maintained until intubation successful yes/no/NA
8. Respiratory therapy notified of need for ventilator yes/no

C. Demonstrates knowledge of procedure and skills to successfully complete procedure: Does Meet/Does Not Meet Standards (Circle One)

1 . Employs monitoring techniques including cardiac/pulse oximetry yes/no
2 . Maintains cervical spine precautions yes/no/NA
3 . Technique appropriate for chosen route of intubation yes/no
4 . Successful intubation of trachea yes/no
5. Adequate ventilation confirmed yes/no
6. Tube secured yes/no

D. Postprocedure Care: Does Meet/Does Not Meet Standards (Circle One)

1. Confirmation of tube placement
   a. Direct visualization of tube through cords yes/no
   b. Auscultation yes/no
   c. End-tidal CO2/capnography yes/no
   d. CXR yes/no/NA
2. Adequate sedation/paralysis yes/no/NA
3. Appropriate ventilator settings yes/no/NA
4. ABG yes/no/NA
5. Procedure note completed yes/no

Complications: (Circle all which occurred)

1. Unrecognized esophageal intubation
2. Hypoxia
3. Cardiac decompensation
4. Dental trauma
5. Laceration of oral mucosa
6. Vomiting/aspiration
7. Endobronchial intubation
8. Air Leak
9. Other (specify)

G. Overall Assessment: Resident does/does not (circle one) demonstrate the knowledge of the indications and contraindications of this procedure and possesses the skills required to successfully complete the procedure independently.

Staff Signature **Staff Provider Stamp**

Date

SAUSHEC EMERGENCY MEDICINE RESIDENCY
OPERATIVE/INVASIVE PROCEDURE SKILLS ASSESSMENT

Patient Number: _____ **Staff Physician: _____**
Diagnosis: _____ **Resident: _____**
Procedure: PERICARDIOCENTECIS **Date of Procedure: _____**

A. Demonstrates knowledge of Indications: Does Meet/Does Not Meet Standards (Circle One)

1. Acute traumatic hemopericardium
2. Acute non-traumatic hemopericardium
3. Non-hemorrhagic cardiac tamponade
4. Tension pneumopericardium
5. PEA
6. Other (specify):

B. Demonstrates knowledge of Contraindications: Does Meet/Does Not Meet Standards (Circle One)

1. Immediate availability of better treatment modality (relative)
2. Lack of appropriate monitoring/resuscitative equipment (relative)

C. Properly prepares the patient: **Does Meet/Does Not Meet Standards (Circle One)**

1. Temporizing measures instituted
   a. Fluid bolus yes/no/NA
   b. Pressors yes/no/NA
2. Premedication with atropine yes/no/NA
3. Equipment prepared (IV, monitor, US) yes/no/NA
4. Patient properly positioned (chest elev at 45) yes/no/NA
5. NGT placed yes/no/NA

D. Demonstrates knowledge of procedure and skills to successfully complete procedure: Does Meet/Does Not Meet Standards (Circle One)

1. Approach identified yes/no
2. Sterile prep/drape yes/no/NA
3. ECG Monitoring (attached to needle) yes/no
4. Fluid aspirated yes/no
5. Indwelling catheter placed yes/no

E. Postprocedure Care: Does Meet/Does Not Meet Standards (Circle One)

1. Confirmation of line placement yes/no/NA
2. Postprocedure CXR yes/no/NA
3. Adequate procedure note yes/no

F. Complications: (Circle all which occurred)

1. "Dry tap"
2. Pneumothorax
3. Hemopericardium
4. Air embolism
5. Dysrhythmias (specify)
6. Sudden pulmonary edema
7. Other (specify)
8. None

G. Overall Assessment: Resident does/does not (circle one) demonstrate the knowledge of the indications and contraindications of this procedure and possesses the skills required to successfully complete the procedure.

Staff Signature **Date** **Staff Provider Stamp**

SAUSHEC EMERGENCY MEDICINE RESIDENCY
OPERATIVE/INVASIVE PROCEDURE SKILLS ASSESSMENT

Patient Number:_____Staff Physician: _____
Diagnosis: _____Resident: _____
Procedure: PERITONEAL LAVAGE Date of Procedure: _____

A. Demonstrates knowledge of Indications: Does Meet/Does Not Meet Standards (Circle One)

1. Ongoing shock with suggested hemoperitoneum
2. Suspected intraperitoneal injury in patient with altered mental status
3. Unexplained shock in patient with multiple extra-abdominal trauma
4. Penetrating flank or back injury suspected of penetrating the peritoneal cavity
5. Penetrating lower chest injury, below 5^{th} ribs anteriorly

B. Demonstrates knowledge of Contrindications: Does Meet/Does Not Meet Standards (Circle One)

1. Obvious signs of intra-abdominal trauma necessitating celiotomy
2. Previous abdominal surgery (relative)
3. Inability to catheterize bladder (relative)

C. Properly prepares the patient: **Does Meet/Does Not Meet Standards (Circle One)**

1. Patient allergies confirmed	yes/no/NA
2. Consent signed and dated	yes/no/NA
3. Nasogastric tube placed	yes/no
3. Foley catheter placed	yes/no/NA
4. Proper instrument tray available	yes/no
5. Patient prepped and draped in sterile manner	yes/no/NA.

D. Demonstrates knowledge of procedure and skills to successfully complete procedure:
Does Meet/Does Not Meet Standards (Circle One)

Skin infiltrated using Lidocaine with epinephrine	yes/no
Proper placement of incision	yes/no/
Midline fascial incision (open technique)	yes/no/NA
Lavage catheter properly inserted into peritoneal cavity, directed into pelvis	yes/no
Performs aspiration prior to lavage	yes/no
Good flow of lavage fluid/and adequate return (least 50-70%)	yes/no

E. Postprocedure Care: Does Meet/Does Not Meet Standards (Circle One)

1. Understands criteria to determine positive vs negative aspirate/lavage (10cc gross blood aspirate, >100,000 RBCs/mm^3, >500WBCs/mm^3)	yes/no
2. Applies proper wound dressing	yes/no/NA
3. Procedure note completed	yes/no

F. Complications: (Circle all which occurred)

Hemorrhage due to injection, incision, producing false positive
Gastric/Intestinal perforation
Urinary bladder perforation
Injury to other peritoneal or retroperitoneal structure requiring operative care

H. Overall Assessment: Resident does/does not (circle one) demonstrate the knowledge of the indications and contraindications of this procedure and possesses the skills required to successfully complete the procedure.

Staff Signature **Staff Provider Stamp**

Date

SAUSHEC EMERGENCY MEDICINE RESIDENCY
OPERATIVE/INVASIVE PROCEDURE SKILLS ASSESSMENT

Patient Number:_____ **Staff Physician: _____**
Diagnosis: _____ **Resident: _____**
Procedure: Rapid sequence Induction/Intubation **Date of Procedure: _____**

A. Demonstrates knowledge of Indications: Does Meet/Does Not Meet Standards (Circle One)
1. Need for supported respiration with inadequate prep for anesthesia/intubation

B. Demonstrates knowledge of Contraindications: Does Meet/Does Not Meet Standards (Circle One)
1. Stable spontaneously breathing patient with nasotracheal or more controlled O.R. Airway placement available.

D. Properly prepares the patient: **Does Meet/Does Not Meet Standards (Circle One)**

Position Patient	yes	no	NA
Suction available	yes	no	NA
Sellig	yes	no	NA
Pre-oxygenation	yes	no	NA
Equipment ready and checked	yes	no	NA
Provisions for alternative airway made	yes	no	NA

D. Demonstrates knowledge of procedure and skills to successfully complete procedure: Does Meet/Does Not Meet Standards (Circle One).

1.	Proper size mask and bag	yes	no
2.	Proper Size tube and Laryngoscope	yes	no
3.	Connected to oxygen source with Oxygen flowing	yes	no
4.	Appropriate Medications/Dosages	yes	no
4.	Adequate technique in visualizing cords	yes	no
5.	Tube placed at adequate initial depth	yes	no
5.	Tube placement confirmed, Ascultation, ETCO2, SAT, CXR	yes	no
6.	Tube secured in place/adjustments made	yes	no

E. Postprocedure Care: Does Meet/Does Not Meet Standards (Circle One)

1. Adequate procedure note	yes	no

F. Complications: (Circle all which occurred)
1. Aspiration
2. Inadequate oxygenation
3. Inability to place tube
4. Hypotension
5. Esophageal intubation
6. Other (specify):

G. Overall Assessment: Resident does/does not (circle one) demonstrate the knowledge of the indications and contraindications of this procedure and possesses the skills required to successfully complete the procedure.

Staff Signature **Date** **Staff Provider Stamp**

SAUSHEC EMERGENCY MEDICINE RESIDENCY
OPERATIVE/INVASIVE PROCEDURE SKILLS ASSESSMENT

Patient Number:_____ Staff Physician: _____
Diagnosis: _____Resident: _____
Procedure: TUBE THORACOSTOMY Date of Procedure: _____

A. Demonstrates knowledge of Indications: Does Meet/Does Not Meet Standards (Circle One)

1. Traumatic Conditions
   a. Pneumothorax
   b. Hemothorax
   c. Hemopneumothorax
   d. Open pneumothorax
   e. Suspected tension pneumothorax
   f. Conditions requiring "prophylactic" surgical management (i.e., penetrating chest trauma requiring PPV)
2. Iatrogenic complication
   a. Central venous line placement
   b. Thoracentesis
   c. Positive Pressure Ventilation
   d. Other (specify)
3. Nontraumatic condition
   a. Primary spontaneous pneumothorax
   b. Secondary spontaneous pneumothorax
   c. IV drug use-associated pneumothorax
   d. Drainage of recurrent pleural effusion
   e. Empyema
   f. Chylothorax

B. Demonstrates knowledge of Relative Contraindications: Does Meet/Does Not Meet Standards (Circle One)

1. Multiple adhesions, blebs
2. Recurrent pneumothorax mandating surgical treatment
3. Need for open thoracotomy
4. Bleeding dyscrasia

C. Properly prepares the patient: **Does Meet/Does Not Meet Standards (Circle One)**

1. Patient allergies confirmed yes/no/NA
2. Consent signed and dated yes/no/NA
3. Patient preparation/positioning adequate yes/no/NA
3. Sterile prep/drape yes/no/NA
4. Local anesthesia yes/no/NA
5. Adequate/appropriate IV sedation/analgesia yes/no/NA

E. Demonstrates knowledge of procedure and skills to successfully complete procedure: Does Meet/Does Not Meet Standards (Circle One)

Employs monitoring techniques appropriate to patient condition yes/no
Tube secured yes/no
Prophylactic antibiotics yes/no/NA

E. Postprocedure Care: Does Meet/Does Not Meet Standards (Circle One)

1. Confirmation of tube placement yes/no
2. Procedure note complete yes/no

F. Complications: (Circle all which occurred)

Bleeding
Infection
Laceration or puncture of nerves or solid organs
Chest tube dislodgement
Subcutaneous placement
Intra-abdominal placement
Air leak
Other (specify)_____

F. Overall Assessment: Resident does/does not (circle one) demonstrate the knowledge of the indications and contraindications of this procedure and possesses the skills required to successfully complete the procedure.

Staff Signature **Date** **Staff Provider Stamp**

SAUSHEC EMERGENCY MEDICINE RESIDENCY
OPERATIVE/INVASIVE PROCEDURE SKILLS ASSESSMENT

Patient Number:_____Staff Physician: _____
Diagnosis: _____Resident: _____
Procedure: VENOUS CUTDOWN Date of Procedure: _____

A. Demonstrates knowledge of Relative Indications: Does Meet/Does Not Meet Standards (Circle One)

1. Venous access in infants
2. All percutaneous peripheral sites for venous access exhausted
3. Hypovolemic shock

B. Demonstrates knowledge of Relative Contraindications: Does Meet/Does Not Meet Standards (Circle One)

1. Less invasive alternatives for venous access exist
2. Coagulation disorder (relative)
3. Impaired healing (relative)
4. Compromised host defense mechanisms (relative)

C. Properly prepares the patient: **Does Meet/Does Not Meet Standards (Circle One)**

1. Patient allergies confirmed	yes/no/NA
2. Consent signed and dated	yes/no/NA
3. Patient preparation/positioning adequate	yes/no/NA
3. Sterile prep/drape	yes/no/NA
4. Local anesthesia	yes/no/NA

G. Demonstrates knowledge of procedure and skills to successfully complete procedure: Does Meet/Does Not Meet Standards (Circle One)

Employs monitoring techniques appropriate to patient condition	yes/no
Full thickness transverse skin incision	yes/no
Vein identified and bluntly dissected from surrounding tissue	yes/no
Distal vein ligated, passes tie about cephalad vessel	yes/no
Venotomy made and plastic cannula inserted	yes/no
Good flow after plastic cannula secured in place	yes/no
Wound closed and sterile dressing applied	yes/no

E. Postprocedure Care: Does Meet/Does Not Meet Standards (Circle One)

1. Procedure note complete	yes/no

F. Complications: (Circle all which occurred)

Hematoma
Perforation of posterior wall of vein
Venous thrombosis
Nerve transection
Arterila transection
Other (specify)_____

H. Overall Assessment: Resident does/does not (circle one) demonstrate the knowledge of the indications and contraindications of this procedure and possesses the skills required to successfully complete the procedure.

Staff Signature **Date** **Staff Provider Stamp**

SAUSHEC EMERGENCY MEDICINE RESIDENCY
OPERATIVE/INVASIVE PROCEDURE SKILLS ASSESSMENT

Patient Number:_____ **Staff Physician: _____**

Diagnosis: _____ **Resident: _____**

Procedure: Wound Care **Date of Procedure: _____**

A. Demonstrates knowledge of Indications: Does Meet/Does Not Meet Standards (Circle One)
Understands the significance of the following wounds:

1. Dirty wounds	Yes	No	NA
2. Wounds exposed for extended length of time	Yes	No	NA
3. Diabetic wounds	Yes	No	NA
4. Wounds that involve tendons/joints	Yes	No	NA
5. Abscesses	Yes	No	NA
6. Paronychia/Felons	Yes	No	NA
7. Animal/Human bites	Yes	No	NA

B. **Properly prepares patient/wound: Does/Does Not meet standards (Circle One)**

1. Obtains consent (verbal or written)	Yes	No	NA
2. Obtains proper equipment	Yes	No	NA
3. Performs neurovascular exam on damaged extremity	Yes	No	NA
4. Irrigates and cleans wound in proper fashion	Yes	No	NA
5. Anesthetizes the area/sedates the child	Yes	No	NA

C. Demonstrates knowledge and skills to successfully complete the procedure: Does/Does Not meet standards (Circle One)

1. Explores the wound for foreign bodies	Yes	No	NA
2. Obtains a hemostatic field	Yes	No	NA
3. Searches for tendon or joint involvement	Yes	No	NA
4. Uses proper technique for wound closure	Yes	No	NA
5. Re-examines neurovascular status	Yes	No	NA

D. Postprocedure Care: Does/Does Not meet standards (Circle One)

1. Gives patient f/u time for re-examination/suture removal	Yes	No	NA
2. Wound care instructions given	Yes	No	NA
3. Procedure note written	Yes	No	NA
4. Antibiotics given	Yes	No	NA
5. Tetanus status corrected/documented	Yes	No	NA

E. Complications: (Circle all that apply)
1. Nerve injury
2. Poor hemostasis
3. Unable to close wound
4. Delayed infection
5. Other (specify): _____

F.Please list type of wound and procedure performed (i. e., simple lac, fight bite, sutures/dermabond/steristrips, etc.)
_____

G. Overall Assessment: Resident does/does not (circle one) demonstrate the knowledge of the indications and contraindications of this procedure and possesses the skills required to successfully complete the procedure.

_____

Staff Signature **Date** **Staff Provider Stamp**

APPENDIX 11 PATIENT LOG SHEET

EMPA RESIDENT____

DATE_________________________ROTATION____

PATIENT LAST NAME	PATIENT LAST 4 SSN	COMPLAINT	DISPOSITION

APPENDIX 12 RECORD OF RESIDENT COUNSELING

EMERGENCY MEDICINE PHYSICIAN ASSISTANT RESIDENCY
BAMC, FORT SAM HOUSTON, TEXAS

NAME_____
SSN_____DATE_____

1. The EMPA resident has been informed of the counselor's role to provide counseling and guidance for the resident with academic performance or personal problems which may affect the resident's academic proficiency.
2. The resident has also been informed of the requirements of the EMPA residency, written exams, crucial objectives, performance checklist, pass/fail determinants, reteach/retest procedures, and probation, extension, and termination procedures.
3. The EMPA resident further acknowledges he/she has read the Emergency Medicine Physician Assistant Residency Guide and fully understands the contents of the guide, and has no further administrative questions about the residency.

_____ _____
Signature, EMPA Resident Signature, Program Director

DATE_____ DATE_____

APPENDIX 13 EVALUATION OF ROTATION

EMERGENCY MEDICINE PHYSICIAN ASSISTANT RESIDENCY EVALUATION SHEET

NAME_____

ROTATION BLOCK_____
Please comment on each of the following aspects of this rotation:
Quality of Didactics:

Quality of Patient Contact:

Staff/EMPA Resident Support:

What aspect of this rotation contributed the most to your education as an EMPA?

Would you recommend this rotation to your peers? Why or why not?

What would you change about this rotation?

Was this a good location site for this rotation?

Was there enough patient contact?

What was your status in regard as to what you were allowed to do in the management of patients? (Intern status, second, third or fourth year resident status?

Was there to much supervision or not enough supervision?

Was staff senior residents available to answer questions about patient care?

Was the reading list adequate for the rotation?

Any future comments on this rotation?

APPENDIX 14

EVALUATION OF EMERGENCY MEDICINE STAFF
BY EMERGENCY MEDICINE PHYSICIAN ASSISTANT RESIDENTS

STAFF'S NAME_____

Please rate the above staff member's performance in the following areas (0-5).

Inadequate-1 Marginal-2 Average-3 Very Good-4 Excellent-5

1. Fund of Knowledge

1 2 3 4 5

2. On line supervising availability

1 2 3 4 5

3. On line teaching ability (bedside)

1 2 3 4 5

4. Lecturing style and quality

1 2 3 4 5

5. Overall availability

1 2 3 4 5

6. Handout quality

1 2 3 4 5

7. Role model

1 2 3 4 5

8. Constrictive criticism to EMPA resident
1 2 3 4 5

If there was one major suggestion I could make to this staff in order to increase their proficiency as an educator, I would recommend:

If there was one strength of this staff member that I would not want them to change, it would be:

If there was one suggestion I could make for this staff member to improve his/her lecturing style, it would be:

APPENDIX 15

DEPARTMENT OF THE ARMY
BROOKE ARMY MEDICAL CENTER
FORT SAM HOUSTON, TEXAS 78234-6200

REPLY TO
ATTENTION OF
MCHE - ED

1 July 2000

BROOKE ARMY MEDICAL CENTER AGREEMENT
FOR PHYSICIAN ASSISTANTS IN TRAINING

1. Educational experience: Brooke Army Medical Center will provide patient care and procedure experience with appropriate supervision to permit the accumulation of knowledge and attainment of skills necessary to meet the requirements of specialty boards as appropriate, and to reach professional maturity in that specialty. Any rotation in or outside Brooke Army Medical Center to achieve the above will be consistent with the overall goals as determined by the program director.

2. Physician Assistant Responsibilities. Physician Assistants are expected to:

a. Develop a personal program of self study for professional growth with guidance from the teaching staff.

b. Participate in safe, effective and compassionate patient care under supervision, commensurate with the level of advancement and responsibility.

c. Participate fully in the educational activities of their program and, as required, assume responsibility for teaching and supervising students and others.

d. Participate in institutional programs and activities involving the medical staff and adhere to established practices, procedures, and policies of the institution.

e. Participate in institutional committees and councils, especially those that relate to patient care review activities.

f. Apply cost containment measures in the provision of patient care.

3. Benefits:

a. Financial support: Pay is based on military rank and length of service.

APPENDIX 15

MCHE-ED
SUBJECT:Brooke Army Medical Center Agreement for Physician Assistants in Training

4. Professional Activities outside the Educational Program:
In accordance with HSC Regulation 600-3 dated 25 May 92, engagement in any off-duty medical practice activities outside the educational program is not permitted during the training period.

5. Harassment: Chapter 6, Interim Change 104, Army Regulation 600-20, 17 September 1993 (pgs 1-37) establishes policy and procedure for discipline and redress of grievances including gender or other forms of harassment.

6. Physician Impairment/Substance Abuse: Policy and education program regarding physician impairment (including substance abuse) are contained in Chapters 7 and 8, Army Regulation 40-68, Quality Assurance, 20 December 1989.

7. Guarantee of Due Process: A copy of Criteria for Withdrawal, Probation and Termination (excerpt from Chapter 6, Section 1, para 6-5, AR 351-3, 8 Mar 88) is attached for signature. While the specific wording in the regulation is for physician interns, residents and fellows, the same criteria apply for physician assistants in training.

[Copies of referenced regulations available in Medical Education Office]

6. I have read and understand all provisions of the foregoing agreement.

(signature) (date)

APPENDIX 15

CRITERIA FOR WITHDRAWAL, PROBATION ANI) TERMINATION Chanter 6. Section 1. Paragraph *6-5.* AR *351-3.*

8~Mar 88

4-5. . Withdrawal, probation, and termination

a. Status. During the period of GME, the officer in training is a student.

b. Withdrawal. An intern, resident, or fellow may be withdrawn from the training program - -

(1) At his or her own request.

(2) By the commander of the medical treatment facility (MTF).

(3) By TSG to meet needs of the Service.

c. Voluntary withdrawal. When an intern, resident, or fellow desires voluntarily to withdraw from training, he or she must submit a request in writing through his or her program director, the director of medical education, and the hospital education committee. The request for withdrawal must include an effective date before it is forwarded to Commander, USAHPSA (A1TN: SGPE-EDM), 5109 Leesburg Pike, Falls Church, VA 22041-3258 for final approval.

d. Probation procedures.

(I) Interns, residents, and fellows may be placed on probation for unsatisfactory performance. Probation may be based on any of the following:

(a) Failure to meet academic or technical performance standards or objectives of the program.
(b) Lack of application.

(c) Conduct considered unprofessional by the program director.

(2) Notification of probation.

(a) A written request for probation will be submitted to the hospital education committee by the program director specifying reasons for the request. A copy of this request will be furnished the individual. A record of this notification will be maintained by the program director. The hospital education committee will consider the request and, if recommended by majority vote, recommend that the individual be placed on probation. An individual may be placed on probation only by the MTF commander.

APPENDIX 15

f . Reports- Forward a special DA Form 1970-R through channels to Commander, USAITPSA (A1TN: SGPE-EDM), Bldg 6, RM 671, 5109 Leesburg Pike, Falls Church, VA 2204 1-3258 within 5 working days after an individual has been placed on probation, relieved from probation, or terminated from his or her training for any reason. This report will ~-

(1) Cover the individual's performance for the period in question.

(2) Be accompanied by a copy of the letter of notification to the individual.

g. MTF commander termination memorandum. When an intern, resident, or fellow is terminated from training by the MTF commander, forward a memorandum of notification (with a copy of the termination memorandum to the individual) to Commander, USAHPSA (ATTN: SGPE-EDM), Bldg 6, RM 671, 5109 Leesburg Pike, Falls Church, VA 22041-3258. This memorandum must be sent-~within 5 working days after termination so that appropriate reassignment orders can be issued.

h. ADSO. Individuals who voluntarily withdraw or are terminated from a GME training program will have an ADSO in accordance with chapter 10.

I have read and I understand the foregoing criteria for withdrawal, probation and/or termination and the provisions for due process set forth therein.

(signature) **(**date)

APPENDIX 16

MCHE-EM

_____
Date

MEMORANDUM FOR: Program Director, EMPA Residency Training Program

SUBJECT Memorandum of Understanding for the EMPA Residency Training Program

1. I understand there are several mandatory requirements for completion of the EMPA Residency Training Program to include, but not limited to the following:

    a. My required article's first draft is due to the Program Director on _____. The final draft is due on_____ .

    b. Grand-rounds are mandatory every Friday at either WHMC or BAMC.

    c. Morning report is mandatory at 0700 if you are coming off the 11-7 shift or are going on the 7-3 shift.

    d. Procedure labs are mandatory every month. It is the responsibility of each resident to inform the off-service chief of his or her responsibility to attend.

    e. Written tests will be taken the last day of each block.

    f. All requests for leave will be during BAMC ED blocks and must be submitted 30 days in advance.

    g. Read and understand the residency guide and manual.

    h. I am to return all textbooks in good condition.

    i. It is my responsibility to obtain my rotation evaluation from off-service and ED evaluators.

    j. It is my responsibility to ensure my procedure checklist is signed off during the residency year.

    k. I must complete successfully all of the 7 critical objects to graduate.

    l. I must successfully pass both the midterm and final written exams.

    m. I must pass my midterm and end of residency oral boards.

    n. Complete all required reading.

NAME (Print/Sign/Date)

APPENDIX 17

SAN ANTONIO UNIFORMED SERVICES HEALTH EDUCATION CONSORTIUM (SAUSHEC) DUE PROCESS POLICY FOR RESIDENTS IN GRADUATE MEDICAL EDUCATION PROGRAMS

I. General.

A. This document outlines the process of management at SAUSHEC for residents who encounter academic, technical, and/or professional conduct problems. The procedures prescribed herein apply to program level remediation, administrative remediation, probation, extension of training, and termination from training. These procedures present a sequence of corrective action emphasizing due process, thorough documentation of all actions, and timeliness of the process.

B. These procedures must be applied uniformly and fairly to all residents and faculty in each SAUSHEC program. The SAUSHEC institutional due process policy applies to all residents in training programs for issues relating to professional or academic performance regardless of the sponsoring uniformed service. Issues of misconduct or noncompliance with uniformed service regulations unrelated to academic or professional performance will be managed according to the policies of the resident's commander and sponsoring uniformed service.

C. Upon entry into a training program, the resident will be provided a copy of this due process policy. The resident will sign a statement acknowledging receipt and review of this document as well as an understanding of its content. This signed statement will be maintained in the resident's training file.

D. A resident's refusal to acknowledge receipt of written recommendations during any process prescribed herein will be recorded in writing but will not result in a delay of any recommended action or proceeding.

II. Definition of Terms.

These terms are defined to conform to the administrative structures of SAUSHEC.

A. SAUSHEC is the GME consortium of Brooke Army Medical Center (BAMC) and Wilford Hall Medical Center (WHMC) which was created to administer and manage military GME programs in San Antonio. SAUSHEC is the ACGME-recognized sponsoring institution for all military GME programs in San Antonio.

B. Dean, SAUSHEC. The institutional official having the authority and the responsibility for oversight and administration of SAUSHEC GME programs. He/she is also the ACGME-designated institutional official for GME for the consortium.

C. Associate Dean for GME, SAUSHEC. Both BAMC and WHMC have Associate Deans for GME each one of whom is also the Director of Medical Education at his/her respective medical center. Working under the direction of the Dean, these individuals will be the on-site, day-to-day managers of GME issues at their respective institutions.

D. Decision Authority. An individual/committee designated in institutional documents as having initial approving authority for adverse actions. The decision authority at SAUSHEC is the GMEC.

E. Appellate Authority. An individual designated in institutional documents as having final authority for an adverse action. The SAUSHEC appellate authority for probations and extensions of training is the Dean. For a termination the appellate authority is the medical treatment facility (MTF) commander of the resident's sponsoring uniformed service.

F. Graduate Medical Education Committee (GMEC). The institutional committee composed of the Dean, Associate Deans, program directors, resident representatives and other SAUSHEC faculty whose charter is to monitor and advise on all aspects of SAUSHEC GME. To conduct business, the GMEC must have a quorum which is 50 percent of the its voting membership present.

G. Institutional Documents. The organizational documents that define the structure and the chain of authority and accountability for the institution sponsoring GME within SAUSHEC.

H. SAUSHEC MTF and MTF commander. A military hospital in which SAUSHEC Graduate Medical Education training occurs. Each SAUSHEC MTF has a commander with military administrative responsibility for the uniformed service residents assigned to his/her command.

I. Uniformed service. SAUSHEC residents are active duty officers that may be from the Army, Air Force, or Navy. Residents on active duty are governed by the SAUSHEC GME policies as well as by rules and regulations of their respective uniformed service.

J. Program training committee. Each SAUSHEC GME program will have a program training committee comprised of key faculty members and resident representatives. The program director will chair this committee which will assist him/her in developing program curricula and policies and which will participate in dealing with residents who may not be meeting program or military standards.

K. Remediation plan. Counseling, program level remediation, Dean's administrative remediation, probation and extension of training are all considered remediation plans designed to help a resident meet program and/or military standards.

L. Adverse actions. Probation, extension in training, and termination from training may be considered reportable adverse actions by many state licensing boards and/or by the National Practitioner Data Bank.

M. Faculty Board. A board of faculty members that are assigned by the Dean to serve as members of a formal resident hearing. (See paragraph XI.)

III. Program Director Responsibility

A. A training file must be maintained for each resident by the Program Director.

B. A training agreement must be maintained for each resident. This agreement will be signed by the resident prior to entry into a GME program and will be maintained in the resident's training file.

C. Program directors must establish effective program training committees to assist in management and improvement of the program and to assess the performance of the residents.

D. Residents must be provided written educational goals and objectives specific to each training year and must be given written performance evaluations documenting whether they are achieving those goals at appropriate intervals. The frequency of evaluations must satisfy program requirements published by the Residency Review Committee of the ACGME. Evaluations should be performed at least semi-annually.

E. Program directors will assess residents and identify residents with deficiencies in knowledge, skills, and attitudes. This includes failure to comply with military service regulations such as those prescribing weight, physical fitness, licensure or other requirements. Program directors are responsible for compliance with the requirements prescribed herein.

F. A remediation plan must be initiated and counseling with the resident documented when a program director identifies a resident with significant deficiencies in knowledge, skills, or professional attitudes for noncompliance with military service requirements.

G. The program director with his/her program training committee will immediately investigate any allegation of unethical behavior, unprofessional conduct, resident health problems or concerns that the resident cannot safely engage in patient care at the level expected of a resident at his/her stage of training. If, during an interview an individual begins to disclose information that indicates a violation of the Uniform Code of Military Justice (UCMJ) may have occurred, the program director will halt the interview immediately, apprise the individual of his/her rights against self-incrimination and immediately contact the proper legal and law enforcement authorities. If the individual discloses information the program director determines may be a violation of UCMJ, the incident must be presented to the GMEC for consideration of adverse action. Any adverse action must afford due process in accordance with this policy document. After the resident circumstances are reviewed, the program director may either allow the resident to continue in his/her duties, or may restrict or suspend the resident's training status and patient care activities pending further investigation.

1. If the resident is allowed to continue in his/her duties, the program director must record in the resident training file the allegation and the results of the inquiry reflecting confidence in the resident.

2. If the program director restricts or suspends the resident's training status and patient care activities, the program director must notify the resident in writing that his/her training status and patient care activities are restricted or suspended

and must specify the deficiencies, acts, or circumstances for which restriction or suspension from training status is imposed; notify, in writing, the clinical department head to whom the resident is assigned that the resident's training status and patient care activities are restricted or suspended; and submit a written record of the allegation and inquiry to the Dean with signed acknowledgement of receipt or a copy from the clinical department chief and the resident.

3. The resident will be advised that this issue will be reviewed by the GMEC and will be given a copy of this due process policy. The Dean will schedule a time to review this proposed action at the next regularly scheduled GMEC meeting or an ad hoc meeting of the GMEC meeting or at an ad hoc meeting of the GMEC.

IV. Documentation of Resident Performance. Documentation begins with annual counseling of goals and objectives followed by written performance evaluations and periodic written statements from the program director describing the success of the resident in achieving designated milestones in professional development.

A. Assessment of the resident's performance should consider the progressive development under supervision of the knowledge, skills, and attitudes required for safe, effective and compassionate patient care commensurate with the resident's level of training and responsibility.

B. When progress is below program standards, the program director must assess:

1. Adequacy of clinical experience in the program.

2. Adequacy of supervision and teaching and scholarly activity in the program.

3. Adequacy of the resident's personal learning program for professional growth with guidance from the teaching staff.

4. Adequacy of the resident's full participation in the educational and scholarly activities of the program.

V. Remediation Plans. Education programs require flexibility in program structure and design. The resident should be given feedback, counseling and faculty assistance to overcome deficiencies. Any action will be thoroughly discussed with the resident and made part of his/her resident training file. When the program director and the program training committee identify residents whose academic, professional or military performance fails to meet expected standards of knowledge, skills or attitudes, they must develop a written remediation plan which will include objective criteria by which improvement can be judged. The resident will sign acknowledgement of receipt of this plan. Residents may be considered for program level remediation, probation, or extension in training based upon any of the following:

A. Failure to meet academic or technical performance standards or objectives of the training program.

B. Lack of application to include--but not limited to--absences, tardiness, and/or failure to perform clinical duties in a timely or adequate fashion.

C. Conduct considered unprofessional that directly affects the practice of medicine, or the course of training, or performance of military duties.

D. Failure to meet professional or administrative responsibilities, such as those prescribing weight, physical fitness or other military standards, licensure or other requirements.

E. Incident of gross negligence or willful misconduct including a violation of the UCMJ.

VI. Program Level Remediation. Program level remediation generally allows for correction of deficiencies without formal probation and should be preceded by documented written counseling between the resident and the program director/program training Committee.

A. In general, program level remediation precedes formal probation except in cases of gross negligence or willful misconduct which can be referred to the GMEC for immediate consideration of adverse action.

B. The Associate Dean must be informed of any program level remediation plan in writing by the program director for review and tracking. However, no formal presentation to the GMEC is required unless the Associate Dean recommends to the Dean that this resident's performance be reviewed by the GMEC.

C. A program level remediation plan should not exceed 60 days nor be extended or repeated without presentation to the GMEC.

D. The program director will provide the resident with clear, written remediation plan which will include the following:

1. Description of specific deficiencies in performance and previous efforts (counseling) to fix them.

2. Methods and resources to be used to improve the noted deficiencies.

3. List of objective measures which must be achieved to be removed from program level remediation.

4. Restrictions or conditions placed on the resident during remediation.

5. Time frame for documentation of improvement not to exceed 60 days.

E. The program director will ensure that the resident understands the deficiencies as well as requirements for improvement.

F. The program director will offer counseling and assistance to the resident to achieve the goals of the remediation and will designate a faculty advisor to assist the resident during remediation.

G. The resident will sign a statement acknowledging receipt of the program level remediation plan. This signed statement will be maintained in the resident's training file and a copied forwarded to the Associate Dean.

VII. Dean's Administrative Remediation.

A. When a resident who is otherwise doing well in his/her academic training fails to meet certain critical administrative milestones required by military or civilian regulatory agencies, e.g., failure to take and/or pass the USMLE; failure to obtain an unrestricted state medical license within 2 years of medical school graduation; or persistent failure to meet military requirements, he/she will automatically be placed on administrative remediation by the Dean.

B. Administrative remediation will be for a period of three months. When the resident completes the administrative requirement, he/she will be returned to normal training status and his/her temporary administrative record expunged.

C. If the resident fails to meet the administrative remediation requirement in 3 months, his/her status will be considered for extension if he/she is making a good faith effort to complete the requirement but has not been successful due to factors beyond his/her control. If the resident is not making a good faith effort to complete the requirement at 3 months or has been unable to complete the requirement after extension, he/she will be brought before the GMEC for consideration of probation, extension of training or termination.

VIII. Probation. See Appendix I.

A program director may propose probation for a resident after a period of program level remediation, after persistent uncorrected poor performance/attitude, or after a single incident of gross negligence or willful misconduct. Probation is a supervised remediation plan to assist the resident in understanding and correcting significant deficiencies in knowledge, skills or attitudes. The period of probation generally will be at least 30 days and usually will not exceed 90 days and will always extend 5 working days beyond a scheduled GMEC. On the recommendation of the program director the GMEC may vote to extend the term of probation for a period not to exceed an additional 90 days. Residents who fail to demonstrate adequate improvement after two consecutive periods of probation generally will be recommended for an extension of training or termination by the program director under due process procedures. Probationary status may end in a return to full training status, extension of training, resignation or termination from training.

A. The proposal for probation may be based upon one or more of the following and must be fully documented:

1. Failure to meet academic, professional, military or technical performance standards of the program.
2. Lack of endeavor in the training program.

3. Lack of application of the resident's knowledge or skill.

4. Unprofessional conduct (medical and/or military).

5. Failure to correct deficiencies despite counseling.

6. Regression or failure to progress after removal from program level remediation or formal probation despite counseling.

7. Severe disciplinary problems.

8. Evidence of substance abuse (in accordance with applicable Service regulations).

9. Incident of gross negligence or willful misconduct to include a violation of the UCMJ. Other circumstances deemed significant by the program director.

10. Other circumstances deemed significant by the program director.

B. To place a resident on probation, the program director must notify the resident that a proposal for probation is being considered. The program director and the program training committee will meet with the resident to discuss the proposal and to advise the resident of his/her right to due process under this policy. At this time the resident can provide verbal feedback to the program director and program training committee. After the meeting the resident will have a minimum of 5 working days to prepare any further written feedback.

C. If, after the meeting and review of the resident's written response, the program director and program training committee decide to recommend probation, the program director will again meet with the resident and will provide him/her with a copy of the probation request as it will be submitted to the Dean. A record of this notification including a signed acknowledgment of receipt by the resident of a copy of the probation request must be maintained in the resident's training file.

D. The program director recommendation to the Dean for the GMEC should include the following:

1. Specific reasons for the proposed probation including a description of prior attempts to resolve the problem.

2. Performance plan which identifies the steps for improvement during probation and the resources available to the resident to accomplish the goals during the probationary period.

3. Measurable endpoints for successful completion of probation.

4. Recommended duration of probation.

5. The notification to the resident proposing probation.

6. The resident's written response, if any, to the probation proposal.

7. The resident's training file which includes documentation of all previous performance evaluations, counseling and results of program level remediation, if applicable.

E. After review by the Associate Dean/Dean, the program director's recommendation will be presented to the GMEC at a scheduled meeting or ad hoc meeting, if necessary. The resident has the option to attend the GMEC meeting or submit a written statement to the committee. No witness or legal representation are authorized for the resident at this meeting. A GMEC decision is determined by a fifty- percent vote. If the GMEC votes to deny the recommendation, the program director is then notified in writing of the GMEC decision by the Dean with specific comments. The program director in turn notifies the resident of the GMEC decision.

F. If the GMEC votes to accept the program director recommendation, then the Dean and the program director meet with the resident and provide the resident the GMEC decision in writing. The resident has the right to accept the decision or to appeal the decision in writing within 5 working days through a faculty board hearing. (See paragraph XI.)

1. This meeting must be documented by the Dean and an acknowledgment signed and dated by the resident, a copy of which is maintained in the resident's training file.

2. The program director will assign a faculty advisor to assist the resident in the probation plan.

3. If appropriate, voluntary medical, mental health, or learning disability evaluation will be offered to the resident at no cost to him/her resident during the probation period. Requests for evaluation outside the institution will be reviewed

case-by-case and honored on the merits of the request. The resident will be responsible for all costs associated with outside evaluations.

4. The program director will submit a written reports to the GMEC of the resident's performance during probation. A copy of these reports will be submitted to the Dean and to the probated resident no later than 3 working days before the next scheduled GMEC meeting. The resident will be requested to sign the report acknowledging receipt. The resident may also submit written statements on his/her behalf to the GMEC.

G. Extension of probation period. An extension of probation can be recommended by the program director for a 90-day period. The resident has the option to attend the GMEC meeting or submit a written statement to the committee. A GMEC decision is determined with a fifty- percent vote. If GMEC votes to approve the extension of probation, the resident can appeal the decision to the Dean within 5 working days of the GMEC meeting and request a faculty board hearing. The Dean will notify the resident in writing of the final decision.

H. The probation period will end in one of the following:

1. Return to normal training status: The program director and the program training committee may determine the resident's performance has improved and meets the stated terms for successful remediation; i.e. all measurable endpoints have been achieved. The program director may then recommend the GMEC remove the resident from probation. Removal from probation requires a fifty percent vote.

2. Extension of training. (See paragraph IX.)

3. Termination. (See paragraph X.)

4. Resignation. (See paragraph XII.)

IX. Extension of Training. See Appendix I.

Extension of training may be necessary to meet acceptable academic requisites for residency training. Extension in training is handled the same as probation. (See paragraph VIII.)

A. The resident has the right to appeal the decision by the GMEC for an extension of training. The appeal is conducted through a faculty board hearing. (See paragraph XI.)

B. Usually, brief periods of absence can be accommodated without extension of training as long as the absence does not interfere with the requisites for residency training. Occasionally an extension of training is necessary for training missed due to medical, personal or administrative reasons unrelated to poor performance. This would not be considered an adverse action. However, a resident has the right to appeal the decision for extension.

C. Since extension of training may affect future professional assignments, special pay, and/or obligations, HQDA/OTSG (DASG-PSZ-MG) and for Army residents and the HQ AFPC/DPAME for Air Force residents, must be notified within 5 working days of the notification by the Dean of the decision to extend training.

X. Termination from Training. See Appendix II.

Termination is the most serious action that can be proposed by a program director and will normally be considered only after a period of formal probation or after a single incident of gross negligence or willful misconduct. A recommendation for termination must be approved by a two-thirds vote of the GMEC.

A. Recommendation for termination must be based upon one of the following:

1. Failure to satisfactorily correct deficiencies while on probation.

2. Regression or failure to satisfactorily progress after removal from probation.

3. When continuation in training presents a hazard to patients.

4. Any act of gross negligence or willful misconduct which can include a pattern of past performance or a single act. Under these circumstances the resident may be placed on administrative duties and removed from patient care responsibilities until resolution of the termination process. Termination under these circumstances requires notification of the appropriate credentialing authority.

5. Failure to meet significant military milestones or requirements despite documented attempts at remediation.

B. The program director must notify the resident that a proposal for termination is being considered. The program director and the program training committee will meet with the resident to discuss the proposal for termination and advise the resident of his/her right to due process under this policy. At this time the resident can provide verbal feedback to the program director and program committee. After the meeting the resident will have a minimum of 5 working days to prepare any further feedback in writing.

C. If, after the meeting and review of the resident's written response, the program director and program training committee decide to recommend termination, the program director will again meet with the resident and will provide him/her with a copy of the termination request as it will be submitted to the Dean. A record of this notification including a signed acknowledgment of receipt by the resident of a copy of the termination recommendation must be maintained in the resident's training file.

D. The recommendation for termination to the Dean should include the following:

1. Specific reasons for the proposed termination and a summary of past attempts to correct the problems.

2. Copy of previous probation request(s), if applicable.

3. The notification to the resident proposing termination.

4. The resident's response, if any, to the termination proposal.

5. The resident training file which includes documentation of all previous performance evaluations, counseling and results of any previous remediation plans, if applicable.

E. The program director recommendation is presented to the GMEC at a scheduled meeting or ad hoc meeting, if necessary. A GMEC decision is determined by a two-thirds vote. If the GMEC votes to deny the termination recommendation, the program director is notified in writing by the Dean of the GMEC decision with specific comments. The program director in turn notifies the resident of the GMEC decision.

F. If the GMEC votes to accept the program director recommendation for termination, the Dean meets with and notifies the resident in writing of this decision and his/her rights to participate in the faculty board hearing. This meeting must be documented by the Dean and an acknowledgment signed and dated by the resident, a copy of which is maintained in the resident's training file.

G. If appropriate, voluntary medical, mental health, or learning disability evaluation will be offered to the resident at no cost to the resident. Requests for evaluation outside the institution will be reviewed case-by-case and honored on the merits of the request. The resident will be responsible for all costs associated with outside evaluations.

H. The Dean subsequently initiates a faculty board hearing to review the GMEC termination decision. (See paragraph XI.)

XI. Faculty Board Hearing

A. Preliminaries. Failure of the resident to attend the faculty board hearing constitutes a waiver by the resident of his/her right to participate in the hearing. If the resident asks to be present, but subsequently cannot attend the scheduled hearing and a reasonable delay would not make it possible for the resident to attend, then the faculty board hearing may proceed with the action in the resident's absence. The circumstances and the necessity of proceeding with a faculty board hearing without the resident present will be clearly recorded in the minutes of the hearing.

B. Impartiality of faculty board. Adverse actions requiring a faculty board hearing are infrequent and will affect a resident's medical career; therefore, it is essential to provide an unbiased due process hearing for the resident and for SAUSHEC. Personnel participating in the faculty board hearing should be able to make a fair and impartial review of the evidence presented. Members of the medical staff are not disqualified from participating in a faculty board hearing because they are personally acquainted with the resident or because they have knowledge of those matters giving rise to the termination action. Any party may petition for disqualification as a member of the faculty board on the basis of bias, prejudice, or interest in the outcome of the proceeding.

C. Members of faculty board.

1. When a hearing is authorized under this policy, the Dean will appoint in writing qualified faculty to serve as members.

a. The faculty board must be composed of at least 3 but no more than 5 members and may include other program directors and faculty.

b. The senior member of the faculty board will be designated as the chairperson.

c. A resident representative will be assigned as a peer review member.

D. The following personnel should not serve as members of the faculty board:

1. A person (e.g., DME, program director, or MTF commander) who has influenced any part of an investigation or action against the resident.

2. A person who has served as an military investigating officer in the resident case.

3. A person whose testimony or recommendation has played a significant part in initiating the action involving the resident.

E. Actions to be considered by the faculty board. Probation, extension of training or termination should be considered for the following examples or for similar circumstances:

1. Academic deficiency not corrected during a period of probation;

2. Single incident of gross negligence;

3. Pattern of inappropriate prescribing;

4. Pattern of substandard care;

5. Act of incompetence or negligence causing death or serious bodily injury;

6. Abuse of legal or illegal drugs or diagnosis of alcohol dependence;

7. Practitioner disability (i.e. psychiatric);

8. Unprofessional conduct.

F. Procedure. The chairperson of the faculty board shall ensure compliance with the following hearing procedures.

1. The resident shall be provided with at least 7 working days' advance notice to gather evidence, to contact witnesses, and to prepare for the hearing. The chairperson will ensure that the resident understands the hearing procedure including his/her right to legal representation.

2. The resident has the right to military or civilian legal counsel during the hearing. This hearing is administrative in nature and therefore legal counsel may consult with the resident but may not address the faculty board directly. A resident may elect to engage a civilian legal counsel at his/her own expense.

3. All materials, documentation, and evidence shall be submitted to the faculty board prior to the hearing with simultaneous distribution of copies to the program director and the resident. Parties may agree to submit additional materials or documentation in advance of the hearing, provided that they agree on the nature, extent, and timing of such document submission and the faculty board agrees to receive such information.

4. The chairperson should consult with legal counsel before conducting the hearing and is encouraged to have a legal advisor present during the proceedings. If legal counsel represents the resident, it is advised that a military legal advisor be detailed for the faculty board hearing. These proceedings are not bound by formal rules of evidence or a strict procedural format because the hearing is administrative in nature. Therefore, the rules of evidence prescribed for trials by courts-martial or for court proceedings are not applicable. The faculty board may question witnesses at the hearing, i.e., faculty, medical staff, program director, and examine documents as necessary. The chairperson and the legal advisor are authorized to administer oaths to hearing personnel and witnesses.

NOTE: A military investigation report for the MTF commander can be provided to the faculty board for their review; however, a military investigation should not be used as a substitute for an objective faculty board hearing review.

5. The faculty board hearing should review all the evidence presented including matters presented by the resident. With the assistance of legal counsel the chairperson should arrange for orderly presentation of evidence. If an investigating officer is designated, he/she may present relevant documentary evidence and testimony at the faculty board hearing. Any objections made by the resident or his/her counsel should be ruled on by the chairperson who may consult with the military legal advisor.

a. The resident and program director are entitled to hear all testimony and examine all evidence that is presented at the hearing. The resident and program director may present evidence and witnesses in support of their respective positions and may ask questions of any of the witnesses.

b. The chairperson shall give all parties full opportunity to submit and to respond to motions, objections, and offers of settlement.

c. Because the formal termination proceeding is an administrative proceeding involving review of a recommended academic decision, discovery of facts is not germane to the faculty board hearing.

d. The hearing will be closed to the public.

6. After evidence is presented the voting members of the faculty board should deliberate in secret and determine by majority vote the recommendations. The chairperson will submit the recommendation in writing to the Dean no more than 2 working days after the hearing. A minority report may be submitted if the faculty board recommendation is not unanimous.

NOTE: The faculty board members should bear in mind their responsibility to clearly document the factual basis for their recommendation(s). General statements should be supported by specifically identified incidents or situations. Case histories relied upon should be tabbed as exhibits to the record and documented by copies of pertinent medical records where feasible.

G. Faculty Board Recommendation.

1. Probation or extension of training. If the recommendation is for probation or extension of training, this is referred to the Dean for administrative action. (See paragraph VIII and IX.)

2. Termination: If the recommendation is for termination, this is referred through the Dean to the MTF commander who will make the final decision.

a. The MTF commander will approve, modify, or disapprove the recommendation of the faculty board and will direct appropriate action. The MTF commander may also recommend sending a resident case back to the faculty board for further review.

b. The Dean shall notify the resident in writing of the MTF commander's decision. If the decision is for termination, the resident shall have 5 working days from receipt of the MTF commander's decision to prepare a written request for reconsideration of that decision. After receipt and examination of a request for reconsideration the MTF commander may revoke the decision to terminate and place the resident on a defined period of probation with a recommended plan of remediation, or he may affirm the decision to terminate. The result of the MTF commander's decision to terminate will be forwarded to HQDA/OTSG (DASG-PSZ-MG) for Army residents and to HQAFPC/DPAME for Air Force residents.

H. Appeal of decision for termination. SAUSHEC has residents from the Army, Air Force, and Navy. Each branch of uniformed military service will apply the appeal process for termination action by its respective service.

XII. Resident Resignation. Residents may submit a written request to the program director for resignation from a program. The request will be considered by the program director, program training committee and forwarded to the Dean with the program director's recommendation which will state the circumstances of the resignation; whether or not performance has been satisfactory up to the time of resignation; how many months of training have been successfully completed by the resident; and whether the resident will be recommended for future GME training in the same specialty or a different specialty. This statement will be provided to the resident at the time of resignation, and the resident will acknowledge receipt of the statement. The GMEC will review the request and will recommend approval or disapproval to the MTF commander whose decision will be based upon the circumstances of the request. This decision will be forwarded to HQDA/OTSG (DASG-PSZ-MG) for Army residents and to HQAFPC/DPAME for Air Force residents.

XIII. Reporting Adverse Actions. When required by Department of Defense regulations or by the specific uniformed service, adverse actions--to include probation, extension of training, and/or termination--will be reported to the MTF credentials office, service specific medical commands, and to the National Practitioner Data Bank.

XIV. Re-Entry Into GME. Once a resident leaves a GME training program for by resignation or termination, there is no option for reinstatement by the institution. The physician may only pursue further GME training through application and selection by a designated GME Selection Board. Applicants must meet all current eligibility requirements when submitting such an application.

References

1. Army Regulation 351-3, July 01

2. Army Regulation 40-68 w/IC 101, Section 4-9, 4-10, 26 Jun 91

3. Army memorandum, MCHO-ME-GME, 26 May 98, Subject: Compliance with Army Medical Licensure Requirements for Participation in Graduate Medical Education (GME)

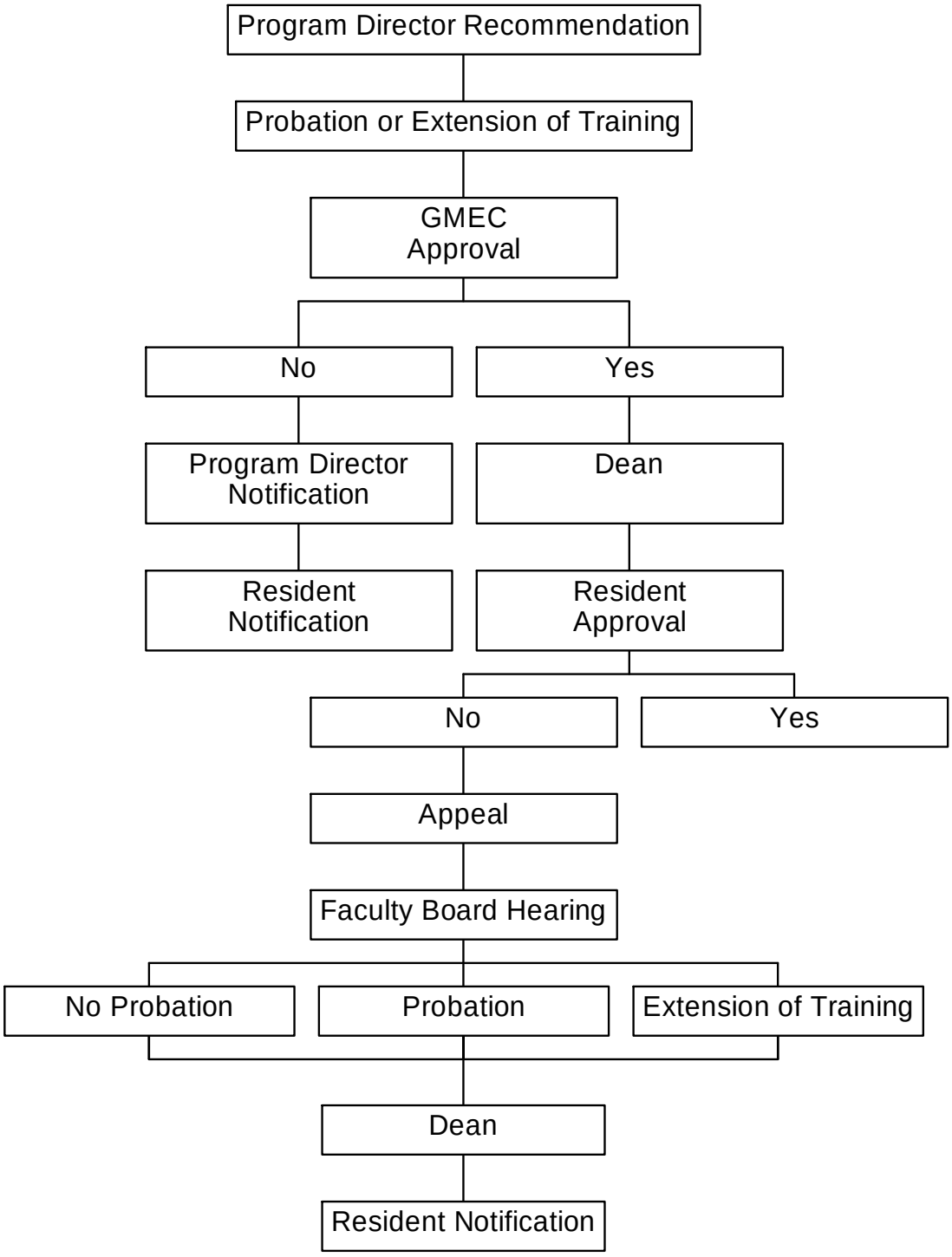
4. Air Force Instruction 41-117, 23 Apr 01

5. National Capital Consortium Handbook, Uniformed Services University of Health Sciences, "G. Policy on Adverse Actions and Due Process", pgs 23-29, http://www.usuhs/gme/ncc.htm, 5 May 2000.

6. University of Washington Resident Physician Policy, pgs 10-20, 2000-2001

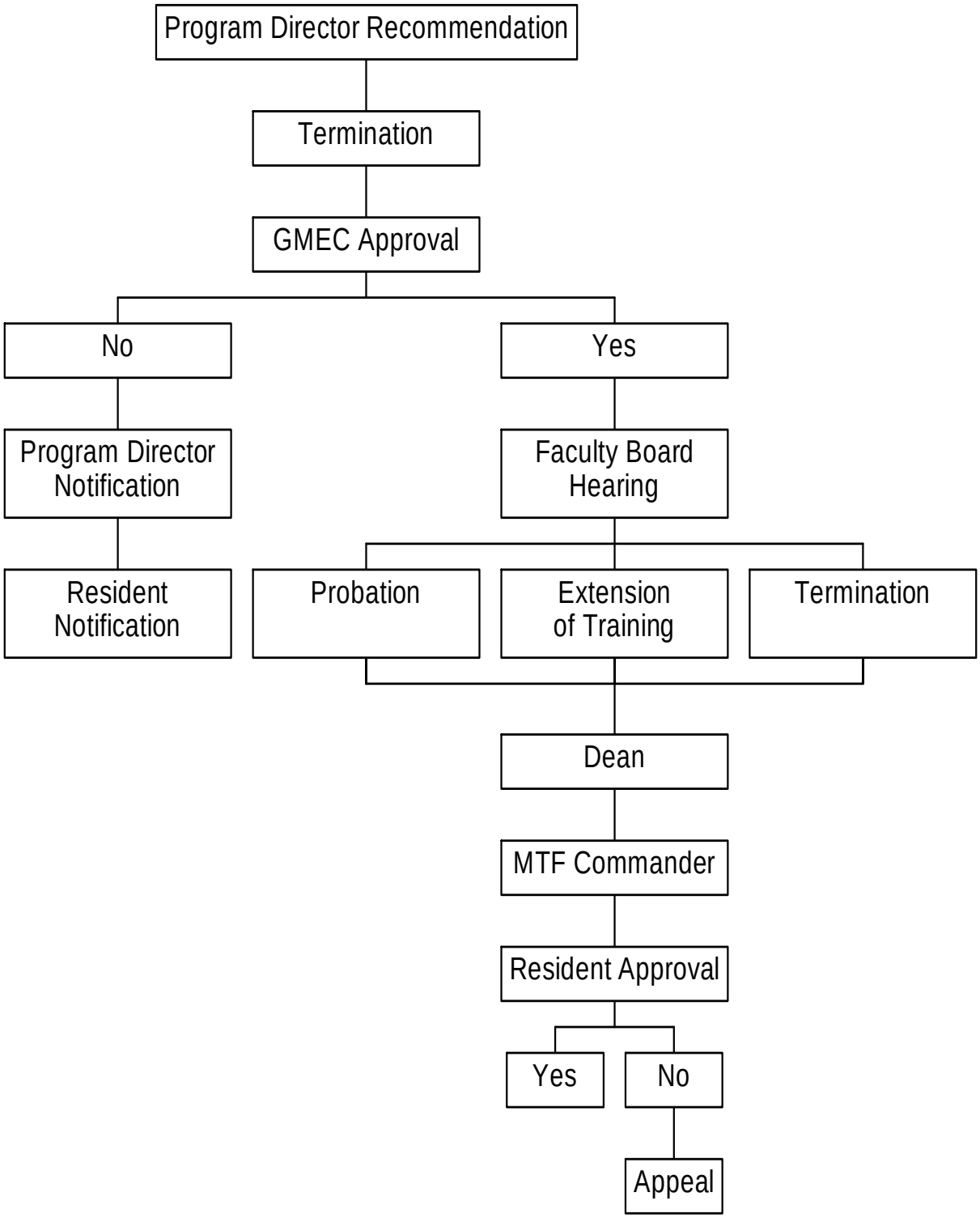
APPENDIX I

Probation or Extension of Training Process



APPENDIX II

Termination Process



APPENDIX 18

RESIDENT PROBATION

MCHE-EM DATE

MEMORANDUM TO: EMPA RESIDENT

FROM: Residency Director, EMPA Residency, United States Army Medical Activity, Brooke Army Medical Center, Department of Emergency Medicine, Fort Sam Houston, Texas 78234

SUBJECT:EMPA Resident Probation

1. This is to inform you of your failure to meet the minimum acceptable academic standards as a resident in the Emergency Medicine Physical Residency Program.
2. You have failed to achieve:

3. You are hereby placed in a probationary resident status for ___ days. If you fail to meet the standard(s) , you may be considered for extension or termination from the Emergency Medicine Physician Assistant Residency.
4. Request you acknowledge receipt of this memorandum by signing below and return this memorandum to me.

a) Signature block, Program Director

b) Signature block, Residency Director

TO: Residency Director , EMPA Residency

FROM: EMPA Resident

I hereby acknowledge receipt of the basic correspondence which informed me of my probationary status.

(c) Signature block, EMPA Residency

APPENDIX 19

NOTIFICATION OF RECOMMENDATION FOR EXTENSION/TERMINATION

MCHE-EM DATE

MEMORANDUM TO: EMPA Resident

FROM: Residency Director, EMPA Residency, United States Army Medical Activity, Brooke Army Medical Center, Department of Emergency Medicine, Fort Sam Houston, Texas 78234

SUBJECT:Notification of Recommendation for Extension or Termination

1. This is to inform you, you are being considered for extension or termination from the Emergency Medicine Physician Assistant Residency.
2. REASONS

3. If you are terminated from the residency, the Chief, Physician Assistant Section, Army Medical Specialist Corps, will be notified and new assignment orders will be requested.
4. Request you acknowledge receipt of this memorandum by completing the section below and returning this memorandum to me.

a) Signature block, Program Director

b) Signature block, Residency Director

TO:Residency Director , EMPA Residency

FROM: EMPA Resident

I hereby acknowledge receipt of the basic correspondence which informed me of my possible extension or termination from the EMPA residency.

c) Signature block, EMPA Resident

APPENDIX 20

FACULTY BOARD

MCHE-EM DATE

MEMORANDUM TO: Residency Director, EMPA Residency, United States Army Medical Activity, Brooke Army Medical Center,Department of Emergency Medicine, Fort Sam Houston, Texas 78234

FROM: EMPA Resident

SUBJECT: Acknowledgement of Appearance at Faculty Board

1. I hereby acknowledge receipt of the basic correspondence.
2. I (wish) (do not wish) to appear before the Faculty Board.
3. I (wish) (do not wish) to obtain counsel to appear with me on by behalf.
4. I (wish) (do not wish) to call in my behalf the following witnesses:

a) Signature block, EMPA Resident

APPENDIX 21

MCHE-EM DATE

MEMORANDUM TO: EMPA Resident

FROM: Residency Director, EMPA Residency, United States Army Medical Activity, Brooke Army Medical Center, Department of Emergency Medicine, Fort Sam Houston, Texas 78234

SUBJECT:Appearance before Faculty Board

1. EMPA Resident_____will appear before the Faculty Board .
2. Faculty Board will meet on_____
at_____
room number_____
building_____
3. The purpose of this Faculty Board meeting is to make recommendations to the Residency Director, EMPA Residency as to whether you should be terminated from the EMPA Residency for the following reasons:
a.
b. etc.
4. The following witnesses will be called:
a.
b. etc.
5. You will be allowed call witnesses to testify in your behalf, to present statements in your behalf, and to use counsel. You also have the right to challenge, for cause, members of the Faculty Board. After oral and written testimony is heard, the Faculty Board will make a recommendation regarding your disposition to the Residency Director, EMPA Residency for his review and decision.
6. After consulting with legal counsel, you have the option to submit names as witnesses and counsel. You must acknowledge receipt of this letter by endorsement and indicate your decision concerning your personal appearance before the Faculty Board NLT 1630 hours on _____.
7. Legal counsel is located in III Corps Headquarters Building, Headquarters Avenue.

a) Signature block, Residency Director, EMPA Residency

TO: Residency Director, EMPA Residency

FROM: EMPA Resident

I hereby acknowledge receipt of this basic correspondence which informed me of my appearance before the Faculty Board.

b) Signature block, EMPA Resident

APPENDIX 22

MCHE-EM DATE

MEMORANDUM TO: EMPA Resident

FROM: Residency Director, EMPA Residency, United States Army Medical Activity, Brooke Army Medical Center Department of Emergency Medicine, Fort Sam Houston, Texas 78234

SUBJECT: Summary of Faculty Board Meeting

1. A Faculty Board meeting was conducted for , EMPA RESIDENT NAME, on, DATE.
2. The Faculty Board considered the evidence and found, EMPA RESIDENT NAME, marginally passed his clinical rotation. Crucial objective number_____can not be certified. This led to the convening of a Faculty Board meeting.
4. The Faculty Board recommends, EMPA RESIDENT NAME, be extended with the provisions he/she successfully pass all remaining crucial objectives without probationary periods.
5. All enclosures and exhibits are being forwarded for your action.

a)Signature block, Residency Director, EMPA Residency

APPENDIX 23

Board Rounds

Introduction:
Board rounds are a time when active provider care comes to a general halt. It is also a time of high liability because communication between offgoing and oncoming providers is occasionally inadequate. Ideal board rounds effectively communicate all pertinent information in the shortest period possible in an effort to minimize the time that patients are not being cared for.

Purpose:
Board rounds serve two general purposes. First and foremost, it serves as the device by which offgoing physicians transfer care of active patients to oncoming providers. In its most basic form, this requires communicating 5 basic items:

- Who the patient is.
- Why they are here.
- What you think their problem is.
- What you have done in workup and management.
- What is left to be done.

The other function of board rounds is education. Interesting cases, physical findings, test results, treatment options, etc. are discussed in a manner in which all can benefit and in which the general practice of emergency medicine is taught to more junior residents, interns, and students.

Template:
Keeping in mind the 5 basic items necessary for transfer of care, the following is an example of what a typical board rounds presentation should be like:

Mr. Smith is a y.o. (White, Black, Asian, Hispanic, etc.) male (insert the past history of the patient only if it is pertinent - for example, nobody cares if the guy has COPD if he is here to have his toenail removed, but a history of PTCA is important in the patient with chest pain) who presents with a chief complaint of (headache, chest pain, abdominal pain, shortness of breath, ingrown toenail, etc.). I think he may have (subarachnoid hemorrhage, unstable angina, constipation, congestive heart failure, an infected ingrown toenail, etc.).

At this point significant historical and physical findings which support your diagnosis (sudden onset with nausea and photophobia, onset with exertion and relieved with rest, 1 week postop from CABG and taking narcotics. orthopnea and pedal edema, pus dripping from nail) or rule out more serious diagnoses (no fever or nuchal rigidity, mediastinum width is normal and pulses are symmetric, no peritoneal signs or fever, crackles in bases but oxygenating well, no history of trauma and no other medical problems) may be inserted, however, entire history, review of systems, and physical exams are to be avoided!

I did (a head CT which was normal, an EKG and cardiac enzymes which show only an old RBBB, a rectal exam which met with firm resistance, a CXR which showed bilateral pulmonary edema and an EKG and cardiac enzymes which were normal, a digital block). I gave him/her - (IV compazine which helped, NTG/ASAlLopressor and he is pain free, a soap suds enema with significant production of stool and symptomatic relief, 80mg of IV Lasix and nitropaste with improvement). I still need to (see the LP results before I make a disposition, call the MOD, give him his discharge paperwork, take the toenail off).

General Principles:
The general goal is to provide pertinent clinical information so that patient care would continue as though the offgoing provider was never leaving.
Volunteering too much useless information just wastes time and puts people to sleep so that important information may get missed.
Avoiding principle number 2 will force the oncoming team to pay attention and allow them to ask questions that should be readily answerable.
It is OK to not have a clue about what is going on provided that a concerted team effort has been undertaken to formulate some semblance of a differential diagnosis and management plan. Remember, these are Emergency Medicine rounds, NOT Medicine rounds; every little piece of minutia and tiny, subtle nuance need not be presented.
The more information you volunteer, the more you are liable to be pummeled with questions both pertinent and impertinent, some of which may leave you with a greasy feeling between your cheeks.

Conclusion:
Board rounds should effectively and concisely communicate the current status of the emergency department to the oncoming team. The board rounds template is one which you should practice when presenting patients to staff.

APPENDIX 24

TABLE OF CONTENTS

Concept of Morning Report

Morning report is based on the American Board of Emergency Medicine (ABEM) Oral Board Examination. It is designed not only to prepare residents for the oral board examination in Emergency Medicine but also to assess the residents' ability to diagnose and to manage specific clinical problems. This format will aid in identifying areas for specific improvement of the residents' oral board technique. It will be used as a teaching aid in order to better identify topics for increased concentration. This is not designed to be punitive or to be used as a formal evaluation for residency graduation requirements.

Below are the support documents outlining how morning report is to be administered. Adherence to this guidelines will better standardize morning report and, as advocated by several oral board review courses, allow the resident time to practice the ABEM oral board format. Flexibility in administration of a morning report case is recognized and required based on the year level of the resident. EM 1 residents may need additional "hints" in order to progress effectively with the case; however, EM 3 level residents should only receive information that is requested in accordance with what they will soon experience during the ABEM oral board evaluation. Residents need to be able to keep track of time and manage the case in the time allotted. Pausing of the case to ask additional questions or to give guidance is discouraged. Additionally, this disrupts the case progression and may confuse the resident even more.

Review of several oral board review manuals and multiple interviews with ABEM oral board graduates have resulted in this conceptual guide. Adherence to this format is expected to optimize the value of this teaching vehicle and to allow continued resident progression and evaluation. This manual has been reviewed by the Residency Director and approved for implementation (see attached).

DEPARTMENT OF THE ARMY
BROOKE ARMY MEDICAL CENTER
FORT SAM HOUSTON, TEXAS 78234-6200

MCHE-ME

14 AUG 01

MEMORANDUM FOR SEE DISTRIBUTION

SUBJECT: Morning Report

1. Morning report has been standardized in order to improve resident learning and to increase preparation for the American Board of Emergency Medicine Oral Examination

2. Attached is the morning report manual with evaluation forms to be used during daily morning report sessions in the SAUSHEC Emergency Medicine Residency Program.

3. Please address any questions to the undersigned at 916-1006.

BARRY J.SHERIDAN, D.O.
LTC, MC, USA
Interim Residency Director

Template for Morning Report Coverage

WHMC

Monday	**Tuesday**	**Wednesday**	**Thursday**	**Friday**
Skill Lab	**Faculty**	Admin Res	Admin Res	GR
Faculty	Faculty	Admin Res	Admin Res	GR
Faculty	Faculty	Admin Res	Faculty	GR
Faculty	Faculty	Admin Res	Faculty	GR

BAMC

Monday	**Tuesday**	**Wednesday**	**Thursday**	**Friday**
Skills Lab	Admin Res	Faculty	Faculty	GR
Faculty	Admin Res	Faculty	Faculty	GR
Faculty	Admin Res	Faculty	Admin Res	GR
Faculty	Admin Res	Faculty	Admin Res	GR

- Admin Resident(s) responsible for
  - ensuring 100% coverage.
  - logging faculty/resident participation and topics covered
- On blocks where there are two Admin residents, the Admin residents will pick up the Monday faculty MR sessions.
- At least 25 days prior to starting an Admin rotation, the resident will coordinate with the CRs and faculty schedulers to publish the MR calendar for the following block (example see attached).
  - SRs/CRs may be substituted for Admin Residents when these individuals are on leave. With prior permission of the program director, EM-2, EM-1/R-1 or Medical Student presentations may also be substituted or included in the schedule.

Time Sequence for Morning Report

Single Patient Encounter

0700- 0715	ED Board turnover
0715-0730	Case presentation
0730-0735	Pathophysiology questions
0735-0750	Lecture/discussion
0750-0755	Individual resident feedback of case/evaluation (please excuse all other residents when feedback is given)

Simulated Situation Encounter
(Multiple Patient Encounter)

0700- 0715	ED Board turnover
0715-0745	Case presentation
0745-0750	Lecture/discussion
0750-0755	Individual resident feedback of case/evaluation (please excuse all other residents when feedback is given)

Role of the Examiner

Playing the role of the examiner will greatly increase your insight into the format, flow and evaluation of the ABEM oral board evaluation. Your performance on this examination will be greatly influenced by learning firsthand how the examiners hear, interpret, and evaluate what a candidate is trying to accomplish on a particular case. Many oral board review course stress this role in order for the candidate to obtain the whole picture of the "exam puzzle."

In the role as examiner it is crucial to organize your case in the oral board format and to review it several times prior to playing the role of the examiner. Depending on the candidate, the case may not proceed as planned. Therefore, the examiner must be prepared to provide, de novo, physical exam findings, laboratory findings, and even x-ray findings that were not part of the original scenario. Reasons for this include, but are not limited to, inappropriate and potentially harmful actions and omissions by the candidate e.g., 1) administration of medications without assessing for allergies, 2) incorrect drug dosages, 3) inappropriate use of fluids in patients with compromised cardiac function, and 4) errors in management the would produce an untoward physiological response which you as the examiner must stimulate.

Under no circumstances should the examiner provider the candidate with any information (historical, physical examination, or lab tests) that was not specifically requested by the candidate.

As the examiner, you will be required to complete a written evaluation of your candidate's performance for the case scenario (see attached evaluation form). Please be familiar with this form prior to the case and provide a copy to the examinee at the conclusion of the case. You will also be required to review the case with the examinee after your talk on the case. Please excuse all other participants of morning report prior to this feedback session.

Timers are required for all cases (either you or someone in the morning report class). Single patient encounters will last 15 minutes and multiple patient encounters will last 30 minutes. **Do not allow your examinee to use extra time**. End each case with "This concludes the management portion of the case." Single patient encounters will be followed by 5 minutes of pathophysiology questions. This will be followed by a 10 minute talk about the case, critical actions and several salient points concerning the treatment for the case topic.

The following are "do's and don'ts" of playing the role of the examiner as outlined by several oral board review courses.

DO	DON'T
Introduce yourself at the beginning of each case and ask the candidate if he/she understands the ABEM oral board format.	Let the candidate know what you are thinking through facial expressions or other mannerisms.
Try to be detached when taking notes, asking questions, and when listening to answers.	Offer information until the candidate performs the necessary action or asks the specific question as defined in the case.
Play the role of the simulated patient, family, friend, nurse, and consultants.	
Provide incorrect or inaccurate information only when part of the patient scenario.	
Provide information only when specifically requested by the candidate.	
Challenge the candidate when he/she initiates a procedure. Ask the candidate "Doctor, how would you perform that procedure."	
In a non-threatening manner, ask the candidate to clarify any confusing statements or actions. This should be equivalent to a nurse asking the physician to clarify an order in clinical practice. If the candidate continues to pursue an incorrect or dangerous action, document it quietly without revealing the error to the candidate during the management portion of the case. Discuss this problem in your feedback session.	
Observe a strict time schedule. Allow only 15 minutes for single patient encounters and 30 minutes for multiple patient encounters.	

Sample Case

60 y/o WM with 20 min SSCP sudden in onset while at the store. EMS contacted by store and patient transported code III.

Initial vital signs: BP 133/81 P 91 R 23 T 98 Pul ox 98% on 4L O2

Patient Name: John Doe

HPI: Difficult history as patient is unsure of his medical problems and exact symptoms. Symptoms started about 20 min ago while walking at the store. He complaints of 7/10 non-radiating SSCP, SOB, nausea and diaphoresis. No history of CAD or functional study in the past. No PE risk factors. No vomiting. No F/C/N or productive cough. EMS contacted by store and gave patient SLNTG en-route without pain relief. He denies recent drug use. No contraindications to Thrombolytic therapy

PMH: ETOH dep
Opiate Dep
Pancreatitis
PSH: Cholecystectomy
Meds: Codeine, Methadone
ALL: NKDA
Fam: no h/o CAD
Soc: 30 pyh smoker, no ETOH recently, Opiate dependence
ROS: negative except HPI
Last Meal; 4hr ago
Tetanus: unknown
Family: Wife initially not present but is following EMS to the hospital. **Examinee must specifically ask patient or EMS if family is there**. Wife concerned about symptoms but unhelpful with history and repeats HPI.

PE:

Gen:	Alert and slightly uncomfortable
HEENT:	PERRL
Neck:	Supple, no bruit, no JVD
Chest:	Tachypnea, Lungs clear
Heart:	Normal exam
Abd:	Soft, NT
Rectal:	NL tone, guaiac neg.
Extrem:	Good perfusion
Neuro:	NL

LAB Data:

EKG:	inferior ST elevation with reciprocal changes in precordial Leads.
CXR:	NL
Chem-7:	Na 140, K 4, Cl 110, CO_2 24, BUN 10, Cr 1, Glu 87
CBC:	WBC 9.8, HCT 45, Hgb 15, Plts 227
Cardiac:	CK 120, MB 4, Trop 0.01
PT/PTT	NL
Tox Scr:	NL

Course

1. O2, ASA, IV access prior to repeat SLNTG, SLNTG, B-Blockade.
2. ECG shows inferior MI, R/O right sided and posterior extension.
3. No responses from above interventions, Nitro drip, Heparin after CXR.
4. Contact Cardiology for PTCA, and review contraindications to thrombolytic therapy.
5. Serial EKG's
6. DDX: MI, PE, PTX, Aortic Dissection, pneumonia, pericarditis, esophageal rupture.
7. Delay cardiology consult until above rule out or dangerous action occurs necessitating a worsened patient condition (i.e. heparin or thrombolytics prior to CXR to r/o aortic dissection).

Critical Actions

IV
O2, Pulse Ox, Monitor

EKG
ASA, Nitro-drip, B-blockade
CXR prior to anticoagulation
Rapid cardiology consult vs. Thrombolytic therapy

Dispo—PTCA

Questions:

1 Advantages of PTCA vs. Thrombolytic therapy
2 Contraindications to thrombolytic therapy.
3 Percentage of right sided extension in inferior wall MI
4 Role of Nitro in AMI
5 Role of Heparin in AMI.

Evaluation Form

Performance will be graded on two criteria based on the ABEM oral board format.

1. Performance criteria
2. Successful completion of the critical actions

1. Performance criteria

1. **Data acquisition**- gathers appropriate data in a complete and efficient manner which is well integrated into the management plan. Scoring is downgraded for gathering unnecessary data or incomplete data.
2. **Problem Solving**- ability to organize data, establish a differential diagnosis, anticipate potential problems in arriving at the appropriate treatment plan.
3. **Patient Management**- treatment decision making, sequence and timing of actions, proper referral and ability to manage multiple patients simultaneously.
4. **Resource Utilization**- organization of information effectively and logically in working through the differential diagnosis. Points are lost for shotgun approach to patient management and inefficient use of resources, tests, and consultants.
5. **Health Care Provided** (Outcome)- overall performance rating on health care provided.
6. **Interpersonal Relations**- ability to successfully address the patient's psychological state and examinee's ability to communicate with staff, consultants and relatives.
7. **Comprehension of Pathophysiology**- understanding of the disease process and its underlying pathophysiology.
8. **Clinical Competence** (Overall)- a combined rating which includes management skills and clinical knowledge.

2. Critical Actions

Each patient scenario will be accompanied by four to five critical actions needed to successfully manage the patient. Also, resident will be graded on actions deemed harmful or potentially harmful to the patient. Examples include:

i. Recognition of impending arrest (O2, Monitor Etc)
ii. Correct treatment for illness/injury
iii. Procedural completion (i.e. intubation)
iv. Post resuscitation management

Attached is a sample feedback form. At this stage feedback forms will not be included in the residents permanent file and will be given to the resident at the conclusion of the case.

Morning Report Feedback/Evaluation Form

Resident Name_____ EM- 1 2 3 Date_____

Case Title_____ Evaluator Name_____

Scoring

1-2 very unacceptable, harmful, gross mismanagement
3-4 unacceptable, deficient in critical actions, dangerous action noted
5-6 acceptable, complete critical actions; minor errors
7-8 very acceptable, complete, efficient, successful management

Critical Action Check List			**Performance Ratings**	
Y	N	_____	Data Acquisition	1 2 3 4 5 6 7 8
Y	N	_____	Problem Solving	1 2 3 4 5 6 7 8
Y	N	_____	Patient Management	1 2 3 4 5 6 7 8
Y	N	_____	Resource Utilization	1 2 3 4 5 6 7 8
Y	N	_____	Health Care	1 2 3 4 5 6 7 8
Y	N	_____	Interpersonal Relations	1 2 3 4 5 6 7 8
			Pathophysiology	1 2 3 4 5 6 7 8
Y	N	Dangerous Actions	Clinical Competence	1 2 3 4 5 6 7 8
		Comments:	Comments:	

1. After the case (and in private) review this form with the resident.
2. Return this form to the residency coordinator for inclusion in the resident's file.

Senior Resident *Examiner* Evaluation Form

Senior Resident Name_____ Date_____

Case_____ Faculty Name_____

Scoring

1-2 very unacceptable
3-4 unacceptable
5-6 acceptable, complete, minor errors
7-8 very acceptable, complete, efficient

Case presentation:

Format	1 2 3 4 5 6 7 8
Flow	1 2 3 4 5 6 7 8
Pathophysiology questions	1 2 3 4 5 6 7 8

Comments:

Review of case and topic:

Review of case	1 2 3 4 5 6 7 8
Lecture	1 2 3 4 5 6 7 8
Fund of knowledge concerning topic	1 2 3 4 5 6 7 8
Overall presentation	1 2 3 4 5 6 7 8

Comments:

1. After the case (and in private) review this form with the senior resident.
2. Return this form to the residency coordinator for inclusion in the senior resident's file.

APPENDIX 25

SAUSHEC Emergency Medicine Residency
Supervision Policy at BAMC DEM

10 November 01

Preamble

1) This policy is in compliance with the following rules and regulations:
   a) BAMC Bylaws
   b) Army Regulations 40-48, 40-66, and 40-68
   c) JCAHCO Standards MS 2.5, MS 6.9, MS 6.9.1
   d) GME Trainee Supervision Policy, Brooke AMC
2) This policy is intended to apply to all physician residents and interns and PA residents or PA rotators (Basic Skills Course) and medical students performing patient care in the BAMC Department of Emergency Medicine and who are under the supervision and control of the faculty (attending) emergency physician or faculty EMPA.
3) By design, this policy is drawn directly from the SAUSHEC EM Resident Manual, and as such, is intended to mirror the manual.

Responsibilities and Duties in the ED

1) Pre-shift responsibilities
   a) The EM1 or R-1 should arrive in time to begin clinical duties at the time of shift change. At BAMC, the EM1 should arrive early enough *before board rounds* to familiarize him/herself with the patients in the Observation Unit and their plans, and write a progress note on those patients. The EM1 report the findings to the faculty coming on shift.
   b) The EM2 is responsible for arriving to the shift in sufficient time to completely inspect and correct deficiencies in the stocking of the airway carts before board rounds.
   c) The EM3 should arrive in time to coordinate administrative aspects such as divert status, bed status, and general situational awareness in the ED.
   d) Emergency Medicine Physician Assistant (EMPA) residents are responsible for general pre-shift duties as for an EM1 and EM2.
2) Shift Change
   a) Shift change is an extremely important event in the ED. The shift begins and ends with board rounds. Board rounds should begin promptly at the change of shift. It is the off-going and on-going senior resident's responsibility to see that board rounds begin on time.
   b) Board rounds serve two purposes. (See board rounds template) First and foremost, it serves as the device by which off-going care provider transfer care of patients to oncoming providers. In its most basic form, this requires communicating 5 basic items: 1) who the patient is, 2) why they are here, 3) what you think their problem is, 4) what you have done in the workup and management, 5) what is left to be done including proposed disposition, if known.
   c) The other function of board rounds is education. Interesting cases, physical findings, test results, treatment options, etc. are discussed in a manner in which all can benefit and in which the general practice of emergency medicine is taught to residents, interns, and students.
   d) Duty is not complete until all patients currently in the ED, including those being evaluated by interns, medical students, and EMPA residents have been checked out to the on-coming residents. The off-going resident should physically introduce the on-coming resident to all patients for which he/she will be responsible. In addition, patients whose arrival to the ED is pending and administrative matters (e.g. lab malfunction, CT scan problems, ICU full, Divert status) should be relayed at the board. A written annotation indicating to whom and at what time patient care responsibilities have been transferred and exactly what is left to be done should be made in the patients' ED record. The oncoming resident must write an accept note summarizing the case and pending items after he/she has reviewed the chart and history/physical.

3) Charting
   a) Complete history and physical exam, diagnosis, impression with discussion of your medical decision making process, ED course, as well as time of arrival/discharge and any other pertinent information
   b) Documentation of all laboratory and radiologic findings.
   c) Complete the SF 513 (Consultation Form) if consultation was secured and ensure it is forwarded to the appropriate service. Complete an electronic SF 513, if applicable.
   d) Residents should never take the SF 558 (ED Treatment Record) away from the ED.
   e) Generally, patients are not be given a copy of the SF 558 prior to discharge. However, in some circumstances, such as a clinic follow-up, it is appropriate to make a photocopy of the chart and instruct the patient to hand carry it to the clinic physician providing the follow-up.
   f) There is a dictation system at WHMC that allows ED charts to be dictated and returned for review and signature in a timely (generally before the end of the shift) manner. All EM2 and EM3 residents are required to dictate their charts. EM1 residents after their second ED block will dictate their charts. A template has been developed to aid dictation.
   g) Diagnosis and procedures should be documented on the SF 558. No abbreviations are to be utilized. List diagnosis by order of priority (most serious first). Symptoms may be preferred method of documenting the diagnoses, e.g. Acute Febrile Illness as opposed to streptococcal pharyngitis
4) Presenting patients
   a) Medical Students
      i) Will present their patient to the senior resident or faculty early on in their evaluation of the patient. If the patient is, or potentially is, seriously ill the student should immediately present the patient to the senior or faculty.
      ii) Medical students will discuss orders and review all lab and x-ray results with the faculty or senior. Generally speaking, if the student presents the patient to the senior (or faculty) he/she should direct all further management questions, results, etc. to the senior (or faculty). This allows the senior some autonomy in managing the department. Students should clarify to whom they should present patients with the senior and faculty before the beginning of the shift.
   b) EM1, R-1 and EMPA residents
      i) Will present their patient to the senior resident or faculty early on in their evaluation of the patient. If the patient is, or potentially is, seriously ill the EM1, R-1 and EMPA residents should immediately present the patient to the senior or faculty.
      ii) Early in the year EM1s, R-1s and EMPA residents should discuss orders and review all lab and x-ray results with the faculty or senior. Generally speaking, if the EM1, R-1 or PA residents presents the patient to the senior (or faculty) he/she should direct all further management questions, results, etc. to the senior (or faculty). This allows the senior some autonomy in managing the department. EM1s , R-1s and PA residents should clarify to whom they should present patients with the senior and faculty before the beginning of the shift.
   c) EM2 and EM3 Residents
      i) Do not need to formally present their uncomplicated patients to the senior resident or faculty physician, however, it is proper practice to keep them informed of the medical management in progress. Complicated patients or potentially unstable patients should always be brought to the attention of the senior resident or faculty.
5) Co-signature
   a) All charts of patients seen by EM1s, rotating interns, and EMPAs must be reviewed and must have a note written by and signed by the senior or faculty prior to the patient's disposition.
   b) All charts of patients seen by medical students must have a note written by the supervising resident or faculty after the SR/faculty has completed their own evaluation. All student charts must be signed by faculty prior to the patient's disposition.
   c) All charts of patients seen by EMPA residents and PA rotators (Basic Skills Course) will be cosigned by either the supervising faculty EMPA or by the supervising senior resident or faculty physician.
   d) All charts of patients seen by residents and students (all types) will be reviewed by the faculty physician (see Chart reviews, below). It is up to the discretion of the faculty to examine the patient.
   e) All charts of patients being transferred or admitted must be co-signed by the faculty on duty prior to disposition. It is the resident's responsibility to present the chart to the faculty in a timely manner for their review and signature.

6) Chart reviews
   a) The faculty on duty will review all resident charts. The faculty may elect to point out deficiencies in your chart verbally or by written notes left in your box. They may require action on your part such as recalling the patient for further evaluation or may be purely educational.
   b) Every attempt will be made by the faculty to provide this feedback while you are physically present in the ED, but this may not be possible due to patient volume, critically ill patients, etc.
7) It is the residents responsibility to notify the senior resident and faculty immediately:
   a) Upon the arrival, by walk-in or ambulance, of any critically ill patients
   b) Upon notification of any patient arriving by ambulance
   c) Upon the arrival of any patient arriving from another clinic or location within the hospital
   d) Upon the need for sedating or vasoactive medications
   e) Of their interpretation of x-rays and EKG's
   f) Upon the need for and prior to consultations
   g) Prior to calling the consultant for admission
   h) Prior to any invasive procedures
   i) Prior to transfer to another facility
   j) Concerning any patient that refuses medical care or wishes to leave against medical advice
   k) Concerning any patient that has an adverse reaction or complication of any medication administered or procedure performed in the ED
   l) About all patients that are dissatisfied or disappointed in their ED treatment

Progression of Responsibility

1) Medical Students
   a) All patient encounters and significantly invasive procedures performed by medical students assigned to the ED will be supervised by the senior resident on duty or the faculty physician.
2) EM-1, EMPA residents and R-1 Rotating Interns
   a) Provide patient care as directed by the faculty, or senior resident. EM-1s, EMPA residents and R-1s have an affirmative responsibility to keep the Senior Resident and/or the faculty informed immediately of all patient encounters described in section 7), above.
   b) Manage the airway on selected resuscitations with direct faculty supervision during ED shifts from 0200-1000 daily.
   c) EM-1s and R-1S will be the EP in charge of the ED Observation Unit (EDOU) at BAMC. This duty entails arriving early to review the history and physical of the patients in the EDOU, learning the plan and what is left to be done, and assuring proper disposition of these patients. The EM2 will also evaluate the patients should their condition change. EMPA residents will not normally be responsible for the OU patients.
3) EM-2
   a) The EM2 ED rotations are designed to allow progressive responsibility in the ED while under the guidance of the EM3 and/or ED faculty. Triage, patient flow patterns, and disposition decisions will be emphasized. Additional emphasis will be placed upon multiple simultaneous patient evaluations and construction of the foundation of the supervisory/administrative aspects of managing an ED.
   b) From the period 0200 to 1000 daily the EM2 assumes the role of the supervisory EM resident ("senior resident")and is responsible for the overall functioning of the department. (See EM3 below)
   c) Manage the airway for all resuscitations between 1000 and 0200.
   d) Acting as a consultant to the rotating interns and EM1s for patients in the ED.
   e) Keep the EM3 resident and/or faculty appraised of the clinical status of his/her patients and immediately bring administrative problems to the attention of the supervising EM3. This mandates an intimate knowledge of patients waiting to be seen, as well as waiting times.
   f) To act as second in command during resuscitations as supervised by the EM3, and manage the airways on resuscitations.
4) EM-3
   a) The EM3 resident will be the individual responsible for the overall management of the entire ED operation. This includes direct supervision and instruction of the more junior housestaff, medical students, EMTs and nursing personnel. The EM3 resident will serve as the team leader during the initial evaluation and stabilization of all critically ill patients. The ED faculty will physically witness and provide a critique of all major resuscitations performed in the ED. Areas of critique include pre-code organization, management of

resources, and maintenance of control and proper sequencing of therapeutic/diagnostic steps. He/she will be ready to assume technical procedures if difficulty is encountered by more junior housestaff.

b) Function as the overall manager of the entire ED/UCC system and will be responsible for its complete operation. The EM3 is expected to know the status of all patients in the ED at any time period.
c) Be responsible for the evaluation and disposition of all patients, and in all resuscitations will serve as the resuscitation leader.
d) Act as consultant to the more junior residents concerning medical and administrative questions, SOP policies, etc.
e) The EM3 will be the primary consultant for, and verify history and physical findings of, all junior housestaff unless otherwise agreed upon by the faculty and EM3 during the shift. He/she will audit and discuss errors or charting techniques on all patient charts that he/she had the responsibility of staffing, and will sign and write a note on these charts.
f) As resuscitation leader, direct the junior housestaff in procedures and maintain overall responsibility for the patient, and provide a written post resuscitation report and critique to all involved.
g) Ascertain that SOPs and administrative policy are carried out to include transfer of patients, ambulance, VIPs, etc. The EM3 is responsible for patient complaints during the shift, and should investigate and report them to the faculty on duty.
h) Discuss all admissions first with the faculty and then with the admitting physician and approve movement of patients to the ward or unit.
i) Help coordinate all admissions through the respective service consultants and evaluate their stability for transfer to ICU or CCU.
j) Monitor patient volume and notify EM faculty when volume exceeds the capacity of providers available.
k) Ensure that care for all recalled patients is documented.
l) Above all, keep the faculty informed of all patients and events of significance.

Licensure and institutional permits

1) The DOD policy, as mandated by the U.S. Congress, states that all resident physicians will have a valid, unrestricted medical license (from any state) by the end of their second year (30 June) of post-graduate training. All EM residents will be required to have an Institutional Permit issued by the state of Texas prior to rotating at non DOD institutions in the state of Texas. Residents with a current medical license from Texas are exempt. Residents are expected to maintain current institutional permits during the entire period of residency training.
2) EMPA residents will maintain NCCPA certification at all times.

Resident Evaluations

1) ED Resident Performance Evaluations
   a) Each resident will periodically be assigned to have his/her performance formally evaluated by the faculty through the use of shift evaluation forms. Residents should be evaluated several times by various faculty over the course of each ED rotation. The goal is at least 5 randomly chosen formal shift evaluations per ED block. Faculty may also elect to complete a shift evaluation on any shift, and are encouraged to do so to document specific strengths or deficiencies noted in a resident's performance.
   b) During selected EM blocks the resident will meet with the Program Director and the Associate Residency Directors for a formalized periodic evaluation based on ED shift evaluations, outside rotation evaluations, test results, research progress, and lecture evaluations. Each resident will have at least 4 summative evaluations per year. A form is completed during each evaluation and maintained in the residents file.
   c) During evening shifts at WHMC and selected day shifts at BAMC the EM1 will be the subject of a focused faculty shift evaluation. There will be two faculty assigned to the shift and one of them will have the responsibility of personally supervising the EM1 and evaluating his/her performance. The goal of the focused faculty shift evaluation is primarily educational. The EM1 will have the opportunity to have a faculty available and dedicated to help him/her gather data effectively, and use that data to develop reasoned diagnostic and therapeutic plans. In addition, it provides a means of closely monitoring the EM1's progress. The goal is to have each EM1 have 2 such shifts per ED block.
   d) When a resident is on an off-service rotation, he/she is evaluated by that service and the evaluation is forwarded to the Program Director. (See enclosure)
   e) After each procedure, each resident should ensure that the supervisory faculty completes a procedure evaluation form specific to the procedure performed.
   f) PA Residents will be required to have 2-3 evaluations by SR or staff during there ED rotation
   g) Off service rotations will have the same requirements as the Physicians (above)

2) Particularly important for off-service rotations, each resident will fill out an evaluation of the rotation he/she hasjust completed and turn in to the chief resident. Historically, these evaluations have been instrumental in maximizing the EM residents learning experience and have led to changes in the curriculum.
3) Twice yearly, residents are required to complete faculty evaluation forms. This is a vitally important tool that the faculty and ED Department Chiefs can use to ensure each faculty is performing maximally. There are multiple mechanisms in place ensuring that the forms remain anonymous. These forms, however, should be completed in a professional and constructive manner.

Faculty

1) Responsibilities of supervision
   a) All faculty must be available for consultation at all times when assigned duty in the ED. Physical presence as appropriate is necessary to provide an opportunity for the direct observation of resident history, exam skills and timeliness of therapeutic interventions.
   b) Particularly in the EM1 or R-1, direct observation of their history and physical is often helpful in assessing their abilities and helping them improve patient care skills. Time management and efficiency are two of the more difficult aspects of emergency medicine to teach. It is vitally important that the faculty observe the residents actions while they are not with their patients to identify habits that are inefficient.
2) Evaluation of resident performance
   a) Direct verbal feedback given to the resident in a constructive manner is perhaps the best teaching tool available to the faculty. It should be accomplished as soon as possible while the resident still recalls the actions and/or thought processes and to correct any potential deleterious effects upon the patient.
   b) Each faculty will submit written shift evaluation forms to the Program Director for each shift and resident for which an evaluation has been assigned. Every effort should be made to discuss these evaluations with the resident. Faculty may also submit additional shift evaluations when he/she desires or feels it is necessary.
   c) Some incidents or actions may necessitate formal written notification of the event to the Program Director. These notifications are at the discretion of the faculty member, but should be accomplished in a timely manner.
3) Each faculty member is responsible for auditing the charts that were completed during their assigned shift. Chart audits are an important tool for evaluation and education of the residents and every opportunity to point out deficiencies in charting should be taken. Exceptionally well-written charts should be commented upon as well. Constructive feedback to the resident can take the form of verbal discussion of the chart or written notifications of deficiencies. There should be an explanation of why they are deficient as well as suggestions for improvement.
4) Each faculty member is responsible for supervising ED procedures. Faculty may delegate direct supervision of the procedure to senior residents, but must remain aware that he/she is ultimately responsible for general supervision.
5) Each faculty member must be physically available for all resuscitations until the stability of the patient is ensured and all key procedures are completed.
6) Charts written by medical students must be reviewed and co-signed by the faculty even if the EM3 or EM2 was primarily providing the staffing support. (see charting section earlier)
7) Chart of patients that are admitted or transferred (or are pending admission or transfer at the end of the faculty's shift) must be reviewed and signed.
8) The faculty EMPA may serve as the supervisor of record for EMPA residents and PA rotators (Basic Skills Course). the general principles of responsibilities of supervision , evaluation of performance, and proper administrative procedures apply. The faculty EMPA will, when appropriate. consult the senior resident or faculty physician.

APPENDIX 26

EMERGENCY MEDICINE PHYSICIAN ASSISTANT CORE COMPETENCY GRID

General Competencies		**Evaluation Methods**		
Patient Care	Clinical Evaluation Exercise	Patient and Procedure Logs	Evaluation and Grading Reports	Procedure Skill Labs
Medical Knowledge	Rotation Specific Examinations	Mid/Final Term Written and Oral Examinations	Morning Reports and Board Rounds	Research Project
Communication Skills	Case Presentations	360 degree Evaluations	Patient Surveys	
Professionalism	Officer Evaluation Reports/Quarterly Counseling	360 degree Evaluations		
Practice Based Learning	Research Project	Case Presentations	Record Review	
Systems Based Learning	EMS Base Station Operator	Direct Faculty Observation with consultants, SWS, and CPS	QI Projects	

APPENDIX 27

MODEL OF THE CLINICAL PRACTICE OF EMERGENCY MEDICINE

SPECIAL CONTRIBUTION
Core Content Task Force II
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Advisory Panel to the Task Force
William J. Koenig, MD, Chair
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Wilma V. Henderson, MD
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Note from the Core Content Task Force II:
The Core Content Task Force II endorses The Model of the Clinical Practice of Emergency Medicine in its current version. However, the Task Force's endorsement does not extend to future documents resulting from this original work.

This article also appears in the June 2001 issue of Academic Emergency Medicine. *ACEP policy statement no. 4297. Also available at www.acep.org.*
Address for reprints: *American Board of Emergency Medicine, 3000 Coolidge Road, East Lansing, MI 48823; 517-332-4800, fax 517-332-2234.*

0196-0644/2001/$35.00 + 0
47/1/115495
[Hockberger RS, Binder LS, Graber MA, Hoffman GL, Perina DG, Schneider SM, Sklar DP, Strauss RW, Viravec DR, Koenig WJ, Augustine JJ, Burdick WP, Henderson WV, Lawrence LL, Levy DB, McCall J, Parnell MA, Shoji KT. The model of the clinical practice of emergency medicine. Ann Emerg Med.June 2001;37:745-770.]

P R E A M B L E

In 1975 the American College of Emergency Physiciansand the University Association for Emergency Medicine(now the Society for Academic Emergency Medicine;SAEM) conducted a practice analysis of the emergingfield of Emergency Medicine. This work resulted in thedevelopment of the current CoreContent of Emergency Medicine, a listing of common conditions, symptoms,and diseases seen and evaluated in emergency departments. The Core Content listing has subsequently been revised 4 times, expanding from 5 to 20 pages. However,none of these revisions had the benefit of empirical analysisof the developing specialty but relied solely uponexpert opinion.Following the most recent revision of the Core Content listing in 1997, the contributing organizations felt that the list had become complex and unwieldy, and subsequently agreed to address this issue by commissioning a task force to reevaluate the Core Content listing and the process for revising the list. As part of its final set of recommendations, the Core Content Task Force recommended that the specialty undertake a practice analysis of the clinical practice of Emergency Medicine. Results of a practice analysis would provide an empirical foundation for content experts to develop a core document that would represent the needs of the specialty. Following the completion of its mission, the Core Content Task Force recommended commissioning another task force that would be charged with the oversight of a practice analysis of the specialty—Core Content Task Force II. The practice analysis relied upon both empirical data and the advice of several expert panels and resulted in *The Model of the Clinical Practice of Emergency Medicine* (Model). The Model resulted from the need for a more integrated and representative presentation of the Core Content of Emergency Medicine. The Model was created through the collaboration of 6 organizations: American Board of Emergency Medicine (ABEM) American College of Emergency Physicians (ACEP) Council of Emergency Medicine Residency Directors (CORD)Emergency Medicine Residents' Association (EMRA) Residency Review Committee for Emergency Medicine (RRC-EM) Society for Academic Emergency Medicine (SAEM)

There are 3 components to the Model: (1) an assessment of patient acuity; (2) a description of the tasks that must be performed to provide appropriate emergency medical care; and (3) a listing of common conditions, symptoms, and disease presentations. Together these 3 components describe the clinical practice of Emergency Medicine and differentiate it from the clinical practice of other specialties. The Model represents essential information and skills necessary for the clinical practice of Emergency Medicine by board-certified emergency physicians. Patients often present to the emergency department with signs and symptoms rather than a known disease or disorder. Therefore, an emergency physician's approach to patient care begins with the recognition of patterns in the patient's presentation that point to a specific diagnosis or diagnoses. Pattern recognition is both the hallmark and cornerstone of the clinical practice of Emergency Medicine, guiding the diagnostic tests and therapeutic interventions during the entire patient encounter. The Model is designed for use as the core document for the specialty. It will provide the foundation for developing future medical school and residency curricula, certification examination specifications, continuing education objectives, research agendas, residency program review requirements, and other documents necessary for the functional operation of the specialty. During the fall of 2000, each of the contributing organizations conducted a thorough review of the document, and ultimately endorsed the following version of the Model. The Task Force recommends that future revisions of this document be inputted, reviewed, and endorsed by the contributing organizations.

Robert S. Hockberger, MD
Chair, Core Content Task Force II
December 12, 2000

O V E R V I E W

There are multiple components of The Model of the Clinical Practice of Emergency Medicine. The components of the Model are given in 2 complementary documents: (1) the Matrix, and (2) the Listing of Conditions and Components.

MAT R I X

The Matrix is organized along 2 principal dimensions: Patient Acuity and Physician Tasks (Table 1). The Matrix represents all possible physician-patient interactions that are determined by patient acuity and the tasks that may be performed during a patient encounter. Patient acuity is most fundamental in determining the priority and sequence of tasks necessary to successfully manage the presenting patient. The Matrix represents how an emergency physician modifies the tasks necessary to perform appropriate patient care based on the patient acuity.

Patient Acuity

An emergency physician's frame of reference in a patient encounter is fundamentally related to the acuityof the patient's condition. Establishing the

acuity level is essential for defining the context for action, the priorities of the patient encounter, and consequently, the order of tasks necessary to manage the patient successfully. In The Model of the Clinical Practice of Emergency Medicine, patient acuity includes critical, emergent, and lower acuity (Table 2).

Table 1.
Matrix of physician tasks by patient acuity.

	Patient Acuity		
Physician Tasks	**Critical**	**Emergent**	**Lower Acuity**
Pre-hospital care			
Emergency stabilization			
Performance of focused history and physical examination			
Modifying factors			
Professional issues			
Diagnostic studies			
Diagnosis			
Therapeutic interventions			
Pharmacotherapy			
Observation and reassessment			
Consultation and disposition			
Prevention and education			
Documentation			
Multi-tasking and team management			

Table 2.
Patient acuity definitions.

Critical	**Emergent**	**Lower Acuity**
Patient presents with symptoms of a life-threatening illness or injury with a high probability of mortality if immediate intervention is not begun to prevent further hemodynamic, airway, respiratory, and/or neurologic instability.	Patient presents with symptoms of an illness or injury that may progress in severity or result in complications with a high probability for morbidity if treatment is not begun quickly.	Patient presents with symptoms of an illness or injury that have a low probability of progression to more serious disease or development of complications.

Physician Tasks

The physician tasks include the range of activities and the dynamic nature of the practice of Emergency Medicine (Table 3). Emergency physicians simultaneously consider multiple factors involved in patient care that may alter the direction of patient management. For example, the approach to the patient can change dramatically when considering a pediatric versus a geriatric presentation of the same complaint, ie, modifying factors. The physician tasks apply to patients of all ages. Although there are no separate sections on the care of pediatric or geriatric patients, users of the document should consider including pediatric and geriatric aspects of patient care related to each task. When considered together, these tasks are directly related to the broad competencies expected of board-certified emergency physicians.

Table 3.
Physician task definitions.
Pre-hospital care - Participate actively in pre-hospital care; provide direct patient care or online or offline medical direction or interact with pre-hospital medical providers; assimilate information from pre-hospital care into the assessment and management of the patient.
Emergency stabilization - Conduct primary assessment and take appropriate steps to stabilize and treat patients.
Performance of focused history and physical examination - Communicate effectively to interpret and evaluate the patient's symptoms and history; identify pertinent risk factors in the patient's history; provide a focused evaluation; interpret the patient's appearance, vital signs and condition; recognize pertinent physical findings;perform techniques required for conducting the exam.
Modifying factors - Recognize age, gender, ethnicity, barriers to communication, socioeconomic status, underlying disease, and other factors that may affect
patient management.
Professional and legal issues - Understand and apply principles of professionalism, ethics, and legal concepts pertinent to patient management.
Diagnostic studies - Select and perform the most appropriate diagnostic studies and interpret the results.
Diagnosis - Develop a differential diagnosis and establish the most likely diagnoses in light of the history, physical, interventions, and test results.
Therapeutic interventions - Perform procedures and nonpharmacologic therapies and counsel.
Pharmacotherapy - Select appropriate pharmacotherapy, recognize pharmacokinetic properties, and anticipate drug interactions and adverse effects.
Observation and reassessment - Evaluate and reevaluate the effectiveness of a patient's treatment or therapy, including addressing complications and potential errors;monitor, observe, manage, and maintain the stability of one or more patients who are at different stages in their work-ups.
Consultation and disposition - Collaborate with physicians and other professionals to evaluate and treat patients, arrange appropriate placement and transfer ifnecessary, formulate a follow-up plan, and communicate effectively with patients, family, and involved health care members.
Prevention and education - Apply epidemiologic information to patients at risk; conduct patient education; select appropriate disease and injury prevention techniques.
Documentation - Communicate patient care information in a concise manner that facilitates quality care and coding.
Multi-tasking and team management - Prioritize multiple patients in the emergency department in order to provide optimal patient care; interact, coordinate, educate, and supervise all members of the patient management team; utilize appropriate hospital resources; have familiarity with disaster management.

Following is a concise example of how patient acuity and physician tasks can be applied to patients presenting with the same complaint of chest pain:
1. A 55-year-old hypertensive diabetic male with crushing chest pain, diaphoresis, and a blood pressure of 60 systolic who is clutching his chest.
Acuity Frame: Critical
Implications: Immediate intervention is necessary to manage and stabilize vital functions. High probability of mortality exists without immediate intervention.
2. A 74-year-old female with a history of angina presenting with 3 to 5 minutes of dull chest pain typical of her angina. She has stable vital signs and her pain is relieved by nitroglycerin.
Acuity Frame: Emergent
Implications: Initiation of monitoring, vascular access, evaluation, and treatment must be performed quickly. Progression in severity, complications, or morbidity may occur without immediate treatment.
3. A 12-year-old female with nontraumatic sharp chest pain lasting for several days that intensifies with movement of the torso.
Acuity Frame: Lower acuity
Implications: Patient's symptoms should be addressed promptly. However, progression to major complications would be unlikely.

LISTING OF CONDITIONS AND COMPONENTS

The Listing of Conditions and Components contains the fundamental, or core, patient conditions that present to emergency departments. The listing is based on data collected by the National Center for Health Statistics at the Centers for Disease Control and Prevention (CDC) during 1995-1996. The CDC data were collected from 40,000 emergency department records statistically representative of

90.3 million emergency department visits in metropolitan and nonmetropolitan short-stay or general hospitals in all 50 states and the District of Columbia. Frequency of occurrence was a primary factor in determining inclusion in the Listing of Conditions and Components. Frequency of occurrence, however, was not the sole determinant of inclusion nor was the number of entries pertaining to a single topic representative of importance. The final list was developed by several expert panels of practicing emergency physicians based on: (1) frequency of occurrence, (2) critical nature of patient presentation, and (3) basic organizational structure. Appendix 1 outlines the diagnostic and/or therapeutic procedures or tests that are essential to the clinical practice of Emergency Medicine. Emergency physicians must know the indications for ordering, be able to perform, and be able to interpret the results of the listed items. Appendix 2 lists the other essential components of Emergency Medicine practice. These include such items as administration; communication and interpersonal issues; research; and risk management, legal, and regulatory issues. Emergency physicians should have a basic knowledge of these components and be able to apply them to their clinical practice.
NOTE: The Listing of Conditions and Components is not intended to be comprehensive. It is intended to be representative of the most frequent conditions seen and those with the most serious implications for patients presenting to the emergency department.

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We thank the seven emergency physicians who assisted the Task Force in pilot testing the national survey used to validate this study. Their input to the process was extremely valuable. In addition, a very special thanks to the 1,084 ABEM diplomates who participated in the national survey during a very busy time of the year; their responses and comments were helpful in finalizing this document.

With special appreciation to Susan M. Dunsmore, administrative assistant, American Board of Emergency Medicine, for her careful and timely preparation of materials, attention to details, and shepherding of people throughout the complex process of developing “The Model.”

LISTING OF CONDITIONS AND COMPONENTS.

1.0 Signs, Symptoms, and Presentations

	Critical	Emergent	Lower Acuity
1.1 General			
Altered mental status	X	X	
Anxiety			X
Apnea	X		
Ataxia		X	X
Back pain	X	X	X
Bleeding	X	X	X
Coma	X		
Confusion		X	
Crying/Fussiness		X	X
Cyanosis	X		
Decreased level of consciousness	X	X	
Dehydration	X	X	
Dizziness	X	X	
Edema		X	X
Failure to thrive		X	X
Fatigue		X	X
Feeding problems			X
Fever	X	X	X
Hypotension	X	X	
Jaundice		X	
Joint pain/Swelling		X	X
Limp		X	X
Lymphadenopathy			X
Malaise		X	X
Multiple trauma	X	X	
Needle stick		X	X
Pain	X	X	X
Paralysis	X	X	
Paresthesia/Dysthesia		X	X
Poisoning	X	X	X
Pruritus		X	X
Rash	X	X	X
Shock	X		
SIDS (See 3.1)	X		
Sleeping problems			X
Syncope	X	X	X
Tremor		X	X
Weakness		X	X
Weight loss		X	X
1.2 Abdominal			
Abnormal vaginal bleeding	X	X	X
Anuria		X	
Ascites		X	X
Colic		X	X

	Critical	Emergent	LowerAcuity
1.2 Abdominal (cont.)			
Constipation			X
Cramps		X	X
Diarrhea		X	X
Dysmenorrhea			X
Dysuria			X
Hematemesis	X	X	
Hematochezia	X	X	X
Hematuria		X	X
Nausea/Vomiting		X	X
Pain	X	X	X
Pelvic Pain		X	X
Peritonitis	X	X	
Rectal Bleeding	X	X	X
Rectal Pain		X	X
Urinary Incontinence			X
Urinary Retention		X	
1.3 Chest			
Chest Pain	X	X	X
Cough		X	X
Dyspnea	X	X	
Hemoptosis	X	X	
Hiccough			X
Palpitations	X	X	X
Shortness of Breath	X	X	
Tachycardia	X	X	
Wheezing	X	X	
1.4 Head and Neck			
Congestion			X
Diplopia		X	
Dysphagia		X	X
Eye Pain		X	X
Headache(See 12.3)	X	X	X
Loss of Hearing			X
Loss of Vision		X	
Rhinorrhea			X
Sore Throat		X	X
Stridor	X	X	
Tinnitus			X
Vertigo		X	X

2.0 Abdominal and Gastrointestinal Disorders

	Critical	Emergent	Lower Acuity
2.1 Abdominal Wall			
Hernias		X	X
2.2 Esophagus			
Infectious disorders			
Candida (See 4.4, 7.5)		X	X
Inflammatory disorders			
Esophagitis		X	X
Gastroesophageal reflux (GERD)			X
Toxic effects of caustic (See 17.1)			
Acid	X	X	
Alkali	X	X	
Motor abnormalities			
Spasms			X
Structural disorders			
Boerhaave's syndrome	X	X	
Diverticula		X	X
Foreign body		X	
Hernias		X	X
Mallory-Weiss syndrome	X	X	
Stricture and stenosis		X	X
Tracheoesophageal fistula	X	X	
Varices	X	X	
Tumors		X	X
2.3 Liver			
Cirrhosis		X	X
Alcoholic		X	X
Biliary obstructive		X	
Drug-induced		X	X
Hepato-renal failure	X	X	
Infectious disorders		X	X
Abscess		X	
Hepatitis			
Acute		X	X
Chronic			X
Tumors		**X**	**X**
2.4 Gall Bladder and Biliary Tract			
Cholangitis	X	X	
Cholecystitis		X	
Cholelithiasis/ Choledocholithiasis		X	X
Tumors		**X**	**X**
2.5 Pancreas			
Pancreatitis	X	X	
Tumors		X	X
2.6 Peritoneum			
Spontaneous bacterial peritonitis	X	X	
2.7 Stomach			
Infectious disorders			X
Inflammatory disorders			
Gastritis		X	X
Peptic ulcer disease		X	X

	Critical	Emergent	Lower Acuity
2.7 Stomach (cont.)			
Hemorrhage	X	X	
Perforation	X	X	
Structural disorders			
Congenital hypertrophic pyloric stenosis		X	
Foreign body		X	X
Tumors		X	X
2.8 Small Bowel			
Infectious disorders		X	X
Inflammatory disorders			
Regional enteritis/ Crohn's disease		X	X
Motor abnormalities			
Obstruction		X	
Paralytic ileus		X	
Structural disorders			
Aortoenteric fistula	X		
Congenital anomalies		X	X
Intestinal malabsorption		X	X
Meckel's diverticulum		X	X
Tumors		X	X
Vascular insufficiency	X	X	
2.9 Large Bowel			
Infectious disorders			
Antibiotic associated		X	
Bacterial		X	X
Parasitic		X	X
Viral		X	X
Inflammatory disorders			
Acute appendicitis		X	
Necrotizing enterocolitis (NEC)	X	X	
Radiation colitis		X	
Ulcerative colitis		X	X
Motor abnormalities			
Hirschsprung's disease		X	X
Irritable bowel			X
Obstruction		X	
Structural disorders			
Congenital anomalies		X	X
Diverticula		X	X
Intussusception	X	X	
Volvulus	X	X	
Tumors		X	X
2.10 Rectum and Anus			
Infectious disorders			
Perianal/Anal abscess		X	X
Perirectal abscess		X	
Pilonidal cyst and abscess		X	X
Inflammatory disorders			
Proctitis			X
Structural disorders			
Anal fissure			X

	Critical	Emergent	Lower Acuity
2.10 Rectum and Anus (cont.)			
Anal fistula		X	X
Congenital anomalies			X

Foreign body		X	X
Hemorrhoids			X
Rectal prolapse		X	
Tumors		X	X
3.0 CARDIOVASCULAR DISORDERS			
3.1 Cardiopulmonary Arrest	X		
SIDS (See 1.1)		X	
3.2 Congenital Abnormalities of the Cardiovascular System			
Disorders due to anatomic anomalies	X	X	X
Genetically transmitted disorders	X	X	X
3.3 Disorders of Circulation			
Arterial			
Aneurysm	X	X	X
Aortic dissection	X		
Thromboembolism		X	
Venous			
Thromboembolism (See 16.6)	X	X	
3.4 Disturbances of Cardiac Rhythm			
Cardiac dysrhythmias	X	X	X
Ventricular	X	X	
Supraventricular	X	X	X
Conduction disorders	X	X	X
3.5 Diseases of the Myocardium,			
Acquired			
Cardiac failure	X	X	
Cor pulmonale	X	X	
High output	X	X	
Low output	X	X	
Cardiomyopathy	X	X	X
Hypertrophic	X	X	X
Congestive heart failure	X	X	
Coronary syndromes	X	X	
Ischemic heart disease	X	X	
Myocardial infarction	X	X	
Myocarditis	X	X	X
Ventricular aneurysm	X	X	X
3.6 Diseases of the Pericardium			
Pericardial tamponade (See 18.1)	X	X	
Pericarditis		X	X
3.7 Endocarditis	X	X	
3.8 Hypertensive Emergencies	X	X	
3.9 Tumors	X	X	
3.10 Valvular Disorders	X	X	X
4.0 CUTANEOUS DISORDERS			
4.1 Cancers of the Skin			
Basal cell			X
Kaposi's sarcoma			X

	Critical	Emergent	Lower Acuity
4.1 Cancers of the Skin (cont.)			
Melanoma			X
Squamous cell			X
4.2 Decubitus Ulcer	**X**	**X**	
4.3 Dermatitis			
Eczema			X
Psoriasis			X
Sebaceous cyst			X
Seborrhea			X
4.4 Infections			
Bacterial			
Abscess		X	X
Cellulitis		X	X
Erysipelas			X
Impetigo			X
Necrotizing infection	X	X	
Fungal			
Candida (See 2.2, 7.5)			X
Tinea			X
Parasitic			
Pediculosis infestation			X
Scabies			X
Viral			
Aphthous ulcers			X
Erythema infectiosum			X
Herpes simplex (See 10.6, 13.1)			X
Herpes zoster (See 10.6)		X	X
Human papillomavirus (HPV) (See 13.1)			X
Molluscum contagiosum			X
Warts			X
4.5 Maculopapular Lesions			
Erythema multiforme		X	X
Erythema nodosum			X
Henoch-Schönlein purpura (HSP)			X
Pityriasis rosea			X
Purpura		X	X
Urticaria		X	X
4.6 Papular/Nodular Lesions			
Hemangioma/Lymphangioma			X
Lipoma			X
4.7 Vesicular/Bullous Lesions			
Pemphigus		X	
Staphylococcal scalded skin syndrome	X	X	
Stevens Johnson syndrome	X	X	
Toxic epidermal necrolysis	X	X	

	Critical	Emergent	Lower Acuity
5.0 ENDOCRINE, METABOLIC, AND NUTRITIONAL DISORDERS			
5.1 Acid-Base Disturbances			
Metabolic or respiratory			

	Critical	Emergent	Lower Acuity
Acidosis	X	X	
Alkalosis	X	X	X
Mixed acid-base balance disorder	X	X	
5.2 Adrenal Disease			
Corticoadrenal insufficiency	X	X	
Cushing's syndrome		X	X
5.3 Fluid and Electrolyte Disturbances			
Calcium metabolism	X	X	X
Fluid overload/Volume depletion	X	X	
Hyperkalemia/Hypokalemia	X	X	X
Hypernatremia/ Hyponatremia	X	X	X
Magnesium metabolism		X	X
Phosphorus metabolism		X	X
5.4 Glucose Metabolism			
Diabetes mellitus			
Type I	X	X	X
Type II		X	X
Complications in glucose metabolism			
Diabetic ketoacidosis (DKA)	X	X	
Hyperglycemia		X	X
Hyperosmolar coma	X	X	
Hypoglycemia	X	X	
Systemic		X	X
5.5 Nutritional Disorders			
Vitamin deficiencies			X
Vitamin excess			X
Wernicke-Korsakoff syndrome		X	
5.6 Parathyroid Disease		**X**	**X**
5.7 Pituitary Disorders		**X**	**X**
Panhypopituitarism		X	
5.8 Thyroid Disorders			
Hyperthyroidism	X	X	X
Hypothyroidism		X	X
Thyroiditis		X	X
5.9 Tumors of Endocrine Glands			
Adrenal		X	X
Pituitary		X	X
Thyroid		X	X
6.0 ENVIRONMENTAL DISORDERS			
6.1 Bites and Envenomation (See 18.1)			
Arthropods		X	X
Insects			X
Spiders		X	X
Mammals		X	X

	Critical	Emergent	Lower Acuity
6.1 Bites and Envenomation (cont.)			
Marine organisms	X	X	X
(See 17.1)			
Snakes	X	X	X
6.2 Dysbarism			
Air embolism	X	X	
Barotrauma	X	X	X
Decompression syndrome	X	X	
6.3 Electrical Injury (See 18.1)	**X**	**X**	**X**
Lightning	X	X	
6.4 High-Altitude Illness			
Acute mountain sickness		X	X
Barotrauma of ascent		X	X
High-altitude cerebral edema	X	X	
High-altitude pulmonary edema	X	X	
6.5 Submersion Incidents			
Cold water immersion	X	X	
Near drowning	X	X	
6.6 Temperature-Related Illness			
Heat			
Heat exhaustion		X	X
Heat stroke	X		
Cold			
Frostbite		X	X
Hypothermia	X	X	
7.0 HEAD, EAR, EYE, NOSE, THROAT DISORDERS			
7.1 Ear			
Foreign body		X	X
Impacted cerumen			X
Labyrinthitis			X
Mastoiditis		X	
Meniere's disease			X
Otitis externa			X
Infective			X
Malignant		X	
Otitis media		X	X
Perforated tympanic membrane (See 18.1)			X
7.2 Eye			
External eye			
Blepharitis			X
Burn confined to eye and adnexa (See 18.1)		X	
Conjunctivitis			X
Corneal abrasions (See 18.1)		X	X
Dacryocystitis		X	X
Disorders of lacrimal system			X
Foreign body		X	X
Inflammation of the eyelids			X

	Critical	Emergent	Lower Acuity
7.2 Eye (cont.)			
Chalazion			X
Hordeolum			X
Anterior pole			

Glaucoma		X	X
Hyphema (See 18.1)		X	X
Iritis (See 18.1)		X	X
Posterior pole			
Choroiditis/Chorioretinitis		X	
Optic neuritis		X	
Papilledema	X	X	
Retinal detachments and defects (See 18.1)		X	
Retinal vascular occlusion		X	
Orbit			
Cellulitis			
Preseptal		X	
Postseptal		X	
Purulent endophthalmitis		X	
7.3 Cavernous Sinus Thrombosis	**X**	**X**	
7.4 Nose			
Epistaxis	X	X	X
Foreign body		X	X
Rhinitis			X
Sinusitis			X
7.5 Oropharynx/Throat			
Dentalgia			X
Diseases of the oral soft tissue			
Ludwig's angina	X	X	
Stomatitis			X
Diseases of the salivary glands			
Sialolithiasis		X	X
Suppurative parotitis		X	
Foreign body	X	X	
Gingival and periodontal disorders			
Gingivostomatitis			X
Larynx/Trachea			
Epiglottitis (See 16.1)	X	X	
Laryngitis			X
Tracheitis		X	X
Oral candidiasis (See 2.2, 4.4)			X
Periapical abscess		X	X
Peritonsillar abscess		X	
Pharyngitis/Tonsillitis			X
Retropharyngeal abscess		X	X
Temporomandibular joint disorders			X
7.6 Tumors		**X**	**X**
8.0 HEMATOLOGIC DISORDERS			
8.1 Blood Transfusion			
Complications	X	X	

	Critical	Emergent	Lower Acuity
8.2 Hemostatic Disorders			
Coagulation defects	X	X	X
Acquired	X	X	X
Hemophilias	X	X	X
Disseminated intra-vascular coagulation	X		
Platelet disorders	X	X	X
Thrombocytopenia		X	X
8.3 Lymphomas		**X**	**X**
8.4 Pancytopenia	**X**	**X**	
8.5 Red Blood Cell Disorders			
Anemias			
Aplastic	X	X	
Hemoglobinopathies		X	X
Sickle cell disease		X	X
Hemolytic		X	
Hypochromic			
Iron deficiency		X	X
Megaloblastic		X	X
Polycythemia		X	X
Methemoglobinemia (See 17.1)	X	X	
8.6 White Blood Cell Disorders			
Leukemia		X	X
Multiple myeloma		X	X
9.0 IMMUNE SYSTEM DISORDERS			
9.1 Collagen Vascular Disease			
Raynaud's disease			X
Reiter's syndrome		X	X
Rheumatoid arthritis (See 11.3)		X	X
Scleroderma		X	X
Systemic lupus erythematosus		X	X
Vasculitis		X	X
9.2 HIV and Manifestations (See 10.6)	**X**	**X**	**X**
9.3 Hypersensitivity			
Allergic reaction		X	X
Anaphylaxis	X		
Angioedema	X	X	
Drug allergies	X	X	X
9.4 Kawasaki Syndrome		**X**	
9.5 Sarcoidosis		**X**	**X**
9.6 Transplant-Related Problems	**X**	**X**	**X**
Immunosuppression		X	X
Rejection	X	X	
10.0 SYSTEMIC INFECTIOUS DISORDERS			
10.1 Bacterial			
Bacterial food poisoning		X	X
Botulism	X	X	
Chlamydia		X	X
Gonococcal infections		X	X
Meningococcemia	X	X	
Mycobacterial infections			
Atypical mycobacteria		X	X

	Critical	Emergent	Lower Acuity
10.1 Bacterial			
Tuberculosis		X	X
Other bacterial diseases	X	X	
Gas gangrene (See 11.6)	X	X	

Sepsis/Bacteremia	X	X	
Shock	X		
Systemic inflammatory response syndrome (SIRS)	X	X	
Toxic shock syndrome	X	X	
Spirochetes			
Syphilis		X	X
Tetanus	X	X	
10.2 Biologic Weapons	**X**	**X**	
10.3 Fungal Infections		**X**	**X**
10.4 Protozoan - Parasites			
Malaria		X	
Toxoplasmosis		X	X
10.5 Tick-Borne			
Ehrlichiosis		X	
Lyme disease		X	
Rocky Mountain spotted fever		X	
10.6 Viral		**X**	**X**
Infectious mononucleosis		X	X
Influenza/Parainfluenza		X	X
Hantavirus	X	X	
Herpes simplex (See 4.4, 13.1)		X	X
Herpes zoster/Varicella (See 4.4)		X	X
HIV (See 9.2)	X	X	X
Rabies	X		
Roseola			X
Rubella			X
11.0 MUSCULOSKELETAL DISORDERS (NONTRAUMATIC)			
11.1 Bony Abnormalities			
Aseptic necrosis of hip		X	X
Osteomyelitis		X	
Tumors		X	X
11.2 Disorders of the Spine			
Disc disorders		X	X
Inflammatory spondylo-pathies		X	X
Low back pain			
Cauda equina syndrome (See 18.1)		X	
Sacroiliitis			X
Sprains/Strains			X
11.3 Joint Abnormalities			
Arthritis			
Septic		X	
Gout		X	X
Rheumatoid (See 9.1)			X
Juvenile			X
Osteoarthrosis			X

	Critical	Emergent	Lower Acuity
11.3 Joint Abnormalities (cont.)			
Congenital dislocation of the hip		X	X
Slipped capital femoral epiphysis		X	
11.4 Muscle Abnormalities			
Myalgia/Myositis			X
Rhabdomyolysis	X	X	
11.5 Overuse Syndromes			
Bursitis			X
Muscle strains			X
Peripheral nerve syndrome			X
Carpal tunnel syndrome			X
Tendonitis			X
11.6 Soft Tissue Infections			
Fasciitis		X	
Felon		X	
Gangrene (See 10.1)	X	X	
Paronychia		X	X
Synovitis/Tenosynovitis		X	X
12.0 NERVOUS SYSTEM DISORDERS			
12.1 Cranial Nerve Disorders			**X**
Bell's palsy			X
Trigeminal neuralgia			X
12.2 Demyelinating Disorders	**X**	**X**	
Multiple sclerosis		X	X
12.3 Headache (See 1.4)	**X**	**X**	**X**
Muscle contraction			X
Vascular		X	X
12.4 Hydrocephalus		**X**	**X**
Normal pressure		X	X
VP shunt		X	
12.5 Infections/Inflammatory			
Disorders			
Encephalitis	X	X	
Intracranial and intra-spinal abscess	X	X	
Meningitis			
Bacterial	X	X	
Viral		X	X
Myelitis		X	
Neuralgia/Neuritis			X
12.6 Movement Disorders		**X**	**X**
Dystonic reaction		X	X
12.7 Neuromuscular Disorders			
Guillain-Barré syndrome	X	X	
Myasthenia gravis	X	X	
12.8 Other Conditions of the Brain			
Dementia (See 14.5)			X
Parkinson's disease			X
Pseudotumor cerebri		X	X
12.9 Seizure Disorders	**X**	**X**	**X**
Febrile		X	X
Neonatal		X	
Status epilepticus	X		
12.10 Spinal Cord Compression	**X**	**X**	

	Critical	Emergent	Lower Acuity
12.11 Stroke			
Hemorrhagic			
Intracerebral	X	X	
Subarachnoid	X	X	

Ischemic			
Embolic	X	X	
Thrombotic	X	X	
12.12 Transient Cerebral Ischemia	**X**		**X**
12.13 Tumors		**X**	**X**
13.0 OBSTETRICS AND GYNECOLOGY			
13.1 Female Genital Tract			
Cervix			
Cervicitis and endo-cervicitis		X	X
Tumors			X
Infectious disorders			
Pelvic inflammatory disease		X	
Fitz-Hugh-Curtis syndrome		X	
Tubo-ovarian abscess		X	
Lesions			
Herpes simplex (See 4.4, 10.6)			X
Human papillomavirus (HPV) (See 4.4)			X
Ovary			
Cyst			X
Torsion		X	
Tumors		X	X
Uterus			
Dysfunctional bleeding		X	X
Endometriosis			X
Prolapse			X
Tumors		X	X
Gestational trophoblastic disease		X	
Leiomyoma			X
Vagina and vulva			
Bartholin's abscess		X	
Foreign body		X	X
Vaginitis/Vulvovaginitis			X
13.2 Normal Pregnancy			**X**
13.3 Complications of Pregnancy			
Abortion		X	
Ectopic pregnancy	X	X	
Hemolysis, elevated liver enzymes, low platelets (HELLP) syndrome	X	X	
Hemorrhage, antepartum			
Abruptio placentae (See 18.2)	X	X	
Placenta previa	X	X	
Hyperemesis gravidarum		X	X
Hypertension complicating pregnancy		X	X
Eclampsia	X	X	

13.3 Complications of Pregnancy (cont.)			
Preeclampsia		X	
Infections		X	
Rh isoimmunization		X	
13.4 High Risk Pregnancy	**X**	**X**	
13.5 Normal Labor and Delivery	**X**		**X**
13.6 Complications of Labor			
Fetal distress	X		
Premature labor (See 18.2)		X	
Premature rupture of membranes		X	
Rupture of uterus (See 18.2	X		
13.7 Complications of Delivery			
Malposition of fetus	X	X	
Nuchal cord	X		
Prolapse of cord	X		
13.8 Postpartum Complications			
Endometritis		X	
Hemorrhage	X	X	
Mastitis		X	X
14.0 PSYCHOBEHAVIORAL DISORDERS			
14.1 Addictive Behavior			
Alcohol dependence			X
Drug dependence			X
Eating disorders		X	X
Substance abuse			X
14.2 Mood Disorders and Thought Disorders			
Acute psychosis	X	X	
Bipolar disorder		X	X
Depression		X	X
Suicidal risk	X	X	
Grief reaction			X
Schizophrenia		X	X
14.3 Factitious Disorders			
Drug-seeking behavior			X
Munchausen syndrome/ Munchausen by proxy		X	X
14.4 Neurotic Disorders			
Anxiety/Panic			X
Obsessive compulsive			X
Phobic			X
Post-traumatic stress			X
14.5 Organic Psychoses			
Chronic organic psychotic conditions			X
Alcoholic psychoses		X	X
Drug psychoses		X	X
Delirium		X	
Dementia (See 12.8)			X
Intoxication and/or withdrawal (See 17.1)			
Alcohol		X	X
Hallucinogens		X	X
Opioids	X	X	X
Phencyclidine		X	

14.5 Organic Psychoses (cont.)			
Sedatives/Hypnotics/ Anxiolytics	X	X	X
Sympathomimetics	X	X	X

and cocaine			
14.6 Patterns of Violence/Abuse/Neglect			
Domestic			
Child, spouse, elder		X	
Homicidal risk	X	X	
Sexual assault	X	X	
Staff/Patient safety		X	
14.7 Personality Disorders			**X**
14.8 Psychosomatic Disorders			
Hypochondriasis			X
Hysteria/Conversion			X
15.0 RENAL AND UROGENITAL DISORDERS			
15.1 Acute and Chronic Renal Failure	**X**	**X**	**X**
15.2 Complications of Renal Dialysis	X	**X**	
15.3 Glomerular Disorders			
Glomerulonephritis		X	X
Nephrotic syndrome		X	X
15.4 Infection			
Cystitis			X
Pyelonephritis		X	
Urinary tract infection (UTI)			X
15.5 Male Genital Tract			
Genital lesions			X
Hernias		X	X
Inflammation/Infection			
Balanitis/Balanoposthitis		X	X
Epididymitis/Orchitis		X	X
Gangrene of the scrotum (Fournier's gangrene)	X	X	
Prostatitis		X	X
Urethritis			X
Structural			
Paraphimosis/Phimosis		X	
Priapism	X		
Prostatic hypertrophy (BPH)			X
Torsion of testis		X	
Testicular masses			X
Tumors			
Prostate			X
Testis			X
15.6 Nephritis		**X**	**X**
Hemolytic uremic syndrome		X	
15.7 Structural Disorders			
Calculus of urinary tract		X	X
Obstructive uropathy		X	
Polycystic kidney disease			X
15.8 Tumors			**X**
16.0 THORACIC-RESPIRATORY DISORDERS			

	Critical	Emergent	Lower Acuity
16.1 Acute Upper Airway			
Disorders			
Infections			
Croup		X	
Epiglottitis (See 7.5)	X	X	
Pertussis/Whooping cough	X	X	
Upper respiratory infection			X
Obstruction	X		
Tracheostomy/ Complications	X	X	
16.2 Disorders of Pleura, Mediastinum, and Chest Wall			
Costochondritis			X
Mediastinitis	X	X	
Pleural effusion		X	X
Pleuritis			X
Pneumomediastinum		X	
Pneumothorax (See 18.1)			
Simple		X	
Tension	X		
Edema			
16.3 Noncardiogenic Pulmonary	X	X	
16.4 Obstructive/Restrictive Lung Disease			
Asthma/Reactive airway disease	X	X	
Bronchitis and bronchiolitis		X	X
Bronchopulmonary dysplasia		X	X
Chronic obstructive pulmonary disease	X	X	X
Cystic fibrosis	X	X	X
Environmental/Industrial exposure	X	X	X
Foreign body	X	X	
16.5 Physical and Chemical Irritants/Insults			
Pneumoconiosis		X	X
Toxic effects of gases fumes, vapors (See 18.1)	X	X	X
16.6 Pulmonary Embolism/Infarct			
Septic emboli	X	X	
Venous thromboembolism (See 3.3)	X	X	
16.7 Pulmonary Infections			
Lung abscess		X	
Pneumonia			
Aspiration	X	X	
Atypical		X	
Bacterial	X	X	
Chlamydia		X	
Fungal	X	X	
Mycoplasmal		X	X
Viral	X	X	X
Pulmonary tuberculosis		X	

	Critical	Emergent	Lower Acuity
16.8 Tumors			
Breast			X
Chest wall			X
Pulmonary		X	X

	Critical	Emergent	Lower Acuity
17.0 TOXICOLOGIC DISORDERS			
17.1 Drug and Chemical Classes			
Analgesics			
Acetaminophen		X	
Nonsteroidal anti-inflammatories (NSAIDS)		X	X
Opiates and related narcotics	X	X	
Salicylates	X	X	
Alcohol			
Ethanol	X	X	X
Glycol	X	X	
Isopropyl	X	X	X
Methanol	X	X	
Anesthetics	X	X	
Anticholinergics/ Cholinergics	X	X	
Anticoagulants	X	X	
Anticonvulsants	X	X	
Antidepressants	X	X	
Antiparkinsonism drugs		X	
Antihistamines and antiemetics		X	
Antipsychotics	X	X	
Bronchodilators		X	
Carbon monoxide	X	X	
Cardiovascular drugs			
Antiarrhythmics	X	X	
Antihypertensives	X	X	
Beta blockers	X	X	
Calcium channel blockers	X	X	
Caustic agents			
Acid	X	X	
Alkali	X	X	
Cocaine	X	X	X
Cyanides, hydrogen sulfide	X	X	
Hallucinogens	X	X	
Hazardous materials	X	X	
Heavy metals	X	X	
Herbicides, insecticides, and rodenticides	X	X	
Household/Industrial chemicals	X	X	X
Hormones/Steroids		X	X
Hydrocarbons	X	X	
Hypoglycemics/Insulin	X	X	
Inhaled toxins	X	X	
Iron	X	X	
Isoniazid	X	X	
Marine toxins (See 6.1)	X	X	X
Methemoglobinemia (See 8.5)	X	X	
Non-prescription drugs	X	X	
Organophosphates	X	X	
Recreational drugs	X	X	X
Sedatives/Hypnotics	X	X	
Stimulants/ Sympathomimetics	X	X	
Strychnine	X	X	
18.0 TRAUMATIC DISORDERS			
18.1 Trauma			
Abdominal trauma			
Diaphragm	X	X	
Hollow viscus	X	X	
Penetrating	X	X	
Retroperitoneum	X	X	
Solid organ	X	X	
Vascular	X	X	
Chest trauma			
Aortic dissection/ Disruption	X		
Contusion			
Cardiac	X	X	X
Pulmonary	X	X	
Fracture			
Clavicle		X	X
Ribs/Flail chest	X	X	X
Sternum		X	X
Hemothorax	X	X	
Penetrating chest trauma	X	X	
Pericardial tamponade (See 3.6)	X		
Pneumothorax (See 16.2)			
Simple		X	
Tension	X		
Cutaneous injuries			
Avulsions		X	X
Bite wounds (See 6.1)		X	X
Burn			
Electrical (See 6.3)	X	X	X
Chemical (See 16.5)	X	X	X
Thermal	X	X	X
Lacerations		X	X
Puncture wounds		X	X
Facial fractures			X
Dental		X	X
Le Fort	X	X	X
Mandibular		X	X
Orbital		X	X
Genitourinary trauma			
Bladder		X	
External genitalia		X	
Renal		X	X
Ureteral		X	

	Critical	Emergent	Lower Acuity
17.1 Drug and Chemical Classes (cont.)			
Mushrooms/Poisonous plants	X	X	
Neuroleptics	X	X	
18.1 Trauma (cont.)			
Head trauma			
Intracranial injury	X	X	
Scalp lacerations/		X	X

Avulsions			
Skull fractures		X	X
Injuries of the spine			
Dislocations/Subluxations	X	X	
Fractures	X	X	X
Sprains/Strains			X
Lower extremity bony trauma			
Dislocations/		X	
Fractures (open and closed)		X	X
Neck trauma			
Laryngotracheal injuries	X	X	
Penetrating neck trauma	X	X	
Vascular injuries			
Carotid artery	X	X	
Jugular vein	X	X	
Ophthalmologic trauma			
Corneal abrasions/		X	X
Lacerations (See 7.2)			
Corneal burns			
Acid		X	
Alkali		X	
Ultraviolet		X	X
Eyelid lacerations		X	
Foreign body		X	
Hyphema (See 7.2)		X	
Lacrimal duct injuries		X	
Penetrating globe injuries		X	
Retinal detachments		X	
(See 7.2)			
Traumatic iritis (See 7.2)		X	X
Otologic trauma			
Hematoma		X	X
Perforated tympanic			X
membrane (See 7.1)			
Pediatric fractures			
Epiphyseal		X	X
Greenstick		X	
Torus			X
Pelvic fracture	X	X	
Soft-tissue extremity injuries			
Amputations/Replantation		X	
Compartment syndromes		X	
High-pressure injection		X	
Injuries to joints		X	X
Knee		X	X
Penetrating		X	
Penetrating soft-tissue		X	X
Periarticular			X
Sprains and strains			X
Tendon injuries			
Lacerations/Transections		X	
Ruptures		X	

	Critical	Emergent	Lower Acuity
18.1 Trauma (cont.)			
Achilles tendon		X	
Patellar tendon		X	
Spinal cord and nervous system trauma			
Cauda equina syndrome (See 11.2)		X	
Injury to nerve roots		X	X
Peripheral nerve injury		X	X
Spinal cord injury	X	X	
Spinal cord injury without radiologic abnormality (SCIWORA)		X	
Upper extremity bony trauma			
Dislocations/Subluxations		X	
Fractures (open and closed)		X	X
18.2 Trauma in Pregnancy			
Abruptio placentae (See 13.3)	X	X	
Perimortem C-section	X		
Premature labor (See 13.6)	X		
Rupture of uterus (See 13.6)	X		
18.3 Multi-system Trauma	X	X	
Blast injury	X	X	

A P P E N D I X 1 .

Procedures and Skills Integral to the Practice of Emergency Medicine.

Airway Techniques

Airway adjuncts

Cricothyrotomy
Heimlich maneuver
Intubation
1. Nasotracheal
2. Orotracheal
3. Rapid sequence
Mechanical ventilation
Percutaneous transtracheal ventilation

Anesthesia

Local
Regional nerve block
Sedation—analgesia for procedures

Blood and Component Therapy Administration

Diagnostic Procedures

Anoscopy
Arthrocentesis
Bedside ultrasonography
Cystourethrogram
Lumbar puncture
Nasogastric tube
Paracentesis
Pericardiocentesis
Peritoneal lavage
Slit lamp examination
Thoracentesis
Tonometry

Genital/Urinary

Bladder catheterization
1. Foley catheter
2. Suprapubic
Testicular detorsion

Head and Neck

Control of epistaxis
1. Anterior packing
2. Cautery
3. Posterior packing/balloon placement
Laryngoscopy
Needle aspiration of peritonsillar abscess
Removal of rust ring
Tooth replacement

Hemodynamic Techniques

Arterial catheter insertion
Central venous access
1. Femoral
2. Jugular
3. Subclavian
4. Umbilical
5. Venous cutdown
Intraosseous infusion
Peripheral venous cutdown

Obstetrics

Delivery of newborn
1. Abnormal delivery
2. Normal delivery

Other Techniques

Excision of thrombosed hemorrhoids
Foreign body removal
Gastric lavage
Gastrostomy tube replacement
Incision/drainage
Pain management (See Anesthesia)
Physical restraints
Sexual assault examination
Trephination, nails
Wound closure techniques
Wound management

Resuscitation

Cardiopulmonary resuscitation (CPR)
Neonatal resuscitation

Skeletal Procedures

Fracture/Dislocation immobilization techniques
Fracture/Dislocation reduction techniques
Spine immobilization techniques

Thoracic

Cardiac pacing
1. Cutaneous
2. Transvenous
Defibrillation/Cardioversion
Thoracostomy
Thoracotomy

Universal Precautions

A P P E N D I X 2 .

Other Components of the Practice of Emergency Medicine.

ADMINISTRATION

Contract Principles
Analysis of Clauses and Components
Employment versus Independent Contractor
Negotiation
Financial Issues
Budget and Planning
Cost Containment
Reimbursement Issues Billing and Coding
Operations
Department Administration
Documentation
Facility Design
Human Resource Management
Information Management
Patient Throughput

Policies and Procedures
Safety and Security
Performance Improvement
Customer Satisfaction and Service
Error Reduction
Practice Guidelines
Pre-Hospital Care
Administration, Management and Operations
Credentialing of providers
Direct patient care
Multi-casualty Incidents
Performance Improvement
Protocol development
Professionalism
Death in ED
Ethics
Impairment
Leadership (Leading, Directing and Mentoring)
Personal Well-being
Professional Development and Learning
Systems-Based Management
Managed Care

COMMUNICATION AND INTERPERSONAL ISSUES
Complaint Management
Conflict Resolution
Interdepartmental and Medical Staff Relations
Team Building
Teaching
RESEARCH
Evidence-Based Medicine
Interpretation of Medical Literature
Performance of Research

RISK MANAGEMENT, LEGAL, AND REGULATORY ISSUES
Accreditation
Compliance
Confidentiality
Consent and Refusal of Care
Emergency Medical Treatment and Active Labor Act (EMTALA)
Liability and Malpractice
Reporting (Assault, Communicable Diseases, National Practitioner Data Bank, etc)
Risk Management

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