

**SAN ANTONIO UNIFORMED SERVICES  
HEALTH EDUCATION CONSORTIUM  
RESIDENCY GUIDE  
2003-2004**



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## I. Introduction

- A. Welcome to the San Antonio Uniformed Services Health Education Consortium (SAUSHEC) Emergency Medicine Residency Program. You are part of a proud history in emergency medicine and a member of one of the nation's oldest and largest emergency medicine residency training programs.
  - 1. The program began in 1978 at Brooke Army Medical Center (BAMC), and in 1987 became a joint program with Wilford Hall Air Force Medical Center (WHMC). In 1991 the Emergency Medicine Physician Assistant Residency Program began at BAMC and has maintained a relationship with the SAUSHEC residency since then.
  - 2. Previous graduates and past faculty have served the armed forces honorably and have gone on to be influential leaders in the specialty and you can expect your experience here to prepare you for similar successes. As such, this guide will introduce you to the structure, format, rules and requirements of the program.
  - 3. New residents and others seeking an overview of the program are invited to review the [applicant brochure](#) that is provided to applicants and others interested in the residency.
- B. This guide is intended for both residents as well as faculty and staff in the program. Off-service rotators, medical students, applicants, and others affiliated with our program will also find the contents useful. As the title suggests, *this is a guide and the contents herein reflect firm guidelines for all to follow*. This residency program, however, is a vibrant and dynamic organization and therefore, the guide may change from time-to-time to reflect the fast pace of graduate medical education in the new millennium. *The program director or his designee may find it necessary to modify or otherwise alter this guide and such changes shall be construed to be in full effect when applied*. Comments and suggested changes to this guide should be forwarded to the program director through the chief resident or faculty mentor.

## II. Overall Goals

- A. Emergency Medicine (EM) is a distinct specialty that focuses upon the evaluation, diagnosis and stabilization of patients with acute illnesses or injuries. The Emergency Physician (EP) initiates treatment, involves consultants, makes disposition decisions and arranges appropriate follow-up for the patient discharged from the Emergency Department (ED).
- B. The [Residency Review Committee](#) (RRC) in the Program Requirements for Residency Education in Emergency Medicine states residencies in EM are designed to prepare physicians for the practice of Emergency Medicine by producing physicians trained to:
  - 1. Provide the recognition, resuscitation, stabilization, evaluation, and care of the full range of patients who present to the emergency department
  - 2. Apply critical thinking to determine the priorities for evaluation and treatment of multiple emergency department patients with different complaints and needs
  - 3. Arrange appropriate follow-up or referral as required
  - 4. Manage the out-of-hospital care of the acutely ill or injured patient
  - 5. Participate in the administration of the emergency medical services system providing out-of-hospital care
  - 6. Provide appropriate patient education directed toward the prevention of illness and injury
  - 7. Engage in the administration of emergency medicine
  - 8. Teach emergency medicine
  - 9. Understand and evaluate research methodologies and their application
  - 10. Understand and apply the principles and practice of continuous quality improvement
  - 11. Manage resource utilization effectively
  - 12. Utilize information resources effectively and apply evidence-based medicine to update their clinical practice
  - 13. Communicate effectively with patients, families, and health-care professionals
  - 14. Utilize resources to address domestic violence and other public health issues, including violence prevention

15. Demonstrate the fundamental qualities of professionalism
  16. Demonstrate how optimal patient care is provided in the context of a larger health-care delivery system by effectively using system resources to support the care of patients
- C. Additionally, all graduates of the SAUSHEC EM Residency Program will be able to:
1. Practice effectively in all areas of the [Model of Emergency Medicine Clinical Practice](#).
  2. Obtain maximal performance on the [American Board of Emergency Medicine](#) (ABEM) certification exam.
  3. Develop the foundations of professional self-development and utilize the principals of academics and research to build a career based on life-long learning.
- D. [ACGME Competencies](#). The ACGME has a requirement that all residents be competent in six key spheres of medical practice. The residency program endeavors to integrate the six competencies into the educational milieu. This is what the ACGME says about the six competencies:
- “The residency program must require that its residents obtain competence in the six areas listed below to the level expected of a new practitioner. Programs must define the specific knowledge, skills, behaviors, and attitudes required and provide educational experiences as needed in order for their residents to demonstrate the following:”
1. *Patient care* that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health.
  2. *Medical knowledge* about established and evolving biomedical, clinical, and cognate (eg, epidemiological and social-behavioral) sciences and the application of this knowledge to patient care.
  3. *Practice-based learning and improvement* that involves investigation and evaluation of their own patient care, appraisal and assimilation of scientific evidence, and improvements in patient care.
  4. *Interpersonal and communication skills* that result in effective information exchange and collaboration with patients, their families, and other health professionals.
  5. *Professionalism*, as manifested through a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population.
  6. *Systems-based practice*, as manifested by actions that demonstrate an awareness of and responsiveness to the larger context and system of health care and the ability to effectively call on system resources to provide care that is of optimal value.
- E. Subspecialties in Emergency Medicine. [The American Board of Medical Specialties](#) recognizes the following official subspecialties of emergency medicine:
1. Toxicology
  2. Hyperbaric and Undersea Medicine
  3. Pediatric Emergency Medicine
  4. Sports Medicine
  5. Emergency Medical Services and the related field of disaster medicine are not official subspecialties (yet) but remain among the most popular fellowships in emergency medicine.
  6. Fellowships in research, administration, faculty development and traumatology offer additional avenues to explore emerging subspecialties in EM.
- F. Educational Environment
1. A residency program is a post-doctoral professional educational endeavor. Its success relies on the collaborative and collegial relationship between faculty and residents.
  2. The resident is fully responsible for his or her education. Success or failure is dependent on the attitude, motivation, effort and skill and knowledge of the resident.
  3. The program, in turn, is responsible for providing a structured environment to facilitate learning and for ensuring competency. The rules in this guide and elsewhere are in place to meet these responsibilities.
  4. Residents are expected to abide by these rules as if they were their own. Furthermore, as they progress in the program, residents are expected to take a sense of ownership of the program and work to improve and strengthen it.

### III. Organization and Structure of the Residency

#### A. SAUSHEC

1. SAUSHEC or the [San Antonio Uniformed Services Health Education Consortium](#) is the umbrella organization for this and all other military-affiliated graduate medical education programs in San Antonio. SAUSHEC members are BAMC and WHMC. SAUSHEC maintains a formal relationship with the [University of Texas Health Sciences Center at San Antonio](#) (UTHSCSA) and shares a number of programs with the university.
2. The Dean, SAUSHEC is the executive in charge of SAUSHEC. The Dean reports to the commanders of BAMC and WHMC.
3. The Directors of Medical Education at BAMC and WHMC are dual-hatted as Associate Deans of SAUSHEC.
4. SAUSHEC has a Graduate Medical Education Committee composed of the Dean and Associate Deans, Program Directors and resident representatives. The GMEC is responsible for all formal institutional and resident actions including graduation, probation and termination. The GMEC meets monthly on the 3<sup>rd</sup> Thursday of the month (except May and December). The site alternates between BAMC and WHMC.

#### B. The Emergency Medicine Residency Program ([see organizational chart](#)) is a joint effort of BAMC and WHMC Departments of Emergency Medicine.

1. The Program Director is appointed by both commanders of BAMC and WHMC at the recommendation of the Dean. The Associate Program Director is appointed by the Dean. Both the PD and APD share responsibility for directing the program. The program directors are responsible for all aspects of the residency and are accountable to the Dean, SAUSHEC.
2. The chief and chair of the Departments of Emergency Medicine at BAMC and WHMC are also leaders in the residency program and share important responsibilities with the program directors on issue of faculty selection, development and educational support and infrastructure of the program.
3. The EM Education Committee is composed of the PD, APD, Department Chiefs/Chairs, ED Service Chiefs, Curriculum Director, Research Director, and Chief Residents. All faculty are invited to participate in all regular monthly meetings. The residency coordinators attend for meeting support and input. The EM Education Committee meets monthly on the same day as the GMEC (see above) and is charged with discussing key residency and resident issues and for making recommendations to the program and associate program director.

#### C. BAMC and WHMC Departments of Emergency Medicine

1. The emergency medicine services at both BAMC and WHMC are organized as full departments within their respective hospitals, affording a status similar to medicine, surgery and other traditional specialties. The mission of each department is to provide emergency medical care to active duty, family members and retirees in our catchment area.
2. In addition to this mission, the departments provide trauma care as part of the south Texas trauma consortium, provide care to selected civilian emergencies such as cardiac arrests that occur nearby, disaster preparedness for the facility and installation, and of course education and training. It is this latter mission that is the focus of the residency.
3. Recently, another mission of the departments has come to the forefront – providing professional staffing for the Army and Air Force operational and deployed forces. This crucial mission represents the core of what makes military medicine special and serves a reminder of the importance of the work that everyone in uniform performs.

#### D. The [Accreditation Council of Graduate Medical Education](#) (ACGME)

1. The ACGME is the accrediting body for all graduate medical education in the military and most civilian programs. The ACGME sets general and specific rules for all residencies to follow.
2. The general rules affect all residencies and are usually administered at the institutional level. The SAUSHEC policies on resident due process and grievances reflect the mandates of the ACGME as implemented by SAUSHEC.
3. The specific rules for each of the specialty residencies and fellowships to follow are promulgated by the Residency Review Committees (RRCs). Each specialty (eg, emergency

medicine) has a separate RRC. The ACGME and RRC rules are published in a thick manual referred to as the "Green Book."

4. The ACGME, through its RRCs, accredits the program. Accreditation status is vital for graduates because the program must be accredited at the time of graduation for graduates to sit for the ABEM certification exam. The ACGME typically reviews programs every 1-5 years, with the interval proportional to the RRCs assessment of the program strength and stability.
5. The ACGME requires the following outcome projects be incorporated by residency programs. The SAUSHEC Emergency Medicine Residency is actively implementing these changes in accordance with the ACGME plan. The program measures these competencies using multiple methods. See the program's [competency evaluation matrix](#) for details.
  - a) Educational Program
    - (1) The residency program must require its residents to obtain competencies in the 6 areas below to the level expected of a new practitioner. Toward this end, programs must define the specific knowledge, skills, and attitudes required and provide educational experiences as needed in order for their residents to demonstrate:
    - (2) Patient Care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health
    - (3) Medical Knowledge about established and evolving biomedical, clinical, and cognate (eg, epidemiological and social-behavioral) sciences and the application of this knowledge to patient care
    - (4) Practice-Based Learning and Improvement that involves investigation and evaluation of their own patient care, appraisal and assimilation of scientific evidence, and improvements in patient care
    - (5) Interpersonal and Communication Skills that result in effective information exchange and teaming with patients, their families, and other health professionals
    - (6) Professionalism, as manifested through a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population
    - (7) Systems-Based Practice, as manifested by actions that demonstrate an awareness of and responsiveness to the larger context and system of health care and the ability to effectively call on system resources to provide care that is of optimal value
  - b) Evaluation
    - (1) Evaluation of Residents
      - (a) The residency program must demonstrate that it has an effective plan for assessing resident performance throughout the program and for utilizing assessment results to improve resident performance. This plan should include:
      - (b) Use of dependable measures to assess residents' competence in patient care, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice
      - (c) Mechanisms for providing regular and timely performance feedback to residents
      - (d) A process involving use of assessment results to achieve progressive improvements in residents' competence and performance
      - (e) Programs that do not have a set of measures in place must develop a plan for improving their evaluations and must demonstrate progress in implementing the plan.
      - (f) The program uses multiple complementary methods to measure resident competency ([see competency evaluation matrix](#)).
  - c) Program Evaluation
    - (1) The residency program should use resident performance and outcome assessment results in their evaluation of the educational effectiveness of the residency program.
    - (2) The residency program should have in place a process for using resident and performance assessment results together with other program evaluation results to improve the residency program.
    - (3) The program has an extensive array of methods to provide program evaluation. See the [internal program evaluation matrix](#) for details.

## IV. Responsibilities and Supervision

### A. Responsibilities and Duties in the ED

#### 1. Pre-shift responsibilities

- a) The EM-1 or off-service R-1 should arrive in time to begin clinical duties at the time of shift change. At BAMC, the EM-1 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 EM-1 or R-1 will report the findings to the faculty coming on shift.
- b) The EM-2 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 EM-3 should arrive in time to coordinate administrative aspects such as divert status, bed status, and general situational awareness in the ED.

#### 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-coming 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 physicians 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, students and physicians' assistants, have been checked out to the on-coming residents. Ideally, the off-going resident should 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 (eg, 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 on-coming resident must write an acceptance 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 the 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) When the chart is first picked up, be sure to stamp (preferred) or print your name on the chart so the clerical and nursing personnel will be able to identify the provider.
- d) All charts must clearly identify (using a stamp or legible printing) the primary ED provider for the patient, whether that is a medical student, EMPA, or resident.
  - (1) Also, clearly identify the supervisor primarily responsible for staffing the patient (eg, the EM-3).
  - (2) Finally, identify the faculty physician of record on the chart.
  - (3) All this name identification is important to fulfill the hospital's obligation to patient safety and trainee supervision.
- e) In most cases, consultations are accomplished electronically using CHCS. Certain emergent and 72 hour consultations require the completion of an SF 513 (Consultation

Form). Recognize that in most cases, a 72 hour consult requires telephonic approval from the consulting service.

- f) Residents should never take the SF 558 (ED Treatment Record), dictations or any other medical records away from the ED.
  - g) Generally, patients are not given a copy of their ED record such as 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.
  - h) 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 EM-2 and EM-3 residents are required to dictate their charts. EM-1 residents after their second ED block will dictate their charts. A template has been developed to aid dictation.
  - i) Diagnoses and procedures should be documented on the ED record. No abbreviations are to be utilized. List diagnoses by order of priority (most serious first). Symptoms may be preferred method of documenting the diagnoses, eg, Acute Febrile Illness as opposed to streptococcal pharyngitis.
4. Interaction with nursing and ancillary personnel
- a) Efficient functioning of the ED requires cooperation of the physicians, nurses, medics, clerical staff, as well as ancillary support services such as laboratory and radiology personnel.
  - b) Residents are expected to behave in a professional manner during interaction with hospital personnel.
  - c) Any perceived problems with the behavior or performance of hospital personnel should be dealt with professionally and brought to the attention of the faculty physician on duty.
5. Interaction with consultants
- a) Effectively interacting with consultants is a vital skill of the successful emergency physician.
  - b) Each resident will have the opportunity to interact with consultants on a daily basis. Disagreements will arise. The EM resident should deal with them professionally and bring the issue to the attention of the senior resident and faculty. Generally speaking, junior residents should involve their senior resident who, in turn should deal with his/her peer on the involved service. The ED faculty should allow the senior resident to resolve issues. If faculty involvement is deemed necessary then the ED faculty should interact with the involved service faculty and in most instances refrain from interacting directly with the residents of another service.

## B. Supervision

1. This policy is in compliance with the following rules and regulations:
  - a) BAMC and WHMC Bylaws
  - b) Army Regulations 40-48, 40-66, and 40-68
  - c) USAF 59<sup>th</sup> Medical Wing Instruction 44-71 "Physician and Dental Trainee Supervision by Credentialed Staff Providers"
  - d) JCAHCO Standards MS 2.5, MS 6.9, MS 6.9.1
  - e) [SAUSHEC Resident Supervision Policy](#)
  - f) 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 or WHMC Department of Emergency Medicine and who are under the supervision and control of the faculty (attending) emergency physician or faculty EMPA.
  - g) It is SAUSHEC policy that any resident involved in a medicolegal or risk management case will notify the program director.
    - (1) In most cases, this can be through routine notification.
    - (2) The purpose is to ensure that the medicolegal or RM case is conducted in the context of the residency program and that the resident's due process rights are protected.
2. Presenting patients
  - a) Medical Students

- (1) Will present all 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.
  - (2) 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 for continuity of care and supervision. Students should clarify to whom they should present patients with the senior and faculty before the beginning of the shift.
- b) EM-1, R-1 and EMPA residents
- (1) Will present all 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 EM-1, R-1 and EMPA residents should immediately present the patient to the senior or faculty.
  - (2) Early in the year EM-1s, 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 EM-1, R-1 or EMPA resident 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 for continuity of care and supervision. EM-1s, 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) EM-2 and EM-3 Residents
- (1) Will formally present their uncomplicated patients to the senior resident or faculty physician when the final treatment plan and disposition are being formulated. However, it is proper practice to keep them informed of the medical management as it progresses.
  - (2) Complicated patients or potentially unstable patients should always be brought to the attention of the senior resident or faculty early in the ED course.
- d) Cosignature
- (1) 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.
  - (2) All charts of patients seen by EM-1s and rotating interns, must be reviewed and must have a note written by and signed by the senior resident on duty or faculty prior to the patient's disposition.
  - (3) 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.
  - (4) 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. The faculty of record will be identified by name on all charts.
  - (5) All charts of patients being transferred or admitted must be cosigned 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) In addition to signature, each chart should have the printed or stamped name of the following (as applicable):
    - (a) Primary provider seeing the patient (e.g. medical student or EM-1)
    - (b) Immediate supervisor (e.g. senior resident)
    - (c) Faculty of record (the faculty in charge at the time of primary assessment and medical decision making.
    - (d) If a provider performs an invasive procedure, then a signed procedure not should be documented.
    - (e) If a patient is in the ED through a shift change, then both pre- and post-shift change personnel will be clearly identified.

- (7) All this identification and signing of the chart is necessary to execute the professional obligations of medical care and to assure full compliance with pertinent regulations.
- (8) Note that the faculty documentation requirements shown above reflect minimums from a GME and patient safety perspective. Requirements for billing may be different than outlined here.
- e) Chart reviews
  - (1) 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.
  - (2) 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.
- f) *It is the residents responsibility to notify the senior resident and faculty immediately:*
  - (1) *Upon the arrival, by walk-in or ambulance, of any critically ill patients*
  - (2) *Upon notification of any patient arriving by ambulance*
  - (3) *Upon the arrival of any patient arriving from another clinic or location within the hospital*
  - (4) *Upon the need for sedating or vasoactive medications*
  - (5) *Of their interpretation of x-rays and EKG's*
  - (6) *Upon the need for and prior to consultations*
  - (7) *Prior to calling the consultant for admission*
  - (8) *Prior to any invasive procedures*
  - (9) *Prior to transfer to another facility*
  - (10) *Concerning any patient that refuses medical care or wishes to leave against medical advice*
  - (11) *Concerning any patient that has an adverse reaction or complication of any medication administered or procedure performed in the ED*
  - (12) *About all patients that are dissatisfied or disappointed in their ED treatment*
- C. Progression of Responsibility
  - 1. Medical Students
    - a) All patient encounters and significantly invasive procedures and exams (e.g., pelvic exam) performed by medical students assigned to the ED will be supervised by the senior resident on duty or the faculty physician.
    - b) All orders will be reviewed and approved by the supervisor prior to implementation by the nursing staff.
  - 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-1 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 EM-2 will also evaluate the patients should their condition change. EMPA residents will not normally be responsible for the OU patients.
    - d) Will not provide medical direction to EMS or out-of-hospital personnel except under direct supervision.
  - 3. EM-2
    - a) The EM-2 ED rotations are designed to allow progressive responsibility in the ED while under the guidance of the EM-3 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) Keep the EM-3 resident and/or faculty apprised of the clinical status of his/her patients and immediately bring administrative problems to the attention of the supervising EM-3. This mandates an intimate knowledge of patients waiting to be seen, as well as waiting times.
  - c) The EM-2 may preferentially staff cases with the faculty. This should be arranged at the beginning of the shift. The EM-2 will still keep the EM-3 informed of his or her patients. This allows the EM-3 to fulfill their role in running the ED.
  - d) During the second half of the academic year, from the 0200 to 1000 daily, the EM-2 assumes the role of the supervisory EM resident ("senior resident") and is responsible for the overall functioning of the department. (See EM-3 below for roles and responsibilities)
  - e) Manage the airway for all resuscitations between 1000 and 0200.
  - f) Provide direct medical direction for EMS and out-of-hospital personnel (e.g., answer the trauma phone).
  - g) Acting as an advisor to the rotating interns and EM-1s for patients in the ED.
  - h) To act as second in command during resuscitations as supervised by the EM-3, and manage the airways on resuscitations.
4. EM-3
- a) The EM-3 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 EM-3 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 EM-3 is expected to know the status of all patients in the ED at any time period.
    - (1) The EM-3 (or EM-2 serving in the role of senior resident in the ED) will keep the faculty informed of all patient dispositions, whether it is discharge, consultation, or admission.
    - (2) The role of the senior resident is to run the ED, supervise and teach junior residents, students and PAs, and to keep the faculty informed.
  - 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 EM-3 will be the primary consultant for, and verify history and physical findings of, all junior housestaff unless otherwise agreed upon by the faculty and EM-3 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 EM-3 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.

**Summary Of Supervision and Responsibility of Trainees And Supervisors In the Emergency Department.**

[Note that the documentation requirements shown in these tables reflect minimums from a GME and patient safety perspective. Requirements for billing may be different than depicted here.]

Level	Key Aspects of Supervision
Medical Student	<ul style="list-style-type: none"> <li>• Early presentation of all patients to senior resident (SR) or faculty</li> <li>• SR/faculty will examine all patients</li> <li>• All orders formally approved by SR/faculty</li> <li>• SR/faculty will write separate note and sign chart</li> <li>• Faculty will cosign all charts</li> </ul>
PA (Basic Skills)	<ul style="list-style-type: none"> <li>• Early presentation of all patients to SR/faculty/EMPA faculty</li> <li>• SR/faculty/EMPA faculty will examine all patients</li> <li>• All orders formally approved by SR/faculty/EMPA faculty</li> <li>• Faculty/EMPA faculty will cosign all charts</li> </ul>
EMPA Resident	<ul style="list-style-type: none"> <li>• Early presentation of all patients to SR/faculty/EMPA faculty</li> <li>• SR/faculty discretion to discuss case and see patient</li> <li>• SR/faculty/EMPA will write separate note and sign chart</li> <li>• Faculty will cosign all charts</li> </ul>
EM-1 R-1	<ul style="list-style-type: none"> <li>• Early presentation of all patients to SR or faculty</li> <li>• SR/faculty discretion to discuss case and see patient</li> <li>• SR/faculty will write separate note and sign chart</li> <li>• Faculty will cosign all charts</li> </ul>
EM-2	<ul style="list-style-type: none"> <li>• Presentation of all patients to SR or faculty prior to disposition</li> <li>• SR/faculty discretion to discuss case and see patient</li> <li>• SR/faculty discretion to write separate note, but will sign chart</li> <li>• Faculty will cosign all charts</li> </ul>
EM-3	<ul style="list-style-type: none"> <li>• Presentation of all patients to faculty prior to disposition</li> <li>• Faculty discretion to discuss case and see patient</li> <li>• Faculty discretion to write separate note</li> <li>• Faculty will cosign all charts</li> </ul>

Level	Key Aspects of Supervisory Responsibility
Senior Resident (EM-3s, and EM-2s on selected shifts)	<ul style="list-style-type: none"> <li>• Run the ED</li> <li>• Be responsible for overall care of all patients in the ED</li> <li>• Supervise and teach all juniors</li> <li>• Keep faculty informed of all patient dispositions</li> <li>• Write notes on all patients seen</li> <li>• Faculty will cosign all charts</li> </ul>
Faculty	<ul style="list-style-type: none"> <li>• Oversight responsibility for all trainees and patients in ED</li> <li>• Supervise and teach all trainees</li> <li>• Faculty will cosign all charts</li> </ul>

D. Licensure and Institutional Permits

1. The DOD policy, as mandated by the US. 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.
2. All EM residents will be required to have an Trainee Institutional Permit issued by the [Texas State Board of Medical Examiners](#) prior to rotating at non DOD institutions in the state of Texas, and is therefore an affirmative requirement of the program. Residents are expected to maintain a current Trainee Institutional Permit during the entire period of residency training. Residents with a current medical license from Texas are exempt from the TIP requirement.
  - a) EMPA residents will maintain [NCCPA](#) certification at all times.
  - b) Residents, as providers in the institution, have an affirmative obligation to maintain currency in certain areas of qualification, to include those listed below.
    - (1) CPR-BLS
    - (2) ACLS
    - (3) Annual clinical or safety requirements of the institution(s)
  - c) Residents failing to attain or maintain these requirements may be administratively removed from clinical duties. Any time lost from the program as a result will have to be made up, and the resident may be subject to formal counseling and other actions.

E. 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 for the faculty to evaluate at least one resident on their shift. Faculty may also elect to complete additional shift evaluations on any shift, and are encouraged to do so to document specific strengths or deficiencies noted in a resident's performance.
  - b) The EM-2 or EM-3 resident serving as the senior resident in the ED is also encouraged to evaluate the junior residents on shift using a shift evaluation form. Completion of such forms will always be done in coordination with the faculty.
  - c) The shift evaluations form the core of the continuous clinical evaluation process for all residents in the program. The collation and scoring of multiple shift evaluation reports over time gives an excellent perspective on the resident's performance in the ED. This continuous summation of focused evaluations is superior than the traditional summative evaluation provided at the end of a given block.
  - d) During selected EM blocks the resident will meet with the Program Director and the Associate Residency Directors for a formalized periodic [summative evaluation](#) based on ED shift evaluations, outside rotation evaluations, test results, research progress, and lecture evaluations. The goal is for each resident to have at least 2-3 summative evaluations per year. A form is completed during each evaluation and maintained in the residents file.
  - e) During most evening shifts at WHMC and selected day shifts at BAMC the EM-1 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 EM-1 and evaluating his/her performance. The goal of the focused faculty shift evaluation is primarily educational. The EM-1 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 EM-1's progress. The goal is to have each EM-1 have 2 such shifts per ED block.
  - f) 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. This is DA Form 1970 and AF Form 494.
  - g) After each procedure, each resident should ensure that the supervisory faculty completes a procedure evaluation form specific to the procedure performed.
  - h) PA Residents will be required to have 2-3 evaluations by SR or staff during their ED rotation
2. Evaluation of off-service residents and students

- a) Residents from off services (e.g., R-1s from the transitional program) will have the same general evaluation requirements as the EM residents (above) but will use a separate evaluation form.
- b) Medical students will have the same general evaluation requirements as the EM residents (above) but will use a separate evaluation form.

## V. Faculty

- A. The successful operation of a residency training program in EM is predicated upon the close involvement of its faculty members. While functioning as a "quality care coordinator" for the services provided within the ED, the faculty must also fulfill a number of critical roles to facilitate the transfer and integration of the concepts involved in emergency medicine to the housestaff. Although variance of style and technique is anticipated and even encouraged, there remain certain constants necessary to fulfill the role of faculty physician. These include resident supervision, formal and informal teaching, and involvement in professional and scholarly activities expected of the academic emergency physician.
- B. Responsibilities of supervision
  - 1. Faculty should be thoroughly familiar with the supervision guidelines as outlined in the Responsibilities and Supervision section, above, as well as BAMC/WHMC and SAUSHEC policies on supervision.
  - 2. IAW the [SAUSHEC Supervision Policy](#) and BAMC/WHMC bylaws, faculty remain ultimately responsible for their patients. Due diligence in supervision is required to execute this responsibility. Faculty supervision does not relieve the resident or student of the responsibility for adequate performance at their level of training nor does it relieve the resident of providing the faculty with timely information on the status of the patients. It does, however, serve to recognize the faculty as the "attending physician of record" with all the rights and responsibilities thereof.
    - a) It is SAUSHEC policy that any resident involved in a medicolegal or risk management case will be communicated to the program director.
    - b) In general, this is defined as official risk management or legal cases where the resident is in jeopardy (as opposed to a mere witness) as a provider, or in cases of patient complaints that have escalated beyond routine channels, and similar events.
    - c) In most cases, program director notification can be through routine means, e.g., a note or email. If necessary, urgent contact is always available.
      - (1) The purpose is to ensure that the medicolegal or RM case is conducted in the context of the residency program and that the resident's due process rights are protected.
      - (2) As a general rule, the attending physician will be the responsible party for these cases, unless the resident acts in a reckless manner or demonstrates disregard for policy or procedure.
  - 3. All faculty must be available for consultation at all times when assigned duty in the ED. Physical presence at the bedside as appropriate is necessary to provide an opportunity for the direct observation of resident history, exam skills and timeliness of therapeutic interventions.
  - 4. Particularly in the EM-1 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, multitasking and efficiency are the more difficult aspects of emergency medicine to teach. It is vitally important that the faculty observe the resident's actions while they are not with their patients to identify habits that are inefficient.
  - 5. The name of the faculty supervising the case, as well as any intermediate supervisors (e.g. EM-3) should be clearly identified on the chart.
  - 6. Every effort should be made to observe the residents performance in obtaining the history and completing a physical exam. Commonly this occurs as a comparison of the faculty's findings to the resident's in separate interviews. Particularly in the EM-1's, 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.

C. Evaluation of resident performance

1. 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.
2. Each faculty will submit one written [shift evaluation form](#) to the Residency Coordinator for each shift the faculty works. 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.
3. Residents (EM-2 or EM-3) serving in the role of senior resident in the ED may complete a shift evaluation form also. This must be coordinated with the faculty to ensure consistency and relevancy.
4. 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.
5. 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.
6. 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.
7. Each faculty member must be physically present for all resuscitations until the stability of the patient is assured and all procedures are completed.
8. Charts written by medical students must be reviewed and co-signed by the faculty prior to the patient's disposition even if the EM-3 or EM-2 was primarily providing the supervision support. (see charting section earlier)
9. Charts 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.
10. 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.
11. As part of the [ACGME's competency project](#), residents can ultimately expect a 360-degree evaluation process. That is, residents will be evaluated from all angles, including
  - a) [Shift evaluations](#) from faculty and senior residents
  - b) [Self evaluations](#)
  - c) [Peer evaluations](#)
  - d) Nursing and ancillary staff evaluations
  - e) Patient evaluations

D. Mentors

1. Each resident will be assigned a [faculty mentor](#).
2. The mentor is responsible for regularly meeting with the resident to discuss issues of academic performance, professional development and wellness.
  - a) The mentor serves as a resource for the resident for advice, guidance and support.
  - b) The mentor may also be called on to serve as a teacher and counselor for formal or informal remediation.
3. Regular contact (in person, formally or informally, or by telephone/email, as appropriate) is essential for the mentoring process.
  - a) During the EM-1 year, mentors should make contact at least every 6 weeks or so with their assigned resident.

- b) During the EM-2 and EM-3 years, the contact can be less frequent and may be on an ad hoc basis, with the goal of contact at least once per quarter.
- E. Evaluation of Faculty
- 1. At least yearly, residents are required to complete [faculty evaluation forms](#). This is a vitally important tool that the faculty and EM Department Chiefs can use to ensure each faculty is performing maximally.
  - 2. There are multiple mechanisms in place ensuring that the forms remain anonymous. These forms will always be completed in a professional, independent, and constructive manner.

## VI. Resident Rotations

- A. Length of Program
- 1. The SAUSHEC Emergency Medicine Residency Program is 3 years (36 months) in length.
  - 2. The full length of the program must be completed before graduation can be certified.
    - a) Residents not completing 36 months of accredited emergency medicine training cannot graduate.
    - b) The 36 months must be graduated, i.e. the training must be progressive. Repeated training does not count.
    - c) Residents who miss training as a result of voluntary or involuntary leaves of absences, illnesses, convalescent leave, or other causes of missed or incomplete training, or who fail one or more blocks of training, will be required to make the missed experience up. This may result in an extension of training.
      - (1) Ordinary leave (vacation) up to 3 weeks each year is accounted for in this program and does not ordinarily count as missed training.
      - (2) However, under no circumstances can a resident receive credit for a year of training unless the resident spends at least 46 weeks in training. This is an ABEM rule. This program is authorized to uphold a more stringent rule and all missed training is subject to make-up.
    - d) Residents with prior GME training may request a variation in the sequence or content of one or more required blocks. The replacement experience will be of an equivalent or greater educational value than the required block. All variances require program director approval. The following rules apply:
      - (1) New EM-1s just graduating from an internship may be granted variations for one or two EM-1 off-service blocks (e.g., a medicine intern may be able to replace ward medicine with a rotation in ICU or EM).
      - (2) New EM-1s who graduated from an internship or have other GME training greater than one year ago generally will be required to complete the regular curriculum without substitution.
      - (3) Residents with recent (last several years) training and certification in an ABMS specialty have achieved a recognized level of expertise and may request variances in selected off-service rotations in the EM-1, EM-2 or EM-3 year commensurate with their documented education.
- B. Educational Philosophy
- 1. Emergency medicine rotations
    - a) There are several types of emergency medicine rotations
      - (1) ED rotations at BAMC and WHMC
      - (2) ED rotations at UTHSCSA and Brackenridge (Peds EM)
      - (3) Trauma-Critical Care at UTHSCSA
      - (4) EM Administration
      - (5) EMS
      - (6) Operational Emergency Medicine at CCRC - USUHS
      - (7) Toxicology
    - b) The focus of these rotations is to build a foundation for professional emergency medicine practice. Residents are expected to be proactive in learning the art and science of

emergency medicine and to attain a degree of proficiency in the profession so as to perform in an unsupervised setting on graduation.

- c) Residents will be held to the high standards of the program and will be closely evaluated by the faculty and senior residents.
- 2. Off-Service Rotations
  - a) There are a number of off-service rotations including:
    - (1) Medicine
    - (2) Surgery
    - (3) MICU, CCU
    - (4) PICU, SICU
    - (5) Anesthesia
    - (6) ObGyn
  - b) The focus of these rotations is severalfold.
    - (1) To obtain clinical experiences not easily obtained in the ED. For example, routine intubations on anesthesia, and deliveries on ObGyn.
    - (2) To become familiar with the practices and priorities of the off-service. In other words, to learn the language and nuances of the consultants that we interact with all the time for the benefit of our patients. This is particularly true for medicine and surgery, and the importance of this experience should not be underestimated.
    - (3) To explore new ways to approach problems that you may encounter in the ED. Specialists have a great deal to teach and their experiences and knowledge should be readily sought. Learn how the anesthesiologists perform procedural sedation in the OR and how the orthopedist splints a fracture in the cast room or ED.
  - c) To this end, residents are expected to participate in the full range of experiences offered on the off-service rotation. Become a full-fledged member of the team and avoid focusing on just those pieces that are perceived to be of direct value to your EM education. Go to the OR on surgery, attend clinic on medicine, and do pain management on anesthesia. A well-rounded physician needs a broad-based education and the time to get it is during residency.
- 3. To ensure the continued value of off-service rotations and to evaluate the educational effectiveness of the program, residents have an obligation to complete [Evaluation of Off-Service Rotation Form](#) following each and every off-service rotation they perform. This information is key to ensuring the highest quality education for all residents.
- C. The Academic Block Schedule
  - 1. The [academic block schedule](#) or “master matrix” is developed each Spring by the program director, residency coordinator and the chief resident selects with the input of the faculty and residents.
  - 2. The schedule is fully integrated and changes must be made with due consideration of the impact on the operation of the EDs and the education of all residents. Use a [Request for Schedule Change Form](#) for all changes will be approved by the program director and recorded by the residency coordinator.
- D. The EM-1 year

The EM-1 will be scheduled for the following rotations:

Orientation	EM	EM	EM	EM
EM	Medicine BAMC/WHMC	MICU BAMC/WHMC	Surgery BAMC/WHMC	CCU BAMC
Anesthesiology BAMC/WHMC	Orthopedics UTHSC EM	Research (1/2 block)	EM (1/2 block)	

The EM-1 year emphasizes the development of didactic and practical skills necessary for the evaluation, stabilization, and disposition of the emergency patient.

1. The ED rotations are designed to maximize exposure to a wide variety of medical and surgical illnesses/injuries in order to develop necessary differential diagnostic and therapeutic intervention skills. Supervision will be tiered with the senior resident (EM-3 or EM-2) on duty in the ED serving as the initial resource and complemented by the supervisory faculty physician.
  - a) During each block there are specific readings assigned (see enclosure) and a monthly quiz (discussed in more detail in the section on didactics).
  - b) Proper ED charting will be emphasized from both a medical and legal standpoint with a 100% chart review format by the supervisory faculty physician.
2. Technical skills will be covered through the following:
  - a) Life Support lab (procedure lab) during the orientation month and on the first Monday of each block when the EM-1 is scheduled in the ED during the year.
  - b) Bedside teaching and supervision by the more senior housestaff and faculty physicians. During the EM-1 year emphasis will be placed on the procedural aspects of resuscitation.
3. Teaching skills will be developed through:
  - a) In-service type lectures to the medics, technicians and prehospital care providers.
  - b) Participation in [Morning Report](#)
  - c) At least one [Grand Rounds Lecture](#) per year.
4. Off-service rotations are designed to provide maximal exposure to targeted patient subpopulations and develop general medical knowledge. Specific didactic and procedural [goals and objectives](#) have been developed for each of these rotations. A supplemental reading list has been generated for each rotation.
5. Specific duties include:
  - a) Participating in and directing in-service programs as directed by the Chief Resident or senior resident.
  - b) Providing patient care as directed by the faculty, Chief Resident or senior resident.
  - c) Providing lectures as requested by the Chief Resident or EM faculty.
  - d) Accomplishing assigned shifts in the ED for those off-service rotations where no call or weekend duties are required.
  - e) Manage the airway during resuscitations from 0200-1000 during the latter half of the academic year.
6. Highlights of certain EM-1 rotations:
  - a) [Orientation](#) – The residency program is proud to offer a comprehensive orientation for all EM-1s during the first block. New residents receive didactics, labs, and introductory shifts during the block. Ample time is allotted for administration and other necessary activities that the new resident and active duty military officer faces. This unique opportunity is a major effort of the faculty and residents and represents the dedication and commitment to the finest emergency medicine training program in the military.
  - b) Orthopedics – This rotation focuses on basic emergency department orthopedics and is conducted at UTHSCSA in conjunction with the Division of Emergency Medicine. Residents historically are assigned to work in the ED 14 nine-hour shifts per block (10 if a week of vacation is taken).
  - c) Anesthesia – This rotation is directed toward basic airway management (intubation) and ventilation (bag-valve-mask) as well as procedural sedation and anesthesia pharmacology.
  - d) Research/EM – This rotation occurs during the winter holiday season and an effort is made to have all EM-1s on the rotation at the same time. A concentrated didactic session on research is conducted in concert with regular ED shifts.
  - e) Medicine, Surgery, MICU, and CCU – these rotations are conducted at both BAMC and WHMC and provide the EM-1 with the grounding necessary to become a broadly effective physician in emergency medicine.

E. The EM-2 year

The EM-2 will be scheduled for the following rotations:

<b>EM</b>	<b>EM</b>	<b>EM</b>	<b>EM</b>	<b>EM</b>
<b>EM</b>	<b>PICU</b> Santa Rosa	<b>Trauma-CC</b> UTHSCSA	<b>SICU</b> BAMC/WHMC	<b>OB/GYN</b> UTHSCSA
<b>EMS</b> Austin	<b>Peds EM</b> Brackenridge	<b>Community EM</b> UTHSCSA		

This year emphasizes continued mastery of the didactic and procedural skills needed to evaluate, stabilize, and formulate a disposition for ED patients. Emphasis will be placed upon multiple simultaneous patient evaluations and construction of the foundation of the supervisory/administrative aspects of managing an ED.

1. The EM-2 ED rotations are designed to allow progressive responsibility in the ED while under the guidance of the EM-3 and/or ED faculty. EM-2s focus on complex cases, effectiveness of care, multitasking, and efficiency. Triage, patient flow patterns, and disposition decisions will be emphasized.
2. Teaching skills will be developed through:
  - a) Bedside teaching of the junior housestaff
  - b) [Morning Report](#) presentations
  - c) At least one [Grand Rounds Lecture](#) per year.
  - d) In-service type lectures to the paraprofessional and nursing staff
  - e) Participation in ATLS-I, ACLS-I, and PALS-I courses will be encouraged.
3. Technical skills will be maintained and expanded through:
  - a) Participation in approximately six Life Support (procedure) Labs during the course of the year.
  - b) Bedside participation/teaching by the ED faculty (the EM-2 will perform procedures during a resuscitation at the direction of the EM-3 resident).
4. Specific duties, goals, and responsibilities are:
  - a) During the latter half of the academic year the EM-2 assumes the role of the senior EM resident from 0200 to 1000 and is responsible for the overall functioning of the department. (See EM-3 below)
  - b) Manage the airway for all resuscitations unless serving as senior resident/resuscitation team leader.
  - c) Acting as a consultant to the rotating interns (R-1s) and EM-1s for patients in the ED.
  - d) Solidify clinical and technical skills with particular emphasis on managing multiple patients simultaneously.
  - e) To provide bedside teaching to the more junior housestaff and ancillary personnel assigned to the ED.
  - f) To keep the EM-3 resident apprised of the clinical status of his/her patients and immediately bring administrative problems to the attention of the supervising EM-3. This mandates an intimate knowledge of patients waiting to be seen, as well as waiting times.
  - g) To act as second in command during resuscitations as supervised by the EM-3 and manage the airways on resuscitations.
  - h) To provide periodic in-service lectures, as assigned by the Program Director or Chief Resident.
  - i) To present at least one quality Grand Rounds lecture complete with handout.
5. Off-service rotations are designed to provide maximal exposure to targeted patient subpopulations and develop general medical knowledge. Specific didactic and procedural

[goals and objectives](#) have been developed for each of these rotations. A supplemental reading list has been generated for each rotation.

6. Highlights of certain EM-2 rotations:
  - a) PICU and SICU – These critical care rotations in the pediatric and surgical areas offer the EM-2 the opportunity to manage a wide variety of critically ill patients. These rotations are conducted at BAMC, WHMC, and [Christus Santa Rosa Hospital](#).
  - b) Pediatric EM – One of the few large emergency medicine-run pediatric EDs in the nation, the [Brackenridge Hospital](#) ED sees over 50,000 children per year. The residency maintains an apartment in Austin for use during this rotation. Residents historically are assigned to work in the Peds ED Sunday through Thursday 1200-2200.
  - c) EMS – A full block is devoted to this important subspecialty. The rotation is an evolving opportunity for an EMS experience in Austin. [Austin EMS](#) is an outstanding system and was recently showcased at the National Association Of EMS Physicians annual meeting for its effectiveness and innovation. The residency maintains an apartment lease in Austin.
  - d) Community EM – Residents work at a busy inner-city ED at UTHSCSA. This rotation offers unprecedented exposure to large volumes of very ill patients, many in the advanced stages of disease. Residents historically are assigned to work in the ED 18 twelve-hour shifts per block (14 if a week of vacation is taken).
  - e) ObGyn – Conducted at [UTHSCSA](#), this clinically-rich environment offers ample opportunity for deliveries and Ob ultrasound.
  - f) Trauma-Critical Care – This is a new rotation for academic year 2003-04. Exciting changes at [UTHSCSA](#) has allowed the development of an emergency-medicine directed experience in the largest trauma center in South and Central Texas.

F. The EM-3 year

The EM-3 will be scheduled for the following rotations:

EM	EM	EM	EM	EM
EM	EM	EM	OP EM CCRC	Toxicology NYC
EM Admin	Research	Elective		

This year emphasizes excellence in the clinical management of multiple patients, as well as affording an opportunity to master administrative skills and clinical areas with which the resident may feel uncomfortable. Contributions to the scientific community of EM will be encouraged through the fulfillment of research requirements. Finally, teaching responsibilities will be expanded. EM-3s are expected to actively participate in the academic enterprises of the residency. EM-3s may participate in additional research, BLS/ACLS/PALS/ATLS/BTLS instruction, EMS, Morning Report, committee activities or other areas of interest.

1. During ED rotations, the EM-3 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 EM-3 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.
2. Teaching skills will be developed through:
  - a) Bedside teaching of the junior housestaff.

- b) [Morning Report](#) presentations and as proctor of MR sessions.
  - c) At least two [Grand Rounds Lecture](#) per year.
  - d) In-service type lectures to the paraprofessional and nursing staff.
  - e) Participation in ATLS-I, ACLS-I, and PALS-I courses will be encouraged.
3. Off-service rotations are designed to provide maximal exposure to targeted patient subpopulations and develop general medical knowledge. Specific didactic and procedural [goals and objectives](#) have been developed for each of these rotations. A supplemental reading list has been generated for each rotation.
4. EM-3 duties, goals, and responsibilities include the following:
- a) Function as the overall manager of the entire ED/UCC system and will be responsible for its complete operation. The EM-3 is expected to know the status of all patients in the ED at any time period.
  - b) Be responsible for the evaluation and disposition of all patients, and in all resuscitations will serve as the resuscitation leader.
  - c) Act as consultant to the more junior residents concerning medical and administrative questions, SOP policies, etc.
  - d) The EM-3 will be the primary consultant for, and verify history and physical findings of, all junior housestaff unless otherwise agreed upon by the faculty and EM-3 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.
  - e) 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.
  - f) Train, organize, and teach pre-hospital providers as part of the "first response" team and be responsible for activation of mass casualty procedures while on duty.
  - g) Ascertain that SOPs and administrative policy are carried out to include transfer of patients, ambulance, VIPs, etc. The EM-3 is responsible for patient complaints during the shift, and should investigate and report them to the faculty on duty.
  - h) Discuss all admissions 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) Present two formal lectures complete with handout.
  - m) Participate as an instructor in at least 2 Lifer Support labs each year and participate in others that are scheduled throughout the year.
5. Highlights of certain EM-3 rotations
- a) Toxicology – This is a world-class rotation at the renowned [New York City Poison Control Center](#). Opportunities exist to interact with some of the most distinguished and internationally-recognized toxicologists in the world. With the war on terrorism and the increased awareness of the chemical warfare threat, toxicology is even a more important subspecialty than ever. The residency leases a modest but clean and comfortable apartment very close to the clinical rotation site.
  - b) EM Administration - This rotation introduces the EM-3 to the basics of ED management including customer service, complaint handling, scheduling, quality improvement and risk management. Additional duties include scheduling and conducting Morning Report and working up to 4 ED shifts. An administrative project is required to complete the rotation. An [Administration Rotation Form](#) has been developed to assist the resident in completing the requirements of the rotation.
  - c) Research – The residency believes that research is so important to the development of effective emergency physicians that a full block is devoted to the planning and implementing of a research project. This opportunity is rarely afforded to residents in other specialties or even in our own specialty, and reflects the value of research. This rotation will be front-loaded into the first half of the academic year to give senior residents

the opportunity to use the time to complete the projects that were initiated in the EM-1 year.

- d) Operational EM – This is a new rotation for AY 03-04. Conducted at the nationally-acclaimed [Casualty Care Research Center](#) of the Uniformed Services University of the Health Sciences in Bethesda, MD, the rotation offers unique experiences in operational medicine and tactical emergency medical support.
- e) [Elective](#) – This is an opportunity for senior residents to explore areas of emergency medicine that they feel will enhance their professional development. Guidelines for electives are as follows:
  - (1) Electives will be selected in conjunction with the program director and faculty mentor
  - (2) All key arrangements (see below) will be completed at least 30 days prior to the start of the elective
    - (a) Electives will generally be one block in length; leave is authorized if the elective is longer than 2 weeks.
    - (b) Resident will submit the following documents for approval:
      - (i) Goals and objectives of the elective
      - (ii) Evaluation plan
      - (iii) Funding and travel plan if out-of-town or if funding is required
      - (iv) Appropriate memoranda of agreements, properly executed and signed, if needed (required for any elective conducted at a civilian institution not affiliated with SAUSHEC; may be required for some federal entities as well).
  - (3) Certain military courses (e.g. flight surgeon course or hyperbaric medicine) may be used as an elective.
    - (a) Course must grant sufficient category I AMA CME credit (or the equivalent) to warrant its use as an academic elective.
    - (b) Funding for such courses is very limited, if available at all from the residency. Central funding is highly encouraged and must be secured by the resident.
  - (4) Nonacademic electives (e.g., EFMB or airborne school) are not authorized as electives. However, they will be considered on a case-by-case basis under the following conditions:
    - (a) Approval is based on merit and is at the discretion of the Program Director
    - (b) Arranged by resident so there is no interference with required clinical and academic duties. Since the activity will not fulfill elective requirements, the resident must still arrange an elective rotation.
    - (c) Funding is generally not available but will not exceed \$200 if program monies are used.
- f) Senior Resident CME Conference
  - (1) It is the goal of the program to send all senior residents in good standing to a national conference such as [SAEM](#) or [AAEM](#).
  - (2) Depending on funding, all or a portion of the conference and preconferences may be offered.
    - (a) Seniors will attend as a class a conference selected by the Program Director, normally in the Spring of the academic year.
    - (b) The purpose of the conference is to:
      - (i) Expose the residents to high quality CME offerings of the specialty in preparation for life-long learning and continuous certification
      - (ii) Introduce the residents to national-level educational material
      - (iii) Allow the residents to meet and interact with national leaders in emergency medicine.

#### G. Chief Residents

- 1. Certain EM-3s will be selected to serve as Chief Residents.
  - a) Chief Residents will be selected in the second half of their second year of residency, usually in the month of March. Usually 6 will be selected. However, fewer chief residents can be selected as determined by the needs of the program. While it is a goal to achieve a balance between Army and Air Force chief residents, the actual selections will be

determined primarily on the strength and merits of the candidates and the needs of the program.

- b) All second year residents in good standing within the program are eligible for consideration.
  - c) A secret ballot vote will be conducted amongst the current first and second year residents. The Program Director will solicit the staff at both WHMC and BAMC for their input. The Program Director will then determine the selection of Chief Residents based on the input received.
  - d) The Program Director will announce the Chief Residents at the appropriate time, usually in early April.
  - e) The newly selected Chiefs will assume their duties upon graduation of the preceding class.
  - f) Incumbent Chiefs and the Program Director will determine transition timeline.
  - g) The Chief Residents will serve in pairs across the three delineated portions of the academic year. The Program Director will determine the sequence and time periods during which the selected chiefs will serve.
2. Chief Resident Responsibilities
- a) Responsibilities related to the faculty:
    - (1) The Chief Residents will act as intermediary between the residents and the program director. However, the program director maintains an open door policy for all residents, and therefore chief residents and junior residents alike must exercise discretion when communicating.
      - (a) In general, routine communications, particularly those relating to scheduling or ED operation should be routed from the junior residents through the chief residents to the program director. This enables the chief residents to fulfill their mission of representing the residents.
      - (b) Personal or academic issues of a confidential nature can be communicated directly to the program director.
    - (2) The Chief Residents are primarily responsible for the implementing program policy and directives. The active Chief Residents are responsible for attending all staff and EM Education meetings at both institutions and represent the residents at all staff functions.
    - (3) It is a general goal that one of the two currently serving chief residents works at each institution during their tenure to provide better access to both residents and faculty.
    - (4) The Chief Residents, at the discretion of the Program Director, should act as the primary interface agents between the staff and residents of other departments for routine interactions such as the scheduling of off-service residents or emergency medicine residents.
  - b) Resident responsibilities:
    - (1) The Chief Residents are the first line supervisors of all residents, responsible for representing the residents and their interests in all matters.
    - (2) Chief residents are to serve as role models and informal mentors for all junior residents.
    - (3) The Chief Residents are physicians in training, responsible for serving as senior residents in both the emergency department and on off-service rotations, responsible for the same performance and academic standards as all residents in training.
  - c) Scheduling responsibilities:
    - (1) Chief Residents are responsible for producing a monthly schedule that provides adequate resident coverage for both BAMC and WHMC during all assigned periods. Chief Residents will schedule both EM and off-service residents in the EDs and will coordinate schedules with staff schedulers at both BAMC and WHMC
    - (2) Chief Residents will ensure that schedules comply with program and RRC guidelines, and are generally equitable for all residents serving in the department. Any deviation of the schedule from program or RRC guidelines mandates immediate consultation with the Program Director.

- (3) The schedule will strive for equal exposure to the teaching faculty and educational opportunities at both institutions. Chief Residents will have the authority to make routine schedule adjustments to meet their primary mission of ED coverage with the caveat that they must track resident work schedules to assure compliance with good work/rest practices, RRC guidelines and equitable treatment of all residents.
  - (4) All schedules are subject to Program Director approval and modification.
  - (5) Chief Residents are the initial approval authority for all leave requests. The Chief Residents will track all residents on leave.
  - (6) [Morning report](#) is a coordinating responsibility of the Chief Residents. The Chief Residents will ensure coordination between the EM-3 on Admin Rotation, staff and other senior residents that results in both institutions providing quality morning reports Monday through Thursday of every week.
  - (7) The Chief Residents will coordinate the [Grand Rounds schedule](#) for all designated Fridays, in cooperation with the Curriculum Director to ensure 4-5 quality lectures are presented. Chief Residents are responsible for assuring all residents are in attendance, keeping strict accountability of attendance to ensure all residents attend a minimum of 70% of lectures in accordance with RRC guidelines. Chief Residents are responsible for the conduct of all residents during Grand Round lectures; they will assure professional and courteous conduct.
- d) Life Support (Procedure) Lab:
- (1) The Chief Residents will assure that the Life Support (Procedure) Lab is coordinated for the first Monday of every block at both WHMC and BAMC.
  - (2) Chief Residents are responsible for coordinating adequate instructors, faculty oversight, and operational supplies are present for a 4-hour teaching block.
  - (3) Chief Residents will ensure the attendance of all available residents and the accurate recording of all procedures done.
  - (4) Chief Residents will supervise the conduct of all residents during the Life Support Lab.
- e) Chief Resident Breakfast
- (1) The chief residents normally arrange a breakfast for all EM residents on the same day as the Life Support (Procedure) Lab.
  - (2) The purpose is to disseminate information and to build esprit de corps.
- f) In-Training Review Sessions
- (1) Chief Residents will arrange and execute the written board review sessions held weekly in the months prior (normally begins in November of each year) to the in-training examination which occurs in late February of each year.
  - (2) Sessions will be focused on review for the written in-training and ABEM written exams.
  - (3) Resident participation is highly encouraged but is voluntary. Dress is casual.
  - (4) Residents traditionally arrive at 1830 with the session starting at 1900 and ending at 2130.
  - (5) Faculty will volunteer to host the sessions at their homes and will provide liquid refreshments.
  - (6) Chief Residents will arrange food for the session.
- g) Resident Rooms
- (1) Chief Residents are responsible for the oversight of rooms used exclusively by residents (e.g. resident room adjacent to the Morgan Conference Room and the Chief Resident office at BAMC).
  - (2) Rooms that are dirty or in disarray communicate disuse or misuse. Periodic inspections and, if necessary, "GI parties" or calls to housekeeping are important to maintaining a professional environment.
- h) Wellness
- (1) Chief Residents schedule and arrange wellness sessions for the residency.
  - (2) These can be informal, ad hoc sessions, and they will also include the 4 formal "Resident Days" each year:

- (a) Summer wellness day in August, traditionally held at a water park other area with opportunities for fun in the sun.
- (b) Winter holiday event occurs during the holiday season and is typically held at a local food and drink establishment.
- (c) Day-After-the-In-training occurs, as you might expect, right after the in-service examination at the end of February and is typically held at a local food and drink establishment.
- (d) Graduation is normally scheduled for the evening of the official SAUSHEC graduation day in early June. The graduation dinner is arranged by the Chief Residents and a special effort is made to accommodate graduates and their families.
- i) Chief Residents will maintain close contact with the residents to ensure timely dissemination of important information. In most instances this is done electronically through e-mail or posting on the resident web site. All residents are required to have a means of receiving email and/or checking the website daily. Email and Internet access is available in a limited fashion at each facility. It is highly recommended that each resident have Internet access and email capabilities at his/her home.
- j) It is the goal of the program to send all new Chief Resident selectees to the SAEM Chief Resident forum in May of each year. Depending on funding, Chief Resident selects will register and attend the Forum as well as a portion of the [SAEM conference](#).

## VII. Didactics

### A. Morning Report

1. Morning Report (MR) is held Monday through Thursday at each institution immediately following morning board rounds, generally from 0715 to 0800. A faculty member or senior resident will typically present an oral-boards style case or multiple patient encounters to the junior resident. The faculty member or senior resident should have prepared a short overview of the topic(s) presented plus a reference handout.
2. [An outline for the conduct of Morning Report](#) has been developed and should be reviewed.
3. The faculty or senior resident conducting Morning Report will complete a [Morning Report Evaluation Form](#) on the resident receiving the case, and will turn the form in to the residency coordinator. When a senior resident is conducting the case, the faculty should complete an evaluation on the senior resident in his or her role as the case proctor using a [Senior Resident Examiner Evaluation Form](#). Routine attendance (outside of the evaluation forms just mentioned) is not required to be taken at Morning Report.
4. Alternative Morning Reports
  - a) Once per month (1<sup>st</sup> Monday of the block) Life Support (Procedure) Lab and Chief Resident Breakfast is conducted in lieu of MR.
  - b) Once per month (3<sup>rd</sup> Tuesday of the month) Trauma Conference is held in lieu of MR at BAMC only.

### B. Grand Rounds

1. Grand Rounds is held each Friday from 0700-1200 (exception: Trauma Conferences start at 0630).
2. The Curriculum Director has the responsibility for planning and scheduling Grand Rounds in accordance with the residency goals and RRC requirements. The [Academic Calendar](#) lists all the Grand Rounds presentations for the year. The Chief Residents coordinate the schedule on a weekly basis and make necessary hour-by-hour adjustments to ensure smooth flow of time. Chief Residents take attendance (residents and faculty). The Program Director has general oversight for grand rounds.
  - a) Core Curriculum – Now called the [Model of Emergency Medicine Clinical Practice](#)
    - (1) Model of Emergency Medicine Clinical Practice will be covered at least once during the course of the three-year program.
      - (a) Some key material (e.g., chest pain) will be covered on an annual cycle, while less critical material may be covered once every 3 years.

- (b) Note that not every single topic and subtopic in the Model of Emergency Medicine Clinical Practice will find its way into Grand Rounds. Readings, Morning Report and other didactic methods may be used to cover some material.
    - (2) EM faculty, consultants, guest lecturers, or residents may present material at Grand Rounds.
  - b) Joint Conferences
    - (1) Trauma Conference is held jointly with the WHMC/UT surgery residents once every two months.
    - (2) EM/Pediatrics Conference is held jointly with the pediatric residents once every two months.
    - (3) EM/IM Conference is held jointly with the BAMC Internal Medicine residents once every two months.
    - (4) Once every month, in lieu of Morning Report, residents at BAMC will attend BAMC Trauma Grand Rounds. See section on Morning Report, above.
  - c) Morbidity and Mortality Conference, designed to review common pitfalls in the practice of EM, is periodically scheduled at each facility.
  - d) Journal Club gives residents and opportunity to review current literature and will be periodically scheduled at each facility.
3. The RRC mandates that EM residents attend a total of 70% of presented conferences throughout the 3 year program. Attendance is mandatory unless:
- a) Residents are off-service *and* out of town (e.g., EMS-Austin, Peds EM-Austin, Toxicology-NYC, Operation EM-Washington, DC)
  - b) Resident has worked Thursday night (overnight) shift at the opposite hospital ED.
  - c) Residents working Thursday night shifts at the same hospital ED are excused at 0900.
  - d) Note the residency has made great effort to secure Friday Grand Rounds for residents on off-service rotations. If you are on an off-service rotation and are scheduled for duty on Friday during Grand Rounds, it is imperative that you notify the chief resident or program leadership.
4. Resident Lectures.
- a) Lecture assignments will be made by the Curriculum Director in conjunction with the Program Director.
  - b) Lectures or presentations will be well-researched, planned and executed. Both content and delivery will be evaluated.
  - c) While not required, MS Power-Point-style lectures are the norm, and should include a balance of text and graphics
  - d) Handouts will be more than a mere duplication of the slides or lecture outline and instead will include key points, important graphs or tables, appropriate text and references/bibliography.
  - e) Each [EM-1 and EM-2](#) resident will be expected to prepare at least one comprehensive Grand Rounds lecture, of approximately 50 minutes.
  - f) [EM-3 residents](#) will give at least two lectures during the academic year.
  - g) Residents are required to review their lecture with their mentor at least 1 month prior to the scheduled time of delivery.
    - (1) Early consultation (e.g., 2 months) with the mentor is a proven method for success and is strongly encouraged for EM-1s.
    - (2) Residents will identify their faculty mentor on the title slide of their presentation to strengthen the resident-faculty bond.
  - h) Resident lectures will be graded by faculty and evaluated by the audience using a [Grand Rounds Speaker Evaluation Form](#) and the feedback received is an important part of the resident evaluation process.
  - i) Residents may be asked to repeat a lecture on the same or different topic or pursue another scholarly activity if his/her performance is not deemed adequate by the Program Director. Residents who deliver substandard lectures and who did not meet with their mentor in a timely fashion and provide the mentor with well-drafted materials to review may be subject to additional sanctions.
5. Readings and Quizzes.

- a) Quizzes covering the assigned reading for each block will be administered on the Friday after the last day of each academic block.
  - b) EM-1s and EM-2s will have the same reading assignments and will take quizzes together. The readings will be out of major and supplemental emergency medicine texts. Generally, the quizzes will be taken and graded in Grand Rounds.
  - c) EM-3s will take a quiz based on the evidence-based readings assigned by the faculty.
  - d) A 70% score is considered passing. Failure of more than 2 quizzes in an academic year is a reason to be considered out of compliance with residency standards.
    - (1)
    - (2)
  - e) Readings planned for AY 2002-03 are as follows:
    - (1) [EM-1 and EM-2](#)
    - (2) [EM-3](#)
    - (3) [Supplemental Reading](#)
6. Life Support (Procedure) Lab
- a) Held the first Monday of each block at both facilities. Provides an opportunity for residents to learn life-saving procedures on an animal model.
  - b) Procedures performed include but are not limited to:
    - (1) Venous Cutdown
    - (2) Diagnostic Peritoneal Lavage
    - (3) Tube Thoracostomy
    - (4) Transvenous Pacemaker
    - (5) Resuscitative Thoracotomy
    - (6) Cricothyrotomy
    - (7) Fishhook removal
    - (8) Suturing techniques
    - (9) Lateral canthotomy and cantholysis
  - c) A faculty member will attend at both WHMC and BAMC.
  - d) Please review the [Life Support \(Procedure\) Lab Guide](#) for details on this exceptional experience.
7. In-Training Examination
- a) Conducted once yearly in February under the auspices of the American Board of Emergency Medicine. This comprehensive exam is comparable to the Written Board Examination in Emergency Medicine.
  - b) It serves as a useful guide for the residents and the Program Director to determine the academic standing of each person relative to his/her national peer group. Resident-led review sessions are conducted prior to the In-Training examination. These are intended to be an informal means of advancing academic knowledge.
  - c) In-Training scores have been demonstrated to correlate with performance on the American Board of Emergency Medicine written examination.
  - d) The residency offers a series of written examination review sessions from November to February. These are arranged and conducted by the chief residents with substantial help from other senior residents. The session is hosted at a faculty house in the evening.
    - (1) Sessions will be focused on review for the written in-training and ABEM written exams.
    - (2) Resident participation is highly encouraged but is voluntary. Dress is casual.
    - (3) Residents traditionally arrive at 1830 with the session starting at 1900 and ending at 2130.
    - (4) Faculty will volunteer to host the sessions at their homes and will provide liquid refreshments.
    - (5) Chief residents will arrange food for the session.

## VIII. Educational Support

### A. [Patient Follow-up Log](#)

1. Patient follow-ups are an essential part of emergency medicine education. Patient follow-ups meet RRC requirements and teach continuity of care and system-based practice.
2. A follow-up log will be kept on all ED blocks including
  - a) BAMC/WHMC ED
  - b) UTHSCSA ED
  - c) Orthopedics (UTHSCSA)
  - d) Trauma-CC (UTHSCSA)
  - e) EMS, Toxicology, Administration, Anesthesia, ObGyn and research blocks do not require logs to be turned in.
  - f) Inpatient rotations (e.g., medicine, surgery, ICU) do not require logs as patient continuity is an integral component of the rotation.
3. A minimum of two (2) outpatient (discharged from ED) and two (2) inpatient (admitted) patients must be logged each block.
  - a) Use the Patient Follow-Up form and turn in no later than the first GR of the following block. Forms are turned in to the Residency Coordinator.
  - b) Logs are periodically reviewed for compliance.
4. Follow-ups can take many forms, including
  - a) Calling the patient at home and getting feedback
  - b) Pulling charts or querying CIS for subsequent evaluations by the patient's PCP or specialist
  - c) Discharge summaries or CHCS consult reviews
  - d) Autopsy reports
  - e) 24 hour ED returns
  - f) 12 hour "abdominal pain" or "wound check" follow-ups
  - g) Going to the inpatient unit to check on the recently admitted patient
  - h) Asking your fellow resident, who is rotating in the ICU, how your patient is doing

### B. Procedure Competency

1. It is the responsibility of each resident to keep an accurate record of any and all procedures performed. Accreditation requirements stipulate the program ensure the procedural competency of all residents. Two complementary systems exist to support this requirement.
  - a) Procedure Log Website
    - (1) The [ACGME](#) hosts a website that is used to log procedures performed.
      - (a) The resident logs on and then uses text boxes and pull-down menus to enter basic information on the procedure performed.
      - (b) The [list of procedures is linked to CPT codes](#) and includes all those listed in the appendix.
    - (2) The residency program will periodically download individual resident and aggregate program data to verify compliance.
  - b) Procedural Competency Evaluation Forms.
    - (1) The program has identified 13 key procedures that the resident will be evaluated for competency. This is accomplished by a supervisor (faculty or senior resident) personally evaluating the performance of the procedure and documenting the results on a [Procedural Competency Form](#), and turning the form in to the Residency Coordinator.
    - (2) The 13 procedures tracked in this system are:
      - (a) Cardioversion/Defibrillation
      - (b) Central Line - Central Venous Access
      - (c) Intubation - Endotracheal Intubation
      - (d) Lumbar Puncture
      - (e) Pacemaker - Transvenous Cardiac Pacing
      - (f) Pericardiocentesis
      - (g) Procedural Sedation
      - (h) Resuscitation

- (i) Surgical Airway
  - (j) Thoracostomy - Chest Tube
  - (k) Thoracotomy - Resuscitative Thoracotomy
  - (l) Ultrasound
  - (m) Wound Repair - Wound Care
2. General guidelines for procedural tracking
    - a) Log all of your procedures on the website. This information is vital to you when applying for hospital privileges and to the residency for continued accreditation by the RRC.
    - b) Procedures from all locations (e.g., BAMC, WHMC, UTHSCSA, etc) and all rotations (e.g., ED, medicine, surgery, MICU, etc) count and should be tracked.
    - c) Procedures on patients as well as cadavers, animal models, and patient simulators should all be tracked on these systems. The website and forms allow for the identification of the model used.
    - d) Please note that resuscitations are to be coded for team leaders only.
  3. As the residency program refines its competency assessment tools, a minimum number of procedures will be established for each resident to perform before being declared competent. Ultimately, residents can expect minimum goals or “gates” for key procedures that must be accomplished before the resident is able to progress to the next level. In the interim, the program has a [list of procedures that residents may perform](#) during each of their EM years under varying levels of supervision.
- C. Military Professionalism
1. Residents are dual-hatted as physicians and as military officers. As such, they are expected to uphold the high standards expected of each profession. Proper military courtesy and customs must be observed, not only on a routine basis, but when interacting with patients, consultants, nursing, and para-professional personnel.
    - a) Proper military bearing includes proper wear of the uniform.
    - b) Residents are expected to travel to and from work in a utility (BDU), class B/service dress uniform, or PT uniform. Residents will wear the utility (BDU) or class B uniform while at military hospitals or may change into hospital-approved scrubs (not personal scrubs) when working clinical shifts or rotations.
    - c) Residents performing rotations at civilian institutions should dress appropriately to that environment which generally means neat and professional civilian attire.
    - d) Grand Rounds and other conferences are considered duty and residents will wear utility (BDU) or class B/service dress uniforms. Exceptions for those coming directly from the adjacent clinical environment (scrubs) or traveling directly from civilian rotations (civilian attire) are granted.
    - e) Uniforms for other events will be the utility (BDU) or class B uniform unless otherwise announced by the program leadership or the event sponsor.
    - f) Uniforms for TDY missions (e.g. CME conferences) will be the class B/service dress uniform. Residents presenting at the conference will wear the class A uniform or service dress uniform with coat. Unless otherwise specified by service regulations or mission, travel on common carriers (e.g. airlines) will be in neat civilian attire. (At press time, the Army authorizes the wear of civilian attire when flying while the Air Force requires the service dress uniform.)
  2. As soldiers/airmen, residents will be expected to complete regular service-specific training or requirements, such as physical fitness testing, random urinalysis testing, and readiness actions. Residents should ensure that they are in compliance with their service’s height/weight standards, and maintain an appropriate level of physical fitness.
    - a) Failure to meet these requirements can subject a resident to a variety of unpleasant actions, to include administrative suspension, removal from the program, or UCMJ.
    - b) Periodic military requirements, such as dental examinations, must be kept up-to-date.
- D. Although the rank structure is paramount in the military, it is important to remember that the rank structure has some modifications in the hierarchy of patient care. For example, a junior resident who is a major is subordinate to a senior resident who is a captain with regards to patient care and medical orders. Proper bearing and courtesy must be maintained, however.

- E. Officer Professional Development (OPD) education will be administered during the academic year, specific to each service, and designed specifically for the military emergency physician. A [military unique curriculum](#) is in place and is undergoing constant improvement.
- F. Training Files
  - 1. All pertinent documents regarding a residents academic and nonacademic performance will be maintained in a training file.
    - a) This may include a CV, military records, licensure information, grades, evaluations, counseling, disciplinary documents, correspondence and summative documents.
    - b) SAUSHEC, ACGME/RRC, and military regulations govern parts or all of the training file
  - 2. Residents should review their file at least quarterly.
    - a) Pay particular attention to licensure renewals, currency of CPR, ACLS and other certifications. Residents are fully responsible for ensuring such credentials are up-to-date.
    - b) Review recent shift evaluations, off-service evaluations and other recent documents.
  - 3. The files will be maintained by the residency coordinator. Resident will never take the file out of the coordinators office nor review their file without in-person supervision. Copies of the content can be requested through the residency coordinator.
- G. EMS Requirement
  - 1. Riding on ground ambulances and flying on helicopters and/or fixed wing aeromedical aircraft are an integral part of military medical force projection.
  - 2. IAW with RRC rules, all residents in this program are hereby notified that they may be required to ride on military or civilian ground ambulances and fly on military or civilian aircraft as part of their training requirements.
- H. EEO/Non-discrimination
  - 1. Equal opportunity, non-discrimination, non-harassment, and consideration of others regulations are managed by the respective services through existing federal and military regulations. Both the BAMC and WHMC commanders subscribe to these rules and it is the policy of this residency to support these regulations to the fullest extent.
  - 2. Residents are required to adhere to these rules as a matter of federal law and military duty.
  - 3. Equal Opportunity counselors are available at both institutions and can be accessed by contacting the NCO in-charge of the particular department or area.
- I. Exposure to Infectious Agents and other Hazards
  - 1. Working in emergency medicine has some inherent risks including exposure to infectious body fluids, hazardous chemicals, ionizing radiation, and violent persons.
  - 2. The resident's and patient's well-being are paramount.
    - a) It is critical to take all reasonable precautions to include the wear of personal protective equipment, verification of immunization status and awareness of your surroundings to minimize the risks.
    - b) These precautions and protective equipment are a job requirement and are not optional. Residents observed or reported not taking proper workplace precautions are subject to program and/or command sanctions.
  - 3. If you are exposed to a hazard (e.g. body fluid exposure or workplace injury), each facility has comprehensive regulations governing the procedures to take. Among other steps, notify the supervising faculty or chief resident immediately and provide routine notification to the program director.
- J. Educational Equipment and Facilities
  - 1. The residency provides equipment and facilities to assist in the educational mission. These are provided at government expense and remain the property of the government. Residents will exercise care in their use, upkeep and security.
  - 2. Apartments
    - a) The residency leases several apartments for use during off-service rotations
      - (1) NYC for the Toxicology rotation
      - (2) Washington for Operational EM
      - (3) Austin (2) for Pediatric Emergency Medicine and EMS

- b) Apartments will be kept neat and orderly at all times. Proper security will be maintained to protect the government property inside and protect the government from liability to the landlord.
      - (1) Only residents rotating on the specific rotations may stay in the apartment. Guests and other residents not rotating on the off-service rotation are not authorized to stay in the apartment. Immediate family members, with program permission, may be permitted under special circumstances.
      - (2) No pets allowed.
- 3. Computers
  - a) Desktop computers are available at both BAMC and WHMC. Residents may gain access to these systems by applying through the institution information management office.
  - b) Laptops are available for the out-of-town rotations. They are provided to the resident to conduct research and educational activities while out of town.
  - c) These computers are government property and all the rules for government computers are in force, including:
    - (1) Keep the computer secure at all times. If it is lost or stolen, file a police report. If the machine is lost, stolen or damaged, a report of survey may be conducted and may find the resident financially liable.
    - (2) Don't install unauthorized programs on the computer.
    - (3) Don't download unauthorized images or other content and don't surf the web where you shouldn't be. Don't send unauthorized emails (e.g., spam).
- 4. Pagers
  - a) As soldiers, airmen, and physicians, residents are expected to be available 24 hours a day for emergencies.
    - (1) Pagers will be worn at all times and all pages answered promptly.
    - (2) If you will be out of touch for an several hours or more (a weekend camping at a local park) be sure to notify the chief resident.
- 5. Internet and email access
  - a) Access to the internet and an email account is a modern educational necessity. All residents are highly encouraged to obtain such access.
    - (1) Most residents prefer home email accounts, however, an account through either BAMC or WHMC can be arranged.
    - (2) Internet access is available through the hospital libraries and at many hospital workstations.
  - b) Much official residency notifications and information is disseminated by electronic means. Residents are expected to check their email and/or visit the residency website regularly. Residents unable to accomplish this must notify the program immediately.
- K. Mailboxes
  - 1. The residency maintains mailboxes at both BAMC and WHMC for the distribution of routine correspondence.
  - 2. Residents will check and empty their boxes at least once each block.
- L. Resident Rooms
  - 1. A resident room is available for use by the residents adjacent to the BAMC DEM. It is a limited-access room with computers, lockers and other educational support materials. Similar resources are available at WHMC in the DEM administrative offices. Additionally, there is a call room at WHMC.
  - 2. Residents are expected to keep the room(s) neat and orderly. They are not storage areas nor personal hangouts.
  - 3. Chief residents are responsible for the overall oversight of any rooms used exclusively by residents (e.g., BAMC resident room).
- M. Travel
  - 1. Residents are authorized TDY to perform out-of-town rotations as well as selected educational opportunities such as a CME conference. Residents are on official orders, therefore:
    - a) Deviation from these orders is not permitted without authorization.

- b) Do not depart on an out-of-town rotation or any other TDY without orders. It is the residents responsibility to obtain a valid set of orders prior to departure. Failure to do so could result in failure to be reimbursed for some or all of the costs of the TDY.
  - 2. Service regulations and the [Joint Travel Regulation \(JTR\)](#) govern the use of TDY and will be followed including
    - a) Mandatory use of government travel credit cards
    - b) Standard per diem rates that determine exactly how much you will be reimbursed for meals and hotel, if applicable
    - c) Mandatory use of government-contracted travel agency to buy tickets (don't buy your own)
    - d) Visit the [GSA website](#) for more information on per diem rates, etc.
  - 3. Residents are required to turn in their TDY settlement to the Residency Coordinator following any TDY
    - a) This is important for budget management
    - b) Not turning in your TDY settlement may preclude you or your peers from going on any further TDY until the budget can be reconciled.
  - 4. As a general rule, residents must always be in some form of status when traveling out of town:
    - a) TDY
    - b) Permissive TDY
    - c) Leave
    - d) Pass
  - 5. The type of status is determined by service regulations and the JTR. In general:
    - a) For rotations (including electives), TDY is the only status authorized as the resident is conducting official government business. This protects the resident by assuring the government assumes responsibility for any injury that may occur to you and for any liability for malpractice that may be alleged.
    - b) In limited quasi-official duties, PTDY may be authorized.
    - c) Leaves and passes are for off-duty activities
  - 6. All time away from the residency (TDY, PTDY, leaves and passes) is subject to Program Director approval. Time spent away from the program in excess of standard policy may subject the resident to an extension of training or other actions to make up the lost time.
- N. Annual acknowledgment
- 1. The program will train residents on an initial and periodic basis various administrative requirements such as key policies.
  - 2. Residents will be asked to complete and sign a periodic [acknowledgement form](#) certifying training.

## IX. Research

- A. Both the [Model of Emergency Medicine Clinical Practice](#) and the [Council of Emergency Medicine Residency Directors](#) (CORD-EM) recognize the importance of training residents in research methodology and critical literature review. This recognition is reflected in EM residency curriculum requirements as published by the [Accreditation Council for Graduate Medical Education](#) (ACGME). Such ability to analyze and critically assess the medical literature becomes even more important after completing formal residency training and certification, as medical journals and other periodicals become the cornerstone of most physicians' continuing medical education (CME).
  - 1. In addition to the importance of self-education, research methodology is taught in emergency medicine residency programs in the hope of fostering continued interest in scientific inquiry among emergency medicine practitioners. Such inquiry has served both to establish the unique body of knowledge that comprises "expertise" in the field of emergency medicine, and has simultaneously pushed-back the "walls of dogma" that have historically surrounded so much of the treatment of acutely ill and injured individuals.

2. The advent of the Evidence-Based Medicine (EBM) movement has furthered these endeavors, and provides a logical model for further investigation and intellectual growth within our chosen specialty.
- B. The SAUSHEC EM Residency Program Research Curriculum is based soundly upon the goals and objectives outlined by CORD-EM and the [SAUSHEC Research Requirements](#). Our specific goals are:
1. Understand the fundamental techniques of critically analyzing biomedical research, and demonstrate the ability to do so in a public forum.
  2. Understand the basic methods of hypothesis development and testing.
  3. Understand various types of study design and methodology.
  4. Be aware of the various methods of obtaining consent for biomedical research.
  5. Understand basic statistical methods and their respective applications.
  6. Develop and reinforce a strong ethical grounding for the conduct of clinical research.
  7. Learn the skills to develop a manuscript that is acceptable for publication in a peer-reviewed journal.
  8. Understand the need for grants and funding of research, and develop a rudimentary understanding of how to pursue research funding both effectively and ethically.
  9. Foster an understanding and potential interest in academic emergency medicine as a career.
- C. Our specific objectives are:
1. Participate in the didactic research course, successfully completing the outlined assignments and the post -test, during the EM-1 year.
  2. Attend and participate actively in EBM Journal Club as schedule permits.
  3. Complete the assignments for the Evidence Based Medicine Reading Module.
  4. Develop and successfully meet the requirements for the “Scholarly Project.” This project may be completed in a number of ways but must include the following elements:
    - a) Problem identification and/or hypothesis formulation and presentation to the IRB.
    - b) A formal phase of information gathering or data collection.
    - c) Critical analysis of the data or information obtained.
    - d) A formal statement or report of interpretation of results and conclusion.
    - e) Formally present an abstract of the “scholarly project” at the SAUSHEC EM Residency Research Assembly, scheduled during the final quarter of each respective academic year.
    - f) Complete required research reading as outlined in the reading guide.
  5. In addition to these required objectives, residents are strongly encouraged to consider the following optional objectives:
    - a) Present your data at a national emergency medicine meeting.
    - b) Submit a paper to a peer-review journal
    - c) Compete in the [Commander’s Resident Research Competition](#).
  6. Residents must select a faculty advisor for their research project. The faculty advisor may be the resident’s faculty mentor or another faculty. With permission of the research director, a faculty member outside of emergency medicine may be selected.
- D. Research Requirement Milestones
1. Specific milestones will be established and residents will be expected to meet them as they progress towards their final project. These milestones are minimums; residents should strive to beat these suspenses well in advance.
    - a) End of EM-1 year (June): Identification of research question; project outline; and initial literature search.
    - b) Middle of EM-2 year (December): Drafted IRB application complete with detailed methods section and consent form; extensive literature search; funding and resource implications plan approved.
    - c) End of EM-2 year (June): Approved IRB; data collection begun.
    - d) Middle of EM-3 year (December): Preliminary data collected; abstract written
    - e) March of EM-3 year: Report to Dean, SAUSHEC on senior resident progress in completing research. Seniors not on target for completion of the project by May are at risk for being placed on probation.

- f) End of EM-3 year (May): Project complete; report written; all elements of research requirement fulfilled.
- 2. Residents not meeting these milestones will not be in compliance with program requirements.
- 3. It is crucial for each resident to identify the research project they will be using to fulfill their graduation requirements. Close coordination with their faculty research advisor and the Research Director(s) is important. All expectations of participation should be worked out in advance.
  - a) Identify the roles of all participants. In general, only one resident can claim to be the principal investigator on a study. Large studies with multiple components may be able to support multiple residents, but this must be approved in advance.
  - b) Identify authorship for future papers submitted to journals. The general rules of journal authorship dictate that the first author is the individual most responsible for producing the manuscript (as opposed to the principal investigator, who takes lead in running the study). Often these are the same individual. The preceding discussion applies to articles submitted for publication. Take note that the resident is wholly responsible for writing up his or her results of the research project to meet graduation requirements.
- 4. The Research Director(s) are responsible for tracking the progress of all resident research and providing regular updates to the program leadership.
- 5. The Research Director(s) will convene an informal board every Spring composed of approximately 3 faculty (including themselves) to review all senior projects. This board will then recommend to the program director whether the resident's research has met requirements for graduation.
- 6. Graduating residents will be required to submit their final report to the IRB prior to receiving credit for the project and being cleared for graduation.
  - a) Residents assigned to San Antonio following graduation have the option of continuing the protocol, pending IRB approval of this extension of the study.
  - b) It is the principle investigators (resident) responsibility to properly close the protocol with the IRB when departing the institution.
- E. Program Evaluation and Review
  - 1. The program is proud to have an extensive array of methods to evaluate the performance and effectiveness of the residency. These are detailed in the [internal program evaluation matrix](#) and include
    - a) SAUSHEC Internal Review
    - b) Annual Housestaff evaluations
    - c) Faculty Evaluations
    - d) Off-Service Rotation Evaluations
    - e) ABEM feedback on In-Training and Certification
  - 2. Residents are encouraged to provide honest and construct feedback on all aspects of their learning environment.

## X. Graduation

- A. Graduation is normally held in the first week in June and is a SAUSHEC-wide event.
  - 1. Residents must meet all requirements of the program to be nominated for graduation.
  - 2. Traditionally, graduating seniors who will be PCSing work their last clinical shift on 15 June and are given the balance of the month to get their affairs in order. Graduates not PCSing can expect to work clinically until the end of June.

### B. Awards

Annual presentations will be made at the senior resident banquet in June of each year. Recipients will receive a plaque/award and their names will be displayed on a main plaque in the Department of Emergency Medicine at Brooke Army Medical Center.

- 1. Michael J. Olinger Outstanding Senior Resident Clinician

The recipient of this award is selected by the Attending Faculty. It is awarded to the Senior Resident that possesses and displays the most outstanding Emergency Department management and teaching skills.

It is named for an outstanding graduate of this program in the early 1990's who is now faculty at the Methodist Hospital – Indiana University program in Indianapolis, Indiana.

2. Junior's Choice for Outstanding Senior Resident

The EM-1 and EM-2 resident body selects this award for the Senior Resident that contributed the most to the advancement of resident learning and well being during their residency.

3. Robert L. Norris Outstanding Resident Researcher

This award is for the Senior Resident that has displayed the most commitment and contribution to the research endeavors of the residency. It is awarded to the senior resident achieving the highest score in the research paper and presentation evaluation.

4. Carey D. Chisholm Staff Teacher of the Year

The resident body selects this award for the Attending Faculty member that has contributed the most to the teaching and advancement of the residents.

5. Screaming Eagle Award

The resident body selects this award for the Attending Faculty member that has contributed the most to the improvement of the residency as a whole.

6. Save of the month

Each month at BAMC and WHMC faculty and residents submit great cases. From these one resident is chosen for his/her instrumental role in making a great diagnosis or managing a case especially well. The resident's name and diagnosis is recorded on a plaque near the Team Center at BAMC.

## XI. Schedule

- A. The resident schedule should be completed NLT one month prior to the beginning of the ED block. The Chief Residents are to ensure timely completion, appropriate coverage and equitability. The number of hours worked must meet the guidelines of the Residency Review Committee (RRC). In general, shifts while on a BAMC/WHMC ED block will be 9 hours of scheduled clinical duty. Each resident will have on average one day per week free from hospital duties.
1. Generally, EM-1s will work 23 shifts in a block, while EM-2s and EM-3s will work 21 and 19 respectively. As a rule, these shift numbers will be maintained to ensure adequate resident clinical experience and to maintain adequate ED coverage.
  2. In all cases, the ACGME and RRC-EM guidelines for work hours will be followed. These rules are in place to improve patient safety and resident learning and avoid serious fatigue-related events. All residents as well as faculty have an obligation to report potential violations to the program leadership.
    - a) RRC-EM work hour rules for ED rotations
      - (1) Maximum 12 hour scheduled ED shifts
      - (2) Equivalent period of rest following shifts
      - (3) One day off in seven
      - (4) Maximum 60 scheduled clinical hours and 72 duty hours per week
    - b) ACGME work hour rules (for other rotations)
      - (1) Maximum 24 hours continuous clinical duty.
      - (2) Additional 6 hours allowed to complete clinical responsibilities and attend conferences. No new patients allowed.
      - (3) One day off in seven
      - (4) On call no more than every third night
      - (5) Maximum 80 hours per week, averaged over 4 weeks
      - (6) Some programs (e.g. internal medicine) may have stricter requirements and these apply equally to EM residents rotating on the service.
  3. Chief Residents are empowered to make routine decisions to effect the schedule within program, RRC and ACGME guidelines. However, the Program Director or his or her designee will have approval authority for the schedule.

- B. The basic schedule appears as follows:
1. Blocks 1-7 of the Academic Year

EM-1, R-1 Shifts	Day	Evenings	Night
	0700	1500	2300
EM-2 Shifts	Day	Evening	
	1000	1800	0200
EM-3 Shifts	Day	Evenings	Nights

2. Blocks 8-13 of the Academic Year

EM-1, R-1 Shifts	Day	Evenings	Night
	0700	1500	2300
EM-2 Shifts	Day	Evenings	Nights
	1000	1800	0200
EM-3 Shifts	Day	Evening	

- C. The intent of the alternating schedules (EM-3s work nights the first half of the year, then the EM-2s work nights, as reflected above) is severalfold:
1. Has more experienced EM-3s available in the EDs 24 hours per day in the first half of the year.
  2. EM-2s are afforded the opportunity to focus on multitasking and efficiency in the first half of the year without having to be distracted by running the ED.
  3. Allows progression of responsibility for EM-2s to run the EDs 0200-1000 in the latter half of the year.
  4. Provides a reasonable balance in terms of optimal ED staffing by residents and a work environment that supports education and rewards seniority.
  5. There are several caveats to this hybrid model of staffing:
    - a) The block schedule needs to be properly balanced since the first and second half of the academic year is not truly equivalent.
    - b) Other asymmetric aspects of the block schedule such as front-loading the EM-3 Research block will also have to be taken into account.
- D. Shift length
1. Shifts are normally 9 scheduled hours in length.
    - a) Shift change times noted on the previous tables reflect the time that board rounds are conducted.
    - b) The shift normally runs one hour later than board round time, thus, the scheduled length is 9 hours.

- c) Residents on a given shift are fully responsible for seeing new patients presenting to the ED up to the moment of primary board rounds, normally held at 0700/1500/2300 daily.
  - d) The hour following board rounds will be fully used to complete turnovers, patient dispositions, charting and the like. If more than an hour is needed to accomplish these tasks, the resident will stay until the job is done. The SRs (on-coming and off-going) should monitor this situation to ensure a balance between completion of clinical duties and assuring junior residents go home at a reasonable time. Residents who complete their work prior to the end of a full 9-hour shift will only depart with the consent of the oncoming SR.
  - e) In any case, duty is not complete until all clinical and administrative obligations on that shift are met. Physicians have an affirmative obligation to their patients to assure good continuity of care and completeness of their evaluation prior to departing.
2. Historically, 12-hour shifts were used on weekends and around the winter holidays to accommodate a decrease in resident availability. On occasion, 12-hour shifts may be implemented for special or unusual circumstances.
  3. Nights prior to Grand Rounds
    - a) On Thursday nights prior to Grand Rounds, the EM-2 or EM-3 and any swing shifts that are ordinarily scheduled to work until 0100-0300 will be released at 2400.
    - b) Every effort will be made to enforce this rule as a matter of safety and well being. Off-going residents should plan for a smooth and effective transition of ED responsibilities to the night resident and/or faculty to ensure a timely end to the shift.
  4. Swing shifts, when scheduled, will normally run 1700-0200.
    - a) Swings are an essential component of the overall ED schedule and therefore residents on swing shifts should always come to work as scheduled and on time. It is inappropriate to call the ED and ask if your services are needed in hopes of being waved-off .
    - b) It is discouraged to send a swing home even if the ED is quiet because demand can surge in the ED with little notice. Swing shifts are an important component of resident education and clinical experience. In this fashion, faculty approval is required to exercise this option.
  5. Residents will be scheduled on Grand Rounds and Procedure Lab days as usual.
    - a) The resident's first priority is to attend this planned educational experience. Faculty will normally cover the EDs during these times.
    - b) Following Grand Rounds (Friday) and after Procedure Lab (normally the first Monday of each block) the resident schedule will be as follows:
      - (1) Day shift that normally would begin at 0700 will instead run 1230-1700
      - (2) Day shift that normally would begin at 1000 will instead run 1230-1900
      - (3) Evening shift that normally would begin at 1500 will run 1700-2300
      - (4) Evening shift that normally would begin at 1800 will run 1900-0200
      - (5) Night shifts and swing shifts are unchanged
  6. The Chief Resident(s) or his/her designee will prepare a back-up roster for illnesses and emergencies for each block. Residents assigned to back-up call must be available by phone or beeper and within 30 minutes of the hospital. The resident originally scheduled to work must arrange a 1:1 "payback" with the resident called in on his/her day off. Exceptions to the payback policy must be approved by the Program Director.
    - a) Backup or "jeopardy" residents have an affirmative responsibility to be in contact (e.g. pager or telephone) in case their services are needed.
    - b) Backup or "jeopardy" residents have an responsibility to be promptly available for duty in case their services are needed to include sobriety and if needed, backup child care.
  7. After a schedule is completed and distributed, each resident is responsible for his/her assigned shifts. Residents may trade shifts subject to approval by the Chief Resident. After changes are made and approved, the affected residents must update the duty rosters in the EDs and department offices. The responsibility of coverage will remain with the originally assigned resident.
  8. Residents arriving late for their assigned shifts will be assigned additional "training hours" according to the following formula: < 5 minutes = 1 hour, 5-10 minutes = 2 hours, 10-15 minutes = 3 hours, > 15 minutes = 9 hours.

- a) This policy is designed to focus the residents attention on punctuality, timeliness and reliability, all key attributes of a successful emergency physician.
  - b) These additional training hours will be accomplished in a timely manner and be reported by the chief resident to the program director.
  - c) These additional training hours will be scheduled to comply with RRC guidelines and good work/rest practices.
- E. Emergency medicine residents on rotations which require no call or weekend duty will work ED weekend shifts as dictated by the rotation requirements and at the discretion of the Program Director.
- 1. EM Administration and Research rotations, 4 shifts
  - 2. Anesthesia, Orthopedics, and ObGyn, 3 shifts to occur on weekends only. These shifts will not interfere with the learning experience of the off-service rotation.
- F. Supervision of the ED requires the presence of a responsible physician. The responsible physician in the ED is the EM resident. To improve supervision, training, and accountability, an EM resident will always be present physically in the ED (except during didactics). It is the SR's responsibility to coordinate the ED duty time to allow for "break time" during the shift. Individual situations that require the resident to be absent from the ED should be worked out with the Senior Resident who will consult faculty if necessary.
- G. Sick Policy
- 1. Residents who are ill and feel they cannot make a shift will call, as early as possible, the Chief Resident to explain the situation.
  - 2. The Chief Resident will exercise discretion in authorizing the sick day by telephone or requiring the ill resident to present to sick call for examination. In any case, the Chief Resident will notify the staff on duty in the affected hospital and will activate the call roster as appropriate. The Program Director should be provided with notification of the sick resident in a timely manner – ordinary colds and flu can be by routine notification while all serious illnesses mandate immediate notification.
    - a) More than one sick day in a given block requires Program Director approval.
    - b) Residents who miss a significant number of clinical or didactic training opportunities through illness may require an extension of training or other adjustments to make up for the lost time.
    - c) Abuse or misuse of sick days undermines unit effectiveness, is a serious breach of responsibility and is highly unprofessional. It will be treated as the serious offense that it is.

## XII. Leave Policy

- A. Ordinary leave must be scheduled at least 30 days in advance, with notable exceptions below. [Application for Leave](#) requests will be given to the Residency Coordinator who provides the DA Form 31 or AF Form 988. The request is submitted through the Chief Residents to the Program Director after prior coordination with the service chief of the service on which the resident is scheduled.
- B. Up to three weeks of leave for all residents are authorized each year, but may only be taken one week at a time. Exceptions with justification will be considered on a case-by-case basis.
- 1. Leave during heavy inpatient services is discouraged, and will only be approved on an individual basis by the service chief and the Program Director. All leave is subject to final approval by the Company Commander (Army residents) or the Squadron Commander (AF residents).
    - a) Leave is permissible during rotations in Community EM, Operational EM at CCRC, Pediatric EM at Brackenridge, PICU at Santa Rosa, SICU-B, Anesthesia, SICU-WHMC, General Surgery-WHMC, General Surgery-BAMC, ObGyn, EMS, Toxicology, Research (EM-3 only), Administration, Orthopedics, and electives longer than two weeks, all subject to approval of the off-service director.
    - b) No leave may be taken during SICU-W, MICU, CCU, Medicine, or ED blocks.
    - c) Leave may be offered for Surgery, subject to approval of the off-service director.

- d) Community EM and Ortho at UTHSCSA closely monitors the number of days off during the block. Residents should not expect more than 7 days of leave and this includes TDY for courses, etc.
  - e) Generally, leave will not be permitted for EM-1s or EM-2s during the month of June unless off-service. Ordinary leave will not usually be permitted for any residents in July.
  - f) Leave during off-service rotations should be taken during the first or last week of the rotation.
2. Leave may be taken during the winter break period (normally a two-week period encompassing X-mas and New Year's Day) if the resident is scheduled for an ED block.
  3. Emergency leave is available for life-threatening events that occur in a close family member. Rules for emergency leave are provided for in service-specific regulations. Emergency leave does not ordinarily count against a resident's 3 week leave limit per year (it is chargeable leave, though). However, if the resident misses a significant amount of time (more than a few days) from training, the resident may incur an extension of training or must otherwise make up the lost educational experience.
  4. Maternity leave (convalescent leave) is authorized per service regulations, normally 6 weeks.
    - a) Planning ahead (if possible) is always recommended as some blocks offer more flexibility than others. However, if the resident misses a significant amount of time (more than a few days) from training, the resident may incur an extension of training or must otherwise make up the lost educational experience.
    - b) Paternity leave is not recognized by service regulation. However, the residency recognizes the importance of family togetherness during the arrival of a new family member. SAUSHEC rules allow a resident to petition for up to 1 week of administrative time away from clinical duties to accommodate a new family member. Approval is based on command approval, the standing of the resident, work schedule, block rotations and other factors. Planning ahead is always recommended as some blocks offer more flexibility than others. However, if the resident misses a significant amount of time (more than a few days) from training, the resident may incur an extension of training or must otherwise make up the lost educational experience.
  5. IAW service regulations and SAUSHEC rules, graduating seniors who are PCSing may be authorized 4 days PTDY for house hunting during training (up to 10 days total may be authorized if the PTDY occurs after graduation). This PTDY does not ordinarily count against a resident's 3 week leave limit per year. However, the PTDY must not interfere with the resident's learning experience and is subject to the ED schedule and approval by the program director and any off-service coordinator as appropriate.

**Table of Leave Requirements and Points of Contact**

<b>Rotation</b>	<b>Advance Notice</b>	<b>Contact</b>
EM – BAMC & WHMC	Not authorized	N/A
Community EM – UTHSCSA	90 days	Dr. David Hnatow 358-2078/2079
Trauma-CC – UTHSCSA	90 days	Dr. David Hnatow 358-2078/2079
Pediatric EM – Brackenridge	60 days	Dr. Shawn Wassmuth 512.324.7024
Ob/Gyn – UTHSCSA	60 days	Dr. Elly Xenakis 567-4953
Operational EM – CCRC, Wash, DC	60 days	Ms. Leslie Sawyers 301.295.4043
EMS – Austin	60 days	Dr. Ed Racht 512.972.7250
Toxicology – NYCPCC	30 days	Dr. Lewis Nelson 212.447.8150
Research	30 days	Drs. Knight & Gerhardt
Administration	30 days	Dr. Hunter 916-5512
Orthopedics – UTHSCSA DEM	90 days	Dr. David Hnatow 358-2078/2079
Anesthesia – WHMC	60 days	Dr. John Lundell 292-7956
Anesthesia – BAMC	30 days	Dr. Stuart 916-2118
SICU – BAMC	Limited – 1 <sup>st</sup> come 1 <sup>st</sup> serve	Dr. Baskin 916-5250
SICU – WHMC	Not usually granted	Dr. Deborah Mueller 292-5950/5821
Surgery – WHMC	Limited – 1 <sup>st</sup> come 1 <sup>st</sup> serve	Dr. Joel Goldberg 292-5906
Surgery – BAMC	Limited – 1 <sup>st</sup> come 1 <sup>st</sup> serve	Dr. Russ Martin 916-1925
PICU – Santa Rosa	60 days	Dr. Richard Taylor 567-5314
Med, CCU, MICU – BAMC & WHMC	Not authorized	N/A

### XIII. Due Process

- A. The program and SAUSHEC has an open door policy. Any resident wishing to discuss an issue with the program director, other program officials, director of medical education, or Dean is encouraged to visit.
- B. Advancement
  - 1. Residents are advanced in academic responsibility based on approval of the Program Director with the advice of the teaching faculty that the resident is prepared to accomplish a new level of responsibilities.
  - 2. This is a formal action and is guided by the [SAUSHEC Due Process Policy](#).
- C. Program-Level Remediation
  - 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.
  - 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.
  - 4. This is an action that is guided by the [SAUSHEC Due Process Policy](#).
- D. Probation/Termination
  - 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 for 30-90 days duration and 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. Such actions will be conducted under the [SAUSHEC Due Process policy](#).
  - 4. Male and Female Ombudsmen are available through SAUSHEC at both WHMC and BAMC. The role of the Ombudsman is to provide unbiased support for the residents in areas requiring conflict resolution. Current Ombudsmen contact can be initiated through the respective Director of Medical Education offices.
- E. Academic and Professional Integrity
  - 1. The SAUSHEC EM Residency's foundation lies in the assumption that participants are adults desiring self-improvement through participation in the residency. An atmosphere of trust must be maintained in order for the successful functioning of such a program.
  - 2. One's conduct in all areas of the residency is assumed to parallel the tremendous moral/ethical obligation the physician assumes at the bedside. For this reason, any of the following may result in summary adverse action to include UCMJ and referral to the SAUSHEC GMEC:
    - a) Lying (eg, falsifying charts/labs/x-rays)
    - b) Cheating (quizzes and examinations are on an honor system)
    - c) Stealing (self-explanatory; includes Uncle Sam, TDY declarations, etc.)
    - d) Gross negligence jeopardizing a patient due to inappropriate behavior (eg, abandonment, leaving duty station without excuse, ignoring faculty patient care plans.)
- F. Additional Policies
  - 1. [SAUSHEC Resident Grievance Policy](#)
  - 2. [SAUSHEC Resident Policy Handbook](#)

## XIV. Wellness

- A. Residency training can be among the most challenging and stressful periods of a physician's career. Residents are expected to care for a large number of patients, many of who may be seriously ill and some of who will die. They are routinely expected to acquire a seemingly infinite body of knowledge and repertoire of skills while working long hours under the supervision of demanding seniors and uncompromising attending staff.
- B. Emergency medicine residents face unique challenges in addition to the stressors shared by all physicians in training. The emergency department practice environment is often characterized by difficult patients and challenging professional relationships. Emergency medicine residents are frequently isolated from their peers in both "off-service" rotations as well as when working in the emergency department. Finally, irregular work schedules and a chaotic training environment result in emotional fatigue as well as physical fatigue that adversely impacts residents' family and social relationships.
- C. The residency faculty share responsibility with the residents for their personal as well as professional development during training. The resident wellness program outlined here has been developed to provide a framework to facilitate emergency medicine residents' personal and professional growth.
- D. The program leadership including the program director, associate program director, department chiefs and chairs, and chief residents have an open door policy. Residents are encouraged to use their chain of command to address problems at the lowest possible level (i.e., begin with the chief resident). However, residents may bring any matter they feel needs attention directly to the program director. The SAUSHEC Dean's Office (Dean and Associate Deans) has a similar open-door policy.
- E. New residents are assigned a [resident advisor and faculty mentor](#). The resident sponsor is responsible for facilitation of the new resident's transition to the training environment, assistance with administrative aspects of hospital and post inprocessing as well as orientation of the new resident's family to San Antonio and the relevant military installations. Throughout the new residents' first year the sponsor remains available to assist their mentoree as needed. Additionally, each new resident is assigned a faculty mentor who acts as liaison between the resident and the residency program leadership.
  - 1. The resident and mentor meet periodically to review the new resident's performance in the emergency department as well as "off-service" evaluations. The mentor assists the new resident in selection and design of a research project and other academic activities and is responsible for review of the resident's assigned Grand Rounds presentations. When necessary, the mentor acts as the resident's advocate to other members of the residency faculty. Normally, the department chiefs/chairs and the program and associate program director do not serve as faculty mentors.
  - 2. In the spirit of professional education, once an initial relationship is established, the resident is just as responsible for initiating ongoing contact with their mentor and sponsor.
    - a) In the EM-1 year, the resident should have contact with the faculty mentor at least every 6 weeks or so. Contact with the resident sponsor is ad hoc.
    - b) In the EM-2 and EM-3 years, the resident should have contact with the faculty sponsor as needed, with a goal of quarterly contact.
- F. In addition to physician wellness-related topics included as part of the didactic program, an afternoon long seminar on "Wellness for Emergency Medicine Residents and Their Families" is conducted as part of the orientation for new residents. This program is presented by a multidisciplinary team consisting of the Chief Residents and representatives from the departments of mental health and pastoral services at both WHMC and BAMC. The seminar is conducted at an out-of-hospital location, and residents' families are invited to participate.
- G. [Resident schedules](#) are designed to support team-building as well as time for personal activities. Generally, residents transitioning from assignment in the emergency department to an inpatient or critical care rotation are not assigned clinical shifts on the last day of the rotation block. On occasion, the emergency medicine faculty provides department coverage through 1500 on the

Grand Rounds days to support “free time” for all emergency medicine residents from 1200-1500 for informal group or individual activities. Additionally, the faculty provides departmental coverage for quarterly “Residents’ Days” associated with the summer, the winter holiday party, the in-service examination and graduation.

- H. The effects of fatigue on resident performance and safety and the safety of patients is an important topic and the program uses several techniques to improve awareness and decrease the deleterious effects of fatigue.
  - 1. Schedules are carefully crafted to avoid chronic and acute sleep deprivation while ensuring adequate clinical experience and exposure to the arduous and unpredictable nature of clinical practice. The [ACGME has a new set of work rules](#) that limit the number of hours a resident can work on off-services. (Emergency Medicine has long recognized the high-intensity nature of the ED and has had strict work rules in place for many years.)
  - 2. Residents should maintain vigilance for the effects of fatigue in themselves and their colleagues and report any potentially dangerous conditions immediately. Lesser potential violations of work rules should also be reported to the chief resident or program leadership for investigation and action.
- I. An orientation picnic for the new EM-1s is held in July, traditionally at a faculty residence. The goal is for all the faculty to meet the new EM-1s. The new EM-1’s place of duty is the picnic and of course, family arte welcome. Maximum faculty participation is encouraged. Em-2 and EM-3 residents are also invited as the schedule allows.
- J. Personal physical fitness is emphasized as an organizational value for members of the United States Army and Air Force.
  - 1. As active duty military officers, residents in SAUSHEC are required to comply with height and weight requirements as well as demonstrate their physical fitness on a standardized fitness test semiannually.
  - 2. In addition to occupational health screening upon assignment to BAMC or WHMC, residents are required to undergo periodic medical and dental evaluations to verify their physical qualifications for continued active service in the military.
- K. Residency training, and particularly training in emergency medicine, can be turbulent and challenging for even the best physicians and the most supportive families. Emergency medicine residents who require additional assistance coping with professional or personal challenges during training are provided a variety of resources for professional, personal and family support. The Chief Residents are always available to assist their colleagues with any matter, and can frequently facilitate resolution of most issues on an informal basis. The resident’s assigned advisor and faculty mentor are also available to assist with issues that the resident may be reluctant to bring to the Chief Residents. Other issues may be more appropriately directed to the Program Director or the Associate Director. Whatever the issue, the important thing is to talk to someone and avoid toughing it out alone.
- L. SAUSHEC maintains an ombudsman program that provides neutral faculty members at both WHMC and BAMC to help the resident negotiate challenging professional or residency-related issues. They can be accessed by contacting the respective GME offices at BAMC (916-2222) or WHMC (292-7443).
- M. Individual and family counseling can be arranged through Behavioral Medicine at BAMC (916-4280 or 2010) or Mental Health at WHMC (292-3821). Spiritual counseling is available from the Department of Ministry and Pastoral Care is available at BAMC (916-1105) and Chaplain Services are available at WHMC (292-7373 or page #0346).



## XV. Enclosures

### **Didactics and Readings**

Academic Calendar  
EM-1 and EM-2 Grand Rounds Assignments  
EM-3 Grand Rounds Assignments  
Goals & Objectives for Off-Service Rotations  
Military Unique Curriculum Overview  
Orientation Schedule  
Reading List for EM-1s and EM-2s  
Senior (EM-3) Reading Program  
Supplemental Reading List

### **Other Educational Information**

Applicant Brochure  
Board Rounds Template  
Dictation Instructions for WHMC ED  
EMRP Organizational Chart  
Life Support (Procedure) Lab Guide  
Master Block Schedule  
Mentor List  
Model of Emergency Medicine Clinical Practice  
Morning Report Guidelines  
Competency Evaluation Matrix  
Internal Program Evaluation Matrix  
Procedure List by EM year  
List of CPT Codes for Tracked Procedures

### **SAUSHEC Guidelines**

SAUSHEC Resident Policy Handbook  
SAUSHEC Due Process Policy  
SAUSHEC Resident Supervision Policy  
SAUSHEC Resident Grievance Policy  
SAUSHEC Research Requirements  
SAUSHEC Commanders Research Award

### **Blank Forms**

Administration Rotation Form  
Application for Leave  
Evaluation of Off-Service Rotations  
Faculty Evaluation Forms  
Follow-Up Log Form  
Grand Rounds Speaker Evaluation Form  
Procedural Competency Forms  
Periodic and Annual Acknowledgment Form  
Request for Elective Form  
Request for Schedule Change Form  
Self Evaluation Form  
Shift Evaluation Form  
Summative Evaluations Forms