

**Brown Medical School Residency Program in Emergency Medicine**  
Rhode Island Hospital/Hasbro Children's Hospital/The Miriam Hospital

## **CLINICAL ROTATION GUIDE**

(Feb. 2006)

This document has been put together in an effort to give our EM residents a resource that provides the answers to most of the commonly asked questions regarding the training program clinical and didactic curriculum. A hard copy of this document is available in the residency office.

### **GOALS**

The Brown Medical School Residency Program in Emergency Medicine program is designed to transform medical school graduates into competent and compassionate emergency physicians. The aim of the program is to produce leaders in the field of emergency medicine, whether it be in clinical practice or in the academic setting. The residency format is designed to give the resident the broadest possible exposure to all relevant fields of medicine, while preserving subspecialty training, electives, and research.

01. **ANESTHESIA ROTATION**
02. **CCU - CRITICAL CARE ROTATION**
03. **EMS ROTATION**
04. **FAST TRACK ROTATION**
05. **MED - MEDICINE WARDS ROTATION**
06. **MICU - MEDICAL INTENSIVE CARE ROTATION**
07. **MIR - MIRIAM EMERGENCY ROOM ROTATION**
08. **NEUROLOGY**
09. **OB/GYN**
10. **ORIENTATION**
11. **ORTHOPEDICS ROTATION**
12. **PEDS - PEDIATRIC WARD ROTATION**
13. **PER - PEDIATRIC EMERGENCY ROOM**
14. **PICU - PEDIATRIC INTENSIVE CARE ROTATION**
15. **PLASTICS ROTATION**
16. **TICU - TRAUMA INTENSIVE CARE ROTATION**
17. **TOXICOLOGY ROTATION**
18. **ULTRASOUND ROTATION**

## 1. ANESTHESIA ROTATION

<b>Institution:</b> The Miriam Hospital	<b>Duration in Months:</b> 1 month
	<b>Year of Training:</b> PGY-1
<b>Educational Objectives:</b>	
<b>Description of Clinical Experience</b>	
<p>These goals will be accomplished through a two week rotation in the Department of Anaesthesiology at the Miriam Hospital during the PGY-1 year and through Emergency department experience. During their aneesthesia rotation residents will be involved in direct patient care from preoperative evaluation through postoperative recovery. Supervision is provided by the faculty of the department of Anaesthesia. The services available to the resident while on this rotation include the Miriam Library and the Brown University Libraries, Medical records department, service attendings and fellows, consultants in subspecialties and regular conference and case discussions. The Emergency medicine resident will have the following duties and responsibilities: direct patient care, consultation under supervision, performance of procedures related to patient care with documentation of completion of intubations and central lines. Work schedule will consist of three to four mornings per week (Tuesday – Friday).Maximum work hours are in compliance with ACGME guidelines.</p>	
<b>Description of Didactic Experiences:</b>	
<p>Residents are required to Emergency Medicine didactic conferences. Any necessary readings are made available through the Emergency Medicine Residency office or on our curriculum website.</p>	
<b>Medical Knowledge and Patient Care Educational Objectives:</b>	
<ol style="list-style-type: none"> <li>1. Airway management           <ul style="list-style-type: none"> <li>• Name the factors that can compromise the airway, airway assessment and maintenance</li> <li>• Demonstrate techniques to maintain an airway, mechanical devices used to maintain airways, their indications and complications</li> <li>• List the use, indications, and complications of neuromuscular blocking agents</li> <li>• Describe the use, indications, and complications of various intubation techniques and cricothyrotomy</li> </ul> </li>   <li>2. Preoperative anaesthesia           <ul style="list-style-type: none"> <li>• Demonstrate with the relevant historical and physical exam considerations in preparation for anaesthesia</li> <li>• Describe the indications, contraindications, techniques and complications of the required monitoring and other clinical interventions required for anaesthesia including (there is however no set expectation that residents will perform foley catheter placement, central venous placement, arterial line placement or swan ganz catheter placement):               <ul style="list-style-type: none"> <li>• Cardiac monitoring</li> <li>• Nasogastric tube placement</li> <li>• Foley catheter placement</li> <li>• Arterial line placement</li> <li>• Central venous line placement</li> <li>• Swan ganz catheter placement</li> </ul> </li> </ul> </li>   <li>3. General anaesthesia induction           <ul style="list-style-type: none"> <li>• Describe the various methods and complications of routine and emergency induction</li> <li>• Describe the treatment of malignant hyperthermia</li> <li>• Describe the pharmacology, indications and complications of various anaesthetic agents</li> </ul> </li>   <li>4. Operative monitoring (generally this takes six months full time)</li> </ol>	

<ul style="list-style-type: none"> <li>• Demonstrate how to monitor and maintain the desired depth of anaesthesia</li> <li>• Describe the indications, techniques of administration, determination of level of anesthesia, pharmacology, and complications of spinal anaesthesia</li> </ul> <p>5. Regional anaesthesia</p> <ul style="list-style-type: none"> <li>• Describe and demonstrate the pharmacology, indications, technique and complications of regional nerve blocks and of intravenous regional anaesthesia. There is no set expectation that regional nerve blocks will be performed by the resident.</li> </ul>
<p><b>Patient Care Competencies:</b></p>
<ol style="list-style-type: none"> <li>1. Demonstrate the use of information technology in order to promote patient care. Examples of this include the use of Lifelinks for retrieving laboratory and radiology reports and the use of the internet to facilitate patient care.</li> <li>2. Develop competency in the performance of procedures required of emergency physicians, as well as performance of physical examination related to a patient's chief complaint.</li> <li>3. Develop knowledge of preventive health aspects of patient care that may be incorporated into the practice of emergency medicine.</li> </ol>
<p><b>Interpersonal and Communication Skill Competencies:</b></p>
<ol style="list-style-type: none"> <li>1. Develop a physician-patient relationship model that creates a therapeutic relationship with patients.</li> <li>2. Develop listening skills that will facilitate communication with patients, their families, and other members of the health care.</li> <li>3. Demonstrate and observe caring and respectful behaviors through patient interactions and observations of more senior residents and attending staff</li> <li>4. Develop interviewing skills that will facilitate patient interaction</li> <li>5. Develop skills at facilitating informed decision-making by patients and their families. To learn of specific situations in which informed decision-making may not be possible due to a patient's medical condition or advance directive.</li> <li>6. Counsel and educate patients and their families of their medical conditions</li> <li>7. .Develop awareness and facilitate the provision of health care within a team of health care providers.</li> </ol>
<p><b>Practice-Based Learning and Improvement Competencies:</b></p>
<ol style="list-style-type: none"> <li>1. Develop methods of analyzing the resident's own practice to improve quality of health care provided.</li> <li>2. Develop a personal program of learning related to the requirements of the rotation in the context of an emergency medicine rotation.</li> <li>3. Identify areas of weakness in medical knowledge and practice relevant to the current rotation, and develop a plan to address these weaknesses during the rotation and beyond.</li> <li>4. Develop skills in the use of evidence from scientific studies to alter the resident's practice of medicine, with the goal of improving the health care provided.</li> <li>5. Develop skills in the use of information technology, and in particular online Medline reference searching.</li> </ol>
<p><b>Professionalism Competencies:</b></p>
<ol style="list-style-type: none"> <li>1. Develop respectful and altruistic attitudes towards patients, their families, and other members of the health care team.</li> <li>2. Incorporate principles of ethics into the practice of medicine. Develop sensitivity to cultural, age, gender, and disability issues that may impede patient care through disruption of physician-patient interaction.</li> </ol>

**Systems-Based Practice Competencies:**

1. Develop an understanding of the interaction of the practice of emergency medicine with that of the larger health care system as a whole.
2. Develop knowledge of the practice and delivery of health care in different systems and environments
3. Develop cost-effective strategies in the practice of emergency medicine.
4. Develop an attitude of being an advocate for the patient within the health care system.
5. Develop a willingness to become involved in a partnership to improve health care and system performance within the emergency department and hospital health care system.

**Evaluation process:**

Emergency Medicine residents will be supervised by other residents, fellows, and attending physicians. Using the Emergency Medicine Resident Evaluation Form, Anaesthesia service attendings complete written evaluations for residents at the end of the rotation. In a situation where resident performance is substandard, the service attending will bring it to the attention of the residency director.

**Feedback Mechanisms:**

Residents receive daily feedback from their supervising attendings on the Anaesthesia service. In addition, either the program director or assistant director meets with the residents twice a year to review their overall performance and give feedback on their overall performance on all rotations.

Have the service directors for all rotations outside the Emergency Department at the primary institution reviewed and agreed to the rotations as described?	YES (X) NO ( )

## 2. CCU ROTATION

<b>Institution:</b> The Miriam Hospital	<b>Duration in Months:</b> 1 month
	<b>Year of Training:</b> PGY-2
<b>Educational Objectives:</b>	
<ol style="list-style-type: none"> <li>1. To experience the care of patients with acute myocardial infarction and unstable angina (MK, PC, SBP)</li> <li>2. To experience the care of infarctions complicated by pulmonary edema, cardiogenic shock, right ventricular infarction, rhythm disturbances, and recurrent ischemia (MK, PC, SBP)</li> <li>3. To learn the current and evolving indications for interventional techniques and lytic therapy and to experience their use (MK, PC).</li> <li>4. To learn the indications for invasive hemodynamics monitoring, participate in its technical performance, and become adept at its proper application (MK, PC).</li> <li>5. To understand post myocardial infarction risk stratification and rehabilitation (MK, PC, SBP).</li> <li>6. To develop the ability to recognize and treat supraventricular and ventricular arrhythmias (MK, PC).</li> <li>7. To learn to diagnose and to treat advanced congestive heart failure (MK, PC).</li> <li>8. To learn the indications for emergency, urgent and permanent cardiac pacing and to develop facility in the application and use of external pacemakers, the placement and use of transvenous pacemakers, and to acquire an awareness of the complications associated with temporary and permanent pacing (MK, PC,SBP).</li> <li>9. To gain experience with patient support devices including ventilators and intra-aortic balloon pumps (MK, PC).</li> <li>10. To gain experience in meeting the emotional and communication needs of critically ill patients and their families (SBP, Prof, ICS).</li> <li>11. To develop a rational approach to allocation of CCU resources, a conceptual basis for triage decisions (SBP).</li> </ol>	
<b>Description of Clinical Experience</b>	
<p>The Miriam Hospital is a major teaching affiliate of Brown University with postgraduate training in internal medicine and a fellowship program in cardiology. The CCU is a very active nine-bed unit staffed by an attending cardiologist, a cardiology fellow, medical residents and interns. The hospital is the locus of an aggressive Interventional Cardiology Program, with ongoing research in this area. Emergency medicine residents function as an integral part of the internal medicine house staff team, evaluating Emergency Department and floor patients for CCU candidacy, working up and managing admissions, and taking call in rotation. Residents participate in daily teaching rounds and conferences as integral members of the CCU team</p> <p>Residents rotating to the Miriam CCU have the following duties and responsibilities:</p> <ol style="list-style-type: none"> <li>1. Direct patient care.</li> <li>2. Consultation under supervision.</li> <li>3. Performance of procedures related to patient care.</li> <li>4. On-call responsibilities on par with other residents (at the same level of training) on the service.</li> </ol>	
<b>Medical Knowledge and Patient Care Educational Objectives:</b>	
<b>Patient Care Competencies:</b>	
<ol style="list-style-type: none"> <li>1. Demonstrate the use of information technology in order to promote patient care. Examples of this include the use of Lifelinks for retrieving laboratory and radiology reports and the use of the internet to facilitate patient care.</li> <li>2. Develop competency in the performance of procedures required of emergency physicians, as well as performance of physical examination related to a patient's chief complaint.</li> <li>3. To develop knowledge of preventive health aspects of patient care that may be incorporated into the practice of emergency medicine.</li> </ol>	

**Interpersonal and Communication Skill Competencies:**

1. Develop a physician-patient relationship model that creates a therapeutic relationship with patients.
2. Develop listening skills that will facilitate communication with patients, their families, and other members of the health care.
3. Demonstrate and observe caring and respectful behaviors through patient interactions and observations of more senior residents and attending staff
4. Develop interviewing skills that will facilitate patient interaction
5. Develop skills at facilitating informed decision-making by patients and their families. To learn of specific situations in which informed decision-making may not be possible due to a patient's medical condition or advance directive.
6. Counsel and educate patients and their families of their medical conditions.
7. Develop awareness and facilitate the provision of health care within a team of health care providers.

**Practice-Based Learning and Improvement Competencies:**

1. Develop methods of analyzing the resident's own practice to improve quality of health care provided.
2. Develop a personal program of learning related to the requirements of the rotation in the context of an emergency medicine rotation.
3. To identify areas of weakness in medical knowledge and practice relevant to the current rotation, and develop a plan to address these weaknesses during the rotation and beyond.
4. To develop skills in the use of evidence from scientific studies to alter the resident's practice of medicine, with the goal of improving the health care provided.
5. To develop skills in the use of information technology, and in particular online Medline reference searching

**Professionalism Competencies:**

1. To develop respectful and altruistic attitudes towards patients, their families, and other members of the health care team.
2. To incorporate principles of ethics into the practice of medicine.
3. To develop sensitivity to cultural, age, gender, and disability issues that may impede patient care through disruption of physician-patient interaction.

**Systems-Based Practice Competencies:**

1. Develop an understanding of the interaction of the practice of emergency medicine with that of the larger health care system as a whole.
2. Develop knowledge of the practice and delivery of health care in different systems and environments
3. Develop cost-effective strategies in the practice of emergency medicine.
4. Develop an attitude of being an advocate for the patient within the health care system.
5. Develop a willingness to become involved in a partnership to improve health care and system performance within the emergency department and hospital health care system

**Description of didactic experiences:**

Attending teaching rounds are conducted every morning from 8-10 a.m. where the care of each patient is reviewed and a daily plan is formulated and discussed. Additionally, there are didactic teaching sessions from 10:30-12:00 three days per week where residents are expected to present cases and review ECG's and relevant journal articles. Any additional necessary readings are made available through the Emergency Medicine Residency office or on our curriculum website.

**Evaluation Process:**

Using the Resident Evaluation Form, CCU service attendings complete written evaluations for residents at the end of the rotation. In a situation where resident performance is substandard, the service attending will bring it to the attention of the residency director.

**Feedback Mechanisms::**

Residents meet with their preceptors several times during the month. In addition, either the program director or assistant director meets with the residents twice a year to review their overall performance. The CCU service attending provides more immediate feedback. This feedback is considered valuable to the residents' education.

Have the service directors for all rotations outside the Emergency Department at the primary institution reviewed and agreed to the rotations as described?	YES (X ) NO ( )

### 3. EMS ROTATION

<b>Institution:</b> Rhode Island Hospital	<b>Duration in Months:</b> 1 month
	<b>Year of Training:</b> PGY-2
<b>Educational Objectives:</b>	
<p>At the completion of this rotation, residents will be able to:</p> <ol style="list-style-type: none"> <li>1. Describe the elements of an EMS system (MK, SBP)</li> <li>2. Describe the specific characteristics of the Rhode Island EMS system, including disaster response assets (MK, SBP).</li> <li>3. Demonstrate familiarity with the equipment and procedures of Lifeguard EMS (MK, PC).</li> <li>4. Demonstrate competence in care of patients during critical care EMS transport (PC, SBP)</li> <li>5. Demonstrate competence in use of Level C PPE (MK, PC).</li> <li>6. Demonstrate competence in training of EMTs using provided curricula (MK, ICS, SBP).</li> <li>7. Understand the functions of an EMS Medical Director (SBP).</li> <li>8. Perform quality assurance review of EMS charts and lead related meetings (SBP).</li> <li>9. Teach EMTs basic and advanced clinical topics in both formal and informal sessions (ICS, MK).</li> </ol>	
<b>Description of Clinical Experience</b>	
<p>1 month during the second year of residency. During this month, half of the resident's time is allotted to Ultrasound training and experience and the other half to EMS. There will be an effort to best schedule the resident's time (given availability of mentors and other issues) in order to receive the majority of didactic ultrasound training at the beginning of the month, allowing a greater focus on EMS and the ability to build ultrasound case volume late in the month. EMS shifts with Lifeguard EMS are 8 hours in length with the start and end times to be determined.</p> <ol style="list-style-type: none"> <li>1. Be present as assigned and in communication with the Lifeguard EMS staff, in uniform, during all Lifeguard EMS shifts.</li> <li>2. Properly care for all equipment.</li> <li>3. Attend all Emergency Medicine morning conferences.</li> <li>4. Attend Rescue Rounds.</li> <li>5. Meet with faculty mentor weekly</li> <li>6. Complete assigned reading and study material</li> <li>7. Complete Lifeguard EMS orientation including Level C PPE training</li> <li>8. Complete training of EMT and/or other Lifeguard EMS observers during shifts.</li> <li>9. Provide patient care, under direct and indirect supervision of the attending physician, for Lifeguard EMS patients.</li> <li>10. Complete relevant documentation</li> <li>11. Review EMS charts for quality improvement purposes as assigned; lead related meetings.</li> <li>12. Review and update EMS protocols as assigned, citing relevant literature</li> </ol>	
<b>Medical Knowledge and Patient Care Educational Objectives:</b>	
<b>Patient Care Competencies:</b>	
<b>Interpersonal and Communication Skill Competencies:</b>	
<b>Practice-Based Learning and Improvement Competencies:</b>	
<b>Professionalism Competencies:</b>	
<b>Systems-Based Practice Competencies</b>	

<b>Description of Didactic Experience:</b>	
Residents will be assigned reading which includes: Introductory EMS material (EMS related chapters from textbooks, The Air medical Physician Association Medical Director's Handbook), Rhode Island Specific Material (Titan Report Station Nightclub Fire, RI EMS Protocols, RI EMA Multiple Casualty Incident Plan), Lifeguard EMS Specific Material (policy and procedure manual), STEP (Simulation-based training in emergency Preparedness curricula), EMS Literature (selected articles from medical journals). During the month residents are required to attend all Emergency Medicine morning conferences and Rescue rounds once a month.:	
<b>Evaluation Process::</b>	
Residents will meet with faculty mentor weekly. Using the Emergency Medicine Resident Evaluation Form the EMS director will complete a written evaluation for each resident at the end of the rotation. In a situation where resident performance is substandard, the service attending will bring it to the attention of the residency director.	
<b>Feedback Mechanisms:</b>	
Informal feedback will be given during weekly meetings with faculty mentor. In addition, either the program director or assistant director meets with the residents twice a year to review their overall performance.	
Have the service directors for all rotations outside the Emergency Department at the primary institution reviewed and agreed to the rotations as described?	YES (X) NO ( )

#### 4. FAST TRACK ROTATION

<b>Institution:</b> The Miriam Hospital	<b>Duration in Months:</b> 1 month <b>Year of Training:</b> PGY-1
<b>Educational Objectives:</b>	
<p>Expose the ED resident to a large variety of straight forward and common emergencies that present to a “Fast Track” Emergency department setting and to refine the ED resident’s ability to perform a rapid and appropriate history and physical exam.</p> <ol style="list-style-type: none"><li>1. Demonstrate knowledge of common ophthalmologic problems such as: conjunctivitis, corneal abrasion and corneal foreign body (MK, PC).</li><li>2. Demonstrate the use of diagnostic tools for ophthalmologic conditions including the slit lamp, wood’s lamp, and Tono Pen (as well as other instruments for measuring intraocular pressure) (MK, PC)</li><li>3. Demonstrate knowledge of common ENT problems such as minor facial trauma, epistaxis and cerumen impaction (MK, PC).</li><li>4. Demonstrate the ability to perform both anterior and posterior nasal packing using a variety of techniques (MK, PC).</li><li>5. Manage a variety of wound presentations including lacerations, abscesses, animal bites, puncture wounds and burns (MK, PC).</li><li>6. Perform multiple soft tissue procedures including a laceration repair, incision and drainage of abscess and minor burn care (MK, PC).</li><li>7. Demonstrate proficiency in local anaesthesia techniques and digital blocks (MK, PC).</li><li>8. Demonstrate ability to manage traumatic and non traumatic musculoskeletal problems (MK, PC).</li><li>9. Demonstrate knowledge of emergent and nonemergent causes of back pain (MK, PC).</li><li>10. Perform splinting, nail trephination, arthrocentesis, and reduction of simple dislocations (MK, PC).</li><li>11. Demonstrate ability to manage a variety of infectious complaints such as sinusitis, pharyngitis, bronchitis, urinary tract infection, sexually transmitted diseases and cellulitis (MK, PC)</li><li>12. Demonstrate knowledge necessary to manage and treat patients presenting with headache (MK, PC).</li><li>13. Demonstrate ability to interact with other members of the medical staff including primary care physicians and consultants (ICS, SBP).</li></ol>	
<b>Description of Clinical Experience</b>	
<p><b>The</b> PGY-1 resident will be assigned to work in the Annex section of the Miriam Hospital Emergency Department, a 7 bed unit dedicated to patients presenting with nonurgent problems as designated by the Emergency Department triage nurse. An average of 40 patients per day is seen in this unit. The resident will work 10 hour shifts on Sunday, Monday, Tuesday, Wednesday, and Thursday of each week during their 4 week block. Shifts are scheduled from 12-10pm except on Monday when they are scheduled from 1-11pm to allow time for EM conference attendance. Maximum work week hours are in compliance with ACGME work hour restrictions.</p>	
<p>Duties and responsibilities will include:</p> <ol style="list-style-type: none"><li>1. Direct patient care under the supervision of the Attending emergency physician.</li><li>2. Attendance at Morbidity and Mortality conference and scheduled didactic lectures at the Miriam Hospital.</li><li>3. Residents must report for all scheduled shifts.</li><li>4. At the completion of the rotation the resident is required to fill out evaluation sheets on all faculty members with whom they have worked.</li><li>5. The resident will keep a log of all procedures performed.</li></ol>	

Supervision: The PGY-1 resident will be under the direct supervision of the On Duty Emergency Physician working in the fast track section of the emergency department. Cases will be presented directly to the attending physician who will discuss evaluation and management options. The attending physician will see all the patients as well.	
<b>Medical Knowledge and Patient Care Educational Objectives:</b>	
<b>Patient Care Competencies:</b>	
<b>Interpersonal and Communication Skill Competencies:</b>	
<b>Practice-Based Learning and Improvement Competencies:</b>	
<b>Professionalism Competencies:</b>	
<b>Systems-Based Practice Competencies:</b>	
<b>Description of Didactic Experiences;</b>	
The resident attends the Miriam Hospital Morbidity and Mortality conference. They will also have the opportunity to attend lectures following the Miriam Hospital monthly Emergency Medicine Morbidity and Mortality conference. They are also required to attend the weekly 5 hour didactic conferences scheduled by the department of emergency medicine. Resources available to the resident while on this rotation include the Miriam Hospital Library and Brown University library. On line resources through the Lifespan intranet, Emergency Department attendings, subspecialty consultants and regular conference.	
<b>Evaluation Process</b>	
The resident will be evaluated by the attending physicians at the end of their four week block. An aggregate evaluation form will be completed and returned to the Emergency medicine residency director. This evaluation will be shared with the resident during their semi annual evaluation. If there are any concerns these will be immediately brought to the attention of the Residency Director.	
<b>Feedback Mechanisms:</b>	
The resident in Emergency Medicine will receive continuous informal feedback from the supervising attending during their shifts. Formal feedback occurs on the end of month evaluation which will be discussed at the resident's semiannual evaluation with the residency director. Any situation in which a resident's performance is substandard will be brought to the Emergency Medicine Residency Program Director's attention directly.	
Have the service directors for all rotations outside the Emergency Department at the primary institution reviewed and agreed to the rotations as described?	YES (X ) NO ( )

## 5. MEDICINE WARDS (MED) ROTATION

<b>Institution:</b> Rhode Island Hospital	<b>Duration in Months:</b> 1 month <b>Year of Training:</b> PGY-1
<b>Educational Objectives:</b>	
<p>Residents must demonstrate knowledge about established and evolving biomedical, clinical, and cognate (e.g. epidemiological and social-behavioral) sciences and the application of this knowledge to patient care.</p> <ol style="list-style-type: none"><li>1. To expose residents to a broad variety of patients and medical conditions in an acute care hospital setting.</li><li>2. To promote independent learning skills among residents caring for acutely ill patients</li><li>3. To provide an educational environment through Morning Report, Attending Rounds, Intern Conference, Ethics Conference and Noon Conferences that will permit resident to learn about conditions existing in their own patients, as well as those patients cared for by their peers.</li><li>4. To promote independent decision-making behaviors consistent with the concept of supervised autonomy</li><li>5. To promote professionalism among residents and interns, whereby residents will understand the importance of their roles as teachers. All housestaff will demonstrate an appreciation of the primacy of the patient's needs and autonomy.</li><li>6. The resident will keep abreast of new scientific knowledge. This knowledge will be obtained via didactic sessions, Grand Rounds, critical review of scientific literature (e.g. journal clubs), computer and web-based resources.</li><li>7. The resident will participate actively in assigned conferences and teaching rounds. These conferences will include medical, ethical, psychosocial issues, and culturally sensitive topics. Residents will participate regularly in required conferences, including Morning Report, intern conference, Grand Rounds, noon conference, journal club, board review, pathology conference, death review, MAR Conference.</li></ol>	
<b>Description of Clinical Experience</b>	
<p>The General Internal Medicine Ward Rotation at RIH is a core inpatient experience during which interns and residents gain knowledge, skills and practice in the care of acutely ill hospitalized patients. The rotation requires a high degree of organization and efficiency, as well as a strong commitment to professionalism.</p> <p>There are eight teams on per month at RIH. Teams are equally divided between Med A and Med B so that one of each is on every call day. Admissions to Med A are primarily patients who have a relationship with an attending - community-based or full time - before admission. That attending becomes the attending of record for that patient. These teams are also assigned a Med A Teaching Attending who conducts attending rounds and is responsible for evaluation and feedback over the course of the month. Med B teams care primarily for "unassigned" service patients, who are assigned to the General Internal Medicine Service attending for that team as the patient's attending of record. The Med B attending conducts attending rounds, combined management and teaching rounds with their post-call teams, provides feedback and is responsible for evaluations.</p> <p>On each day there are two teams on call. Each team consists of one resident (2<sup>nd</sup> or 3<sup>rd</sup> year) and one or two interns. In addition there may be a 3<sup>rd</sup> or 4<sup>th</sup> year medical student and/or a pharmacy student. This rotation is designed around the "go home at night" model with each team on call every 4<sup>th</sup> night (q4). During "on-call" days each team admits up to 5 patients per intern/10 patients per resident and leaves hospital in the evening, signing out to the night float team. There are generally no admissions on "post-call" days. The following day is "short-call" day during which each team admits 2 new patients per intern. These patients will have been admitted overnight by the second year night float. There are generally no admissions on the fourth day in the cycle, "pre-call" day. Per the admission algorithm, the</p>	

cap is five admissions per on-call intern. On short call days, the cap is two per intern. ACGME guidelines permit interns to accept up to two additional patients as transfers from other medical services (i.e. MICU transfers, patients on a non-teaching service that become teaching); these patients are preferentially distributed to the on call team. Short call admissions will have been worked up and admitted by the night float resident. On weekends (Friday and Saturday nights) if your team does not cap, each post-call intern may take a holdover(s) to reach their admission cap (five total).

During the first half of the academic year, formal sign out rounds will take place every evening in the Residents lounge between 4:30 and 5pm. All teams are responsible for remaining in the hospital until this time. On-call teams will take sign out from teams going home and provide cross-coverage for their patients until 8pm. The interns on-call will carry the cross-cover beepers (Med A or B) during the entire day but will not provide cross-coverage until after 5pm sign-out. At 8pm the night float teams arrive and the on-call interns sign out all patients to the night float interns. The on-call resident will sign out new patients to the NF3 at this time. The NF1's will carry the cross-cover beepers. Though on-call teams sign-out at 8pm they will be continuing to work with their patients until they leave the hospital. Good communication should exist between teams until the on-call team leaves the hospital. Use of the web sign-out system is required for all interns and sub-interns. Orientation to this system, as well as the goals and objectives of the rotation, will take place on the first day of the rotation for interns each month. From 8a-8p, the On Call Team will respond to all codes; from 8p-8a the Night Float Team will respond to all codes. Code pagers will be carried by the on-call residents, NF3, and NF2.

**Interns** are the primary care providers for all patients on their services. When they are unavailable (night, days off, continuity clinic), the intern will sign over responsibility to their resident, night float, or day float as appropriate. Interns are responsible for primary documentation of patient evaluation & management in the patient record.

All interns are supervised by their **resident** or, in the case of a resident's day in the ambulatory setting, a designated day float. The resident must approve all plans set forth by the intern and be contacted for any change in management plan or intervention.

- Intern will pre-round on patients before and during AM Report in preparation for team rounds.
- Intern, together with resident, will receive report on short-call admissions prior to AM Report from Night Float
- Intern serves as primary provider for all patients assigned to him/her. Intern is responsible for initial evaluation of the newly hospitalized patient, documenting a full admission history and physical examination on the Department of Medicine standard admission form, and writing all admission orders utilizing the Physician Order Management System (POM).
- Intern is responsible for examining and monitoring the progress of their patients on a daily basis, noting all laboratory and other data in a timely manner, discussing the management plans with the resident, and writing daily progress notes.
- Intern is responsible for collecting all relevant information on the patient, including reviewing old medical records.
- Intern is responsible for family and patient communication and should serve as liaison between the team and the patient.
- Intern presents all patient cases to the resident and attending on rounds, with exception if the patient is also cared for by a medical student in which case the student will present.
- Intern is responsible for performing all procedures (or observing those they have not yet performed under supervision) within the scope of the generalist on the patients for whom they are caring. Interns will keep a procedure log using the web-based procedure documentation system located on the Internal Medicine Residency Home Page. They will indicate their supervisor, level of proficiency, reason for procedure, outcome and complications, if any.
- Intern is responsible for the dictation of all discharge summaries on unassigned ("service") patients no

more than 30 days following the discharge of each patient.

- Intern **is not** responsible for the dictation of discharge summaries on patients of private or full-time faculty. Intern **is** responsible for discharge paperwork and coordinating after-hospital care services and documents (“yellow forms”) on such patients.
- Interns will present cases at and attend intern conference on Fridays at Noon.
- Interns will attend noon conference, attending rounds and ethics conferences.
- Intern will admit no more than 5 new patients per admitting day and no more than 8 new patients in a 48-hour period.
- Intern will not be responsible for the on-going care of more than 12 patients at a given time.
- Intern will submit written evaluation of resident and attending and rotation upon completion of the rotation.
- Interns will comply with Duty Hours Policy.

Residents and interns are supervised by the **attending** of record and/or teaching attending for the patient, who will collaborate and confirm/modify the team’s plans while providing patient-centered clinical teaching. DGIM faculty at RIH supervise housestaff on Med B and are available 24 hours/7 days/week by pager (on-call schedule with pager numbers on Residency Intranet Website). Med A teams supervised by attending of record, who is available or covered by colleagues according to a regular schedule accessible by office phone. The attending of record has ultimate responsibility for the patient.

**Chief Residents** are program director/chief of service designees who provide guidance and, where appropriate, back-up supervision of the intern or resident in the event that assistance is necessary. The resident or intern will contact the chief resident at the specific institution during the day (or the chief resident on-call at night - on-call schedule with pager numbers on Residency Website) when such assistance is required

**Chief of Service** (RIH Tammaro, TMH Schiffman, PVAMC Anderson) are available for assistance either directly to the resident or through the chief resident.

### **Medical Knowledge and Patient Care Educational Objectives:**

#### **Patient Care Competencies:**

1. Residents must be able to provide patient care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health.
2. Demonstrate the use of information technology in order to promote patient care. Examples of this include the use of Lifelinks for retrieving laboratory and radiology reports and the use of the internet to facilitate patient care.
3. At the end of this rotation, the intern should be able to obtain a complete history including a chief complaint, history of present illness, review of systems, past medical history, social history paying particular attention to cultural and religious beliefs, as well as a family history, developmental history, and list of medications, allergies, and vaccines.
4. The intern should access old medical records and obtain information pertaining to previous hospitalizations, clinic visits, laboratory work and studies from all available sources, including the patient, family and primary physician.
5. Develop competency in the performance of procedures required of emergency physicians.
6. Develop knowledge of preventive health aspects of patient care that may be incorporated into the practice of emergency medicine.

#### **Interpersonal and Communication Skill Competencies:**

Residents must be able to demonstrate interpersonal and communication skills that result in effective information exchange and teaming with patients, their patients’ families, and professional associates.

1. Develop a physician-patient relationship model that creates a therapeutic relationship with

- patients.
2. Develop listening skills that will facilitate communication with patients, their families, and other members of the health care.
  3. Develop interviewing skills that will facilitate patient interaction
  4. Develop skills at facilitating informed decision-making by patients and their families. To learn of specific situations in which informed decision-making may not be possible due to a patient's medical condition or advance directive.
  5. Develop awareness and facilitate the provision of health care within a team of health care providers.
  6. The intern should be able to present a history and physical exam in a clear and concise manner.
  7. The intern should be able to explain to the patient & family the diagnosis, nature of the disease and the expected clinical course.
  8. The intern should be able to effectively communicate medical information in a written format. Notes should be clear, legible, timely and provide content which accurately reflects the patient's current status and planned management strategies. All notes should indicate time and date, and include a header indicating the role of the author
  9. Residents will make explanations in clear, common-parlance language, avoiding use of medical jargon, and using graphic aids (including informal sketches) where helpful to get points across.
  10. Residents will ask patient's/family's concerns and questions and address these specifically and directly to ensure that patient/family have received information in the desired degree of detail.
  11. Residents will clearly identify differences in patient/family and medical perspectives, bringing such differences into open discussion, and explaining the rationales for medical actions that differ from patient/family preferences and values.
  12. Residents will write clearly and legibly when hand-writing instructions or other information for patients/families
  13. Residents will help to ensure that written or printed information for patients/families is language-congruent and literacy appropriate: using straightforward language and comprehensible and culturally appropriate illustration.
  14. Written communications in patient charts will effectively permit subsequent caregivers to understand the nature of the patient interaction and the goals and plans for the encounter as well as future encounters when applicable.
  15. Resident and Intern notes will be dated, timed and clearly indicate the role of the author. including such non-medical resources as Social Work, Case Management, Ethics Committee, Risk Management,
  16. Interns will be able to prepare and present case presentations and lead discussions at intern conference among peers
  17. Resident will prepare & present case presentations and lead in-depth discussions at AM report among peers and faculty.
  18. Resident will complete end-of-rotation evaluations and provide timely feedback for interns in order to direct their professional growth and development

#### **Practice-Based Learning and Improvement Competencies:**

Residents must be able to investigate and evaluate their patient care practices, appraise and assimilate scientific evidence, and improve their patient care practices.

1. Develop methods of analyzing the resident's own practice to improve quality of health care provided.
2. Develop a personal program of learning related to the requirements of the rotation in the context of an emergency medicine rotation.
3. To identify areas of weakness in medical knowledge and practice relevant to the current rotation, and develop a plan to address these weaknesses during the rotation and beyond.
4. To develop skills in the use of evidence from scientific studies to alter the resident's practice of medicine, with the goal of improving the health care provided.

5. To develop skills in the use of information technology, and in particular online Medline reference searching. The resident is expected to regularly review both textbook and primary source literature to maintain up to date understanding of specific topics that have arisen in practice.
6. The resident should actively seek feedback and advice on practice from peers, mentors, staff, and patients alike to gain greater objective insight into their strengths and weaknesses.
7. The resident will gain basic skills in literature search methodologies using standard web-based medical literature search engines such as Ovid, MD Consult, Pubmed.
8. The resident will have familiarity with a variety of computer and hand-held computer based resources for looking up medications, dosing, and other topics of use to the general internist.
9. The resident will actively participate in lectures and discussions with peers and experts on the topics related to the care of their patients.
10. The resident is expected to take a proactive approach to enhancing their knowledge. The resident is expected to “think out loud”, ask for guidance, and actively seek input on their practice and knowledge base from their mentors.

### **Professionalism Competencies:**

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

1. To develop respectful and altruistic attitudes towards patients, their families, and other members of the health care team.
2. To incorporate principles of ethics into the practice of medicine.
3. To develop sensitivity to cultural, age, gender, and disability issues that may impede patient care through disruption of physician-patient interaction.
4. Residents will ask patients/family members how they wish to be addressed; avoid addressing adults by first name unless specifically invited to do so.
5. Residents will know and avoid breach of the boundaries of the physician/patient relationship, including but not limited to strict avoidance of sexual or romantic suggestiveness or involvement with patients/family members.
6. Residents will operate with respect for patient confidentiality at all times.
7. Residents will place patient safety and care above all competing considerations at all times.
8. Residents will make reasonable efforts to act as advocates for their patients.
9. Residents will place patient safety as their first priority without compromising their own safety or the safety of others that they are supervising.
10. Residents will make every effort to elicit and to accommodate, to the fullest extent of their ability, differing religious and cultural needs and values in delivering medical care— but are under no obligation to accommodate requests based upon any form of identity-group prejudice.
11. Residents will clearly and openly identify and repudiate statements of prejudice made by professional colleagues, and will not permit their actions as physicians to be influenced by such prejudice.
12. Residents will cultivate the ability to identify and articulate their own cultural values and preferences, comforts and discomforts; and to be self aware in attempting to deliver fair and optimal medical care to all patients – including recognizing their obligation to transfer care to another physician should the occasion arise in which personal values or biases interfere with such care delivery to any patient or family.
13. Residents will use language that is neutral as to assumptions of gender, sexual preference, religion, race/ethnicity, etc. when making general comments and explanations.
14. Residents will scrupulously maintain patient confidentiality, and specifically reassure patients/families of the confidentiality of their personal and medical information.
15. Residents will know and be able to describe the proper boundaries of the physician/patient relationship, and will consistently and conscientiously avoid any breach of these boundaries.

**Systems-Based Practice Competencies:**

Residents must demonstrate an awareness of and responsiveness to the larger context and system of health care and the ability to effectively call on system resources to provide care that is of optimal value. By the end of their training, residents are expected to have attained competence in the following goals.

1. Develop an understanding of the interaction of the practice of emergency medicine with that of the larger health care system as a whole.
2. Develop knowledge of the practice and delivery of health care in different systems and environments
3. Develop cost-effective strategies in the practice of emergency medicine.
4. Develop an attitude of being an advocate for the patient within the health care system.
5. Develop a willingness to become involved in a partnership to improve health care and system performance.
6. The resident will learn how to work within a multidisciplinary team to develop a care plan for their patients.
7. The resident will become familiar with hospital and community based health care professionals and their roles in groups such as social work, mental health professionals, PT, OT, dietitians, and VNA etc.
8. The resident will evaluate how interacting with the above groups and health professionals affects their own practice.
9. The resident will maintain responsible communications by phone and letter with their patient's primary care physician.
10. The resident will learn how and when to appropriately refer patients to subspecialists and how to communicate effectively with the subspecialist.

**Description of Didactic Experiences:**

1) Attending Rounds; 2) Intern Conference; 3) Combined Management/Teaching Rounds; 4) Morning Report ; 5) Ethics Conference - one session per month per team in place of attending rounds; scheduled by CMR ; 6) Clinical Evaluation Exercise - Med B attending conducts for interns on short call day; 7) Noon Conference – see curriculum/topic list by subspecialty, as well as schedule, on residency home page intranet site; 8) Monthly Mortality Review Sessions - review of all deaths on medical services; 9) Pathology Review Session - once monthly during noon conference; review of all pathology specimens from patients each month; 10) MAR Conference – Medical Admitting Residents Conduct noon conference on topics relevant to triage decision-making; 11) Journal Club – review of current literature and critical appraisal skills – conducted 2x/month at RIH

**Computer-Assisted Educational Materials:**

All housestaff have access to full-text literature search and retrieval capacity through the hospital computer network. Terminals are located on all floors in all clinical areas. Residents also have access to radiology, pulmonary and hematology teaching files.

**Evaluation Process:**

Evaluation of the **intern's** successful completion of the goals outlined below will be carried out by the attending and resident. This evaluation form will be turned in to the EM residency program director for review. Evaluation of the **rotation** will be carried out at the end of the month by the intern and resident.

**Feedback Mechanisms:**

The end of month evaluation is reviewed with each individual resident at their semiannual evaluation with the program director or assistant program director. Any concerns brought to the attention of the program director are discussed immediately with the resident involved.

Have the service directors for all rotations outside the Emergency Department at the primary institution reviewed and agreed to the rotations as described?	YES (X ) NO ( )

## 6. MEDICAL INTENSIVE CARE (MICU) ROTATION

<b>Institution:</b> The Miriam Hospital	<b>Duration in Months:</b> 1 month
	<b>Year of Training:</b> PGY-1 and PGY-3
<b>Educational Objectives:</b>	
<ol style="list-style-type: none"> <li>1. To develop facility in the monitoring and integration of care provided by the critically ill medical and surgical patients (MK, PC).</li> <li>2. To experience the management of delayed post-operative complications, sepsis, and multiple organ failure (MK, PC).</li> <li>3. To reinforce prior exposure to nutritional support of the medical and surgical patient, and experience the problems peculiar to the critically ill patient (MK, PC, SBP)</li> <li>4. To develop facility in the differential diagnosis and management of medical shock states (MK, PC).</li> <li>5. To experience the management of upper and lower gastrointestinal bleeding (MK, PC).</li> <li>6. To be exposed to the continued definitive care of the poisoned patient, particularly tricyclic antidepressant, acetaminophen and salicylate overdoses (MK, PC).</li> <li>7. To experience the management of specific problems in oxygenation and ventilatory support in respiratory failure, including COPD with decompensation, severe asthma, overwhelming pneumonia, adult respiratory distress syndrome, flail chest/pulmonary contusion, and permeability pulmonary edema (MK, PC).</li> <li>8. To experience the management of acute renal failure, hepatic failure, multiple organ failure and sepsis (MK, PC).</li> <li>9. To participate in the management of neurosurgical patients with closed head injury, subarachnoid hemorrhage, intracerebral hemorrhage, neoplastic disease and spinal injury (MK, PC).</li> <li>10. To gain exposure to nutritional and fluid/electrolyte management of the critically ill medical patient (MK, PC).</li> <li>11. To recognize and appropriately address supraventricular and ventricular arrhythmias (MK, PC).</li> <li>12. To reinforce facility with central circulation access/monitoring devices and techniques, arterial catheter placement and care, thoracostomy tube and abdominal drain management, temporary pacemakers, continuous CSF drainage devices, continuous renal replacement (CWH), airway management and the operating principles and proper application of mechanical ventilators (MK, PC).</li> <li>13. To reinforce appropriate use of blood products and their alternatives (MK, PC, SBP).</li> <li>14. To develop an appreciation for the salient issues in intensive care unit resource allocation and an approach to rational triage decision-making (MK, SBP, PBL).</li> <li>15. To gain exposure and experience with cost-effective application and utilization of medical technology (MK, PC, SBP).</li> <li>16. To broaden experience in meeting the emotional and communication needs of critically ill patients and their families (ICS, Prof).</li> <li>17. To gain experience and knowledge with the medical-legal aspects of End-of-Life care (PC, ICS, Prof).</li> </ol>	
<b>Description of Clinical Experience</b>	
<p>The Medical Intensive Care Unit (MICU) at the Miriam Hospital is a 16 bed combined medical-surgical facility staffed by full time, Board Certified intensivists and fellows in critical care. Separate coronary care and step-down units exist with independent nursing, resident and attending coverage. The MICU deals primarily with multi-system disease, though overflow from other units, particularly the CCU, does occur. Residents rotate through the MICU for one month during their PGY-1 and PGY-3 years. Emergency medicine residents have responsibilities comparable with the equivalent level of Internal Medicine resident, and are supervised and provide direct care for all unit patients in concert with this principle. They are responsible for the initial evaluation and management of patients admitted to their care as well as the supervision of medical interns. They are also responsible for making decisions</p>	

about unit candidacy for floor and Emergency Department patients. Emergency medicine residents serve as integrated team members who take call on a rotating basis with two other junior and senior medical resident/intern teams. Residents are required to attend all daily attending rounds and teaching conferences. In addition to any readings provided by the unit staff, they have a required reading list prepared by the Department of Emergency Medicine.

**Emergency medicine residents rotating on the Medical Intensive Care Unit (MICU) have the following duties/responsibilities:**

1. Direct patient care.
2. Consultation under supervision
3. Performance of procedures related to patient care.
4. On-call responsibilities on par with other residents (at their level of training) on the service
5. Duty hours in compliance with the ACGME requirements

**Medical Knowledge and Patient Care Educational Objectives:**

**Patient Care Competencies:**

1. Demonstrate the use of information technology in order to promote patient care. Examples of this include the use of Lifelinks for retrieving laboratory and radiology reports and the use of the internet to facilitate patient care.
2. Develop competency in the performance of procedures required of emergency physicians, as well as performance of physical examination related to a patient's chief complaint.
3. To develop knowledge of preventive health aspects of patient care that may be incorporated into the practice of emergency medicine.

**Interpersonal and Communication Skill Competencies:**

1. Develop a physician-patient relationship model that creates a therapeutic relationship with patients.
2. Develop listening skills that will facilitate communication with patients, their families, and other members of the health care.
3. Demonstrate and observe caring and respectful behaviors through patient interactions and observations of more senior residents and attending staff
4. Develop interviewing skills that will facilitate patient interaction
5. Develop skills at facilitating informed decision-making by patients and their families. To learn of specific situations in which informed decision-making may not be possible due to a patient's medical condition or advance directive.
6. Counsel and educate patients and their families of their medical conditions.
7. Develop awareness and facilitate the provision of health care within a team of health care providers.

**Practice-Based Learning and Improvement Competencies:**

1. Develop methods of analyzing the resident's own practice to improve quality of health care provided.
2. Develop a personal program of learning related to the requirements of the rotation in the context of an emergency medicine rotation.
3. To identify areas of weakness in medical knowledge and practice relevant to the current rotation, and develop a plan to address these weaknesses during the rotation and beyond.
4. To develop skills in the use of evidence from scientific studies to alter the resident's practice of medicine, with the goal of improving the health care provided.
5. To develop skills in the use of information technology, in particular online Medline reference searching.

**Professionalism Competencies:**

1. To develop respectful and altruistic attitudes towards patients, their families, and other members of the health care team.

2. To incorporate principles of ethics into the practice of medicine.
3. To develop sensitivity to cultural, age, gender, and disability issues that may impede patient care through disruption of physician-patient interaction.

**Systems-Based Practice Competencies:**

1. Develop an understanding of the interaction of the practice of emergency medicine with that of the larger health care system as a whole.
2. Develop knowledge of the practice and delivery of health care in different systems and environments
3. Develop cost-effective strategies in the practice of emergency medicine.
4. Develop an attitude of being an advocate for the patient within the health care system.
5. Develop a willingness to become involved in a partnership to improve health care and system performance within the emergency department and hospital health care system.

**Description of Didactic Experience**

Although their clinical responsibilities in the MICU take preference, emergency medicine residents are encouraged to attend the Monday morning conference series when possible. Attending rounds are held daily to discuss individual cases, review pathophysiologic processes, and introduce evidence based therapies. Thrice weekly didactic conferences and weekly medical and surgical M&M conferences also occur, and several critical care topics are presented by the attending staff during the month. Both a core curriculum and pertinent medical literature are distributed by the ICU director to each resident at the start of the rotation.

**Evaluation Process:**

Using the Emergency Medicine Resident Evaluation Form, MICU service attendings complete written evaluations for residents at the end of the rotation. In a situation where resident performance is substandard, the service attending will bring it to the attention of the residency director. In addition, feedback is provided regularly throughout the rotation by supervising residents, fellows and attendings on teaching rounds and one on one patient care experiences.

**Feedback Mechanisms:**

Residents meet with their preceptors several times during the month. In addition, either the program director or assistant director meets with the residents twice a year to review their overall performance. The MICU service attending provides more immediate feedback. This feedback is considered valuable to the residents' education

Have the service directors for all rotations outside the Emergency Department at the primary institution reviewed and agreed to the rotations as described?	YES (X ) NO ( )

## 7. MIRIAM EMERGENCY ROOM (MER) ROTATION

<b>Institution:</b> The Miriam Hospital	<b>Duration in Months:</b> 1 month - PGY-3 .5 month - PGY-4
	<b>Year of Training:</b> PGY-3, 4
<b>Educational Objectives:</b>	
<ol style="list-style-type: none"> <li>1. Expose the resident to patients of all ages with a broad spectrum of undifferentiated illness and injury mixed in a single emergency department (MK, PC, SBP).</li> <li>2. Evaluate, stabilize and manage a wide array of common moderate to high acuity patients in a community emergency department (MK, PC, SBP, ICS, Prof).</li> <li>3. Refine their history and physical examinations skills (MK, PC, ICS).</li> <li>4. Demonstrate the ability to prioritize patients based on acuity (MK, PC, SBP).</li> <li>5. Develop a detailed management plan (MK, PC)</li> <li>6. Demonstrate appropriate interpersonal/communication skills in dealing with consult and referral services on patient care issues (ICS, SBP)</li> <li>7. Develop and practice laboratory and radiology interpretation skills (MK, PC).</li> <li>8. Demonstrate an understanding of transfer requirements and EMTALA regulations (SBP).</li> <li>9. Demonstrate efficiency in patient evaluations (MK, PC, ICS, SBP).</li> <li>10. Demonstrate advanced ability at deciding upon and effecting patient disposition (SPB, PBL).</li> <li>11. Demonstrate an increased awareness of patient flow considerations (SBP, PBL).</li> <li>12. Demonstrate insight into the development of a particular personal practice style (PBL).</li> <li>13. Perform teaching activities for the junior residents both in the clinical and didactic environments (MK, ICS, Prof).</li> </ol>	
<b>Description of Clinical Experience</b>	
<p>Emergency medicine residents spend a one month rotation in the Emergency Department at the Miriam Hospital. The main objective of this rotation is to immerse the PGY-2 resident in a highly efficient community emergency department. They will build on their medical knowledge acquired thus far in their training and incorporate new strategies for improved systems based practice in a community emergency department. Additionally, this rotation requires the acquisition of advanced interpersonal skills when dealing with the patient population and the private attending staff that cares for the patient. Residents evaluate patients in the medium to high acuity treatment areas of the emergency department.</p>	
<p>Duties and responsibilities include:</p> <ul style="list-style-type: none"> <li>• The residents will manage multiple patients simultaneously under the direct supervision of an Emergency Medicine attending physician.</li> <li>• Teaching and supervision of medicine residents on the EM rotation</li> <li>• Participation in quality improvement activities</li> <li>• Participation in all offered emergency medicine conferences</li> <li>• Duty hours will be approximately 50/week in compliance with ACGME duty hour requirements.</li> <li>• Residents must report for all scheduled shifts.</li> </ul>	
<b>Medical Knowledge and Patient Care Educational Objectives:</b>	
<b>Patient Care Competencies:</b>	
<b>Interpersonal and Communication Skill Competencies:</b>	
<b>Practice-Based Learning and Improvement Competencies:</b>	
<b>Professionalism Competencies:</b>	
<b>Systems-Based Practice Competencies:</b>	

<b>Description of Didactic Experience</b>	
All Emergency Medicine residents rotating at the Miriam Hospital Emergency Department are required to attend an orientation session, attend monthly morbidity & mortality rounds at the Miriam Hospital and attend lectures provided for the residents after the monthly faculty meeting. Additionally, residents are allowed time to attend the weekly 5 hour didactics provided by the Emergency Medicine residency at Rhode Island Hospital. The PGY 4 resident at the Miriam hospital will be expected to present a topic for rotating junior resident or at the monthly faculty M&M conference.	
<b>Evaluation Process:</b>	
At the completion of the month residents are required to fill out an evaluation sheet on all faculty they have worked with. Residents will keep a log of all procedures performed. At the end of the month residents receive a consensus evaluation completed in aggregate by the Miriam ED faculty.	
<b>Feedback Mechanisms:</b>	
During the month residents will get informal feedback from the attending physicians directly supervising them. Attendings are queried as to resident performance and behavior at monthly attending meetings midway through the rotation. Major problems, issues or concerns are brought to the resident's attention by the rotation director or their designee.	
Have the service directors for all rotations outside the Emergency Department at the primary institution reviewed and agreed to the rotations as described?	YES (X ) NO ( )

**8. NEUROLOGY ROTATION**

<b>Institution:</b> Rhode Island Hospital	<b>Duration in Months:</b> 1 month
	<b>Year of Training:</b> PGY-2
<b>Educational Objectives:</b>	
<ol style="list-style-type: none"> <li>1. Learn how to perform a neurological history and physical examination (MK, PC, ICS, Prof)           <ol style="list-style-type: none"> <li>(a) Perform a <u>neurological history</u>, including types of symptoms, location, duration, exacerbating and relieving factors, previous neurological history, other past history, medications, allergies, family history, and pertinent social history.</li> <li>(b) Perform a <u>mental status examination</u>, including level of consciousness, orientation, mood, affect, speech, memory (immediate, recent, and remote), attention span, calculation (appropriate for level of education), judgment, hallucinations, and abnormal ideation (homicidal, suicidal, and delusional).</li> <li>(c) Perform a <u>neurological physical examination</u>, including motor, sensory, cerebellar, cranial nerves, reflexes, Romberg, gait, and neurovascular exams.</li> </ol> </li> <li>2. Understand principles for ordering diagnostic studies, including CT scan, MRI scan, spine and back x-rays, myelogram, EEG, nerve conduction and EMG, and lumbar puncture as well as evaluating results for these studies (MK, PC, SBP).</li> <li>3. Using all the information gathered, generate an appropriate differential diagnosis that is based on neuroanatomy and neurophysiology in the areas of vascular disease (transient vs. permanent, hemorrhage vs. infarction), headache, seizures, demyelinating processes, infectious (meningitis, encephalitis, abscess), toxic or metabolic disorders, neoplasms, disorders of the peripheral nervous system, neuromuscular diseases, and alterations in level of consciousness (MK, PC).</li> <li>4. Learn the initial management of patients with neurological emergencies, including coma and alterations in mental status, seizures, headache, acute or evolving stroke, syncope, CNS infections, and alcohol or other drug withdrawal (MK, PC).</li> </ol>	
<b>Description of Clinical Experience</b>	
<p><b>Description of clinical experiences:</b></p> <p>These goals are accomplished through a one-month rotation in the Department of Neurology at Rhode Island Hospital during PGY-1 and through Emergency Department experience. During the neurology rotation, residents are involved in multiple consultations on patients with neurological problems. The faculty of the Department of Neurology provides supervision.</p> <p>During one month of the PGY-1 year, residents are assigned to the neurology consult service and function at the same level as first-year neurology residents. EM residents are under the direct supervision of senior neurology residents and attending neurologists. EM residents have daily responsibility in performing consultations on patients with acute neurological problems in a variety of sites, including the Emergency Department and inpatient wards. They participate in teaching rounds related to these patients and take call on a basis on par with neurology residents at the same level of training. During these on-call evenings, EM residents are primarily involved in acute evaluations in the Emergency Department and initial care of these inpatients subsequent to their admission. Rhode Island Hospital is the site of the Brown University Residency in Neurology and boasts a very active service. Emergency medicine residents function at the same level as neurology residents in caring for inpatients, with the same duties and responsibilities. Residents participate in case conferences, rounds, and grand rounds held with attending neurology faculty. A reading list is provided by the Department of Emergency Medicine in addition to any readings provided by the Department of Neurology.</p> <p>Emergency medicine residents rotating on the neurology service have the following duties and responsibilities:</p>	

<ol style="list-style-type: none"> <li>1. Direct patient care.</li> <li>2. Consultation under supervision.</li> <li>3. Performance of procedures related to patient care.</li> <li>4. On-call responsibilities on par with other residents (at the same level of training) on the service in compliance with ACGME duty hour restrictions.</li> </ol>
<b>Medical Knowledge and Patient Care Educational Objectives:</b>
<b>Patient Care Competencies:</b>
<ol style="list-style-type: none"> <li>1. Demonstrate the use of information technology in order to promote patient care. Examples of this include the use of Lifelinks for retrieving laboratory and radiology reports and the use of the internet to facilitate patient care.</li> <li>2. Develop competency in the performance of procedures required of emergency physicians, as well as performance of physical examination related to a patient's chief complaint.</li> <li>3. To develop knowledge of preventive health aspects of patient care that may be incorporated into the practice of emergency medicine.</li> </ol>
<b>Interpersonal and Communication Skill Competencies:</b>
<ol style="list-style-type: none"> <li>1. Develop a physician-patient relationship model that creates a therapeutic relationship with patients.</li> <li>2. Develop listening skills that will facilitate communication with patients, their families, and other members of the health care.</li> <li>3. Demonstrate and observe caring and respectful behaviors through patient interactions and observations of more senior residents and attending staff</li> <li>4. Develop interviewing skills that will facilitate patient interaction</li> <li>5. Develop skills at facilitating informed decision-making by patients and their families. To learn of specific situations in which informed decision-making may not be possible due to a patient's medical condition or advance directive.</li> <li>6. Counsel and educate patients and their families of their medical conditions.</li> <li>7. Develop awareness and facilitate the provision of health care within a team of health care providers.</li> </ol>
<b>Practice-Based Learning and Improvement Competencies:</b>
<ol style="list-style-type: none"> <li>1. Develop methods of analyzing the resident's own practice to improve quality of health care provided.</li> <li>2. Develop a personal program of learning related to the requirements of the rotation in the context of an emergency medicine rotation.</li> <li>3. To identify areas of weakness in medical knowledge and practice relevant to the current rotation, and develop a plan to address these weaknesses during the rotation and beyond.</li> <li>4. To develop skills in the use of evidence from scientific studies to alter the resident's practice of medicine, with the goal of improving the health care provided.</li> <li>5. To develop skills in the use of information technology, and in particular online Medline reference searching</li> </ol>
<b>Professionalism Competencies:</b>
<ol style="list-style-type: none"> <li>1. To develop respectful and altruistic attitudes towards patients, their families, and other members of the health care team.</li> <li>2. To incorporate principles of ethics into the practice of medicine.</li> <li>3. To develop sensitivity to cultural, age, gender, and disability issues that may impede patient care through disruption of physician-patient interaction.</li> </ol>
<b>Systems-Based Practice Competencies:</b>
<ol style="list-style-type: none"> <li>1. Develop an understanding of the interaction of the practice of emergency medicine with that of the larger health care system as a whole.</li> </ol>

<p>2. Develop knowledge of the practice and delivery of health care in different systems and environments</p> <p>3. Develop cost-effective strategies in the practice of emergency medicine.</p> <p>4. Develop an attitude of being an advocate for the patient within the health care system.</p> <p>5. Develop a willingness to become involved in a partnership to improve health care and system performance within the emergency department and hospital health care system.</p>	
<p><b>Description of Didactic Experience</b></p>	
<p>Residents are required to attend emergency medicine weekly conferences during this rotation. Topics related to neurology are covered in the core curriculum. Residents are also required to attend the neurology daily morning report and weekly grand rounds.</p>	
<p><b>Evaluation Process:</b></p>	
<p>Using the Emergency Medicine Resident Evaluation Form, neurology service attendings complete written evaluations for residents at the end of the rotation. In a situation where resident performance is substandard, the neurology service attending will bring it to the attention of the residency director.</p>	
<p><b>Feedback Mechanisms:</b></p>	
<p>Residents meet with their preceptors several times during the month. In addition, either the program director or assistant director meets with residents twice a year to review their overall performance. The neurology faculty provides more immediate feedback.</p>	
<p>Have the service directors for all rotations outside the Emergency Department at the primary institution reviewed and agreed to the rotations as described?</p>	<p>YES (X ) NO ( )</p>
<p></p>	<p></p>

## 9. OBSTETRICS & GYNECOLOGY (OB/GYN) ROTATION

<b>Institution:</b> Women & Infants Hospital	<b>Duration in Months:</b> 1 month
<b>Year of Training:</b> PGY-1	
<b>Educational Objectives:</b>	
To become familiar with the diagnosis and management of common gynecologic problems which may present to the Emergency Department to include the following (MK, PC):	
<ol style="list-style-type: none"> <li>1. Demonstrate knowledge of infectious diseases including sexually transmitted diseases, pelvic inflammatory disease, and bartholinitis.</li> <li>2. Demonstrate knowledge of the following abnormalities of reproductive physiology: dysfunctional uterine bleeding, ovarian cysts, fibroids, endometriosis, pelvic foreign bodies, estrogen withdrawal states, and sexual assault.</li> </ol>	
To become familiar with the identification and management of both normal and abnormal physiology of pregnancy including (MK, PC):	
<ol style="list-style-type: none"> <li>1. Demonstrate knowledge of drug safety during pregnancy</li> <li>2. Demonstrate knowledge of standard prenatal care</li> <li>3. Demonstrate knowledge of the work up and differential diagnosis of vaginal bleeding in all three trimesters</li> <li>4. Demonstrate knowledge of identification and management of ectopic pregnancy</li> <li>5. Nausea and vomiting in pregnancy</li> <li>6. Infections during pregnancy: pyelonephritis, appendicitis, cholecystitis, STDs, HSV</li> <li>7. Demonstrate identification and management of trauma during pregnancy</li> <li>8. Demonstrate identification and management of preterm labor</li> <li>9. Demonstrate identification and management of pregnancy induced hypertension</li> </ol>	
To develop techniques and management of normal and abnormal delivery (MK, PC):	
<ol style="list-style-type: none"> <li>1. Cervical examination</li> <li>2. Spontaneous vaginal delivery of fetus and placenta</li> <li>3. Shoulder dystocia</li> <li>4. Placental malformations</li> <li>5. Tocometry patterns</li> <li>6. Breech presentations</li> <li>7. Nuchal cord</li> <li>8. Post partum hemorrhage</li> <li>9. Amniotic fluid embolism</li> <li>10. Repair of vaginal lacerations</li> </ol>	
To learn skills necessary to the management of gynecologic conditions (MK, PC)	
<ol style="list-style-type: none"> <li>1. pelvic examination</li> <li>2. trans vaginal ultrasonography</li> <li>3. word catheter insertion</li> </ol>	
<b>Clinical Experience:</b>	
<p>The PGY-1 will be integrated as a member of the Obstetrics team at Women and Infants hospital, an obstetrical referral center for southeastern New England providing approximately 10,000 deliveries per year. As a member of the team the Emergency Medicine resident will care for patients on the labor and delivery floor, in the triage/intake area, and participate in didactics along with the Ob/Gyn residents. On the labor floor the residents learn the mechanics of the normal vaginal delivery as well as the identification and management of complications of abnormal delivery. In the triage/intake unit residents provide care to women in all stages of labor and learn management of various gynecologic diseases.</p>	

It is expected that the the emergency medicine resident will spend 10 hours a day, Monday through Friday providing primary patient care in all areas under direct supervision of either an attending Ob/Gyn physician or senior Ob/Gyn resident.

Duties and responsibilities will include:

1. Direct patient care
2. Consultation under supervision
3. Performance of procedures related to patient care
4. On call responsibilities on par with other residents on the service at their level of training.
5. Work hours in compliance with ACGME work hour guidelines

#### **Medical Knowledge and Patient Care Educational Objectives:**

#### **Patient Care Competencies:**

4. Demonstrate the use of information technology in order to promote patient care. Examples of this include the use of Lifelinks for retrieving laboratory and radiology reports and the use of the internet to facilitate patient care.
5. Develop competency in the performance of procedures required of emergency physicians, as well as performance of physical examination related to a patient's chief complaint.
6. To develop knowledge of preventive health aspects of patient care that may be incorporated into the practice of emergency medicine.

#### **Interpersonal and Communication Skill Competencies:**

8. Develop a physician-patient relationship model that creates a therapeutic relationship with patients.
9. Develop listening skills that will facilitate communication with patients, their families, and other members of the health care.
10. Demonstrate and observe caring and respectful behaviors through patient interactions and observations of more senior residents and attending staff
11. Develop interviewing skills that will facilitate patient interaction
12. Develop skills at facilitating informed decision-making by patients and their families. To learn of specific situations in which informed decision-making may not be possible due to a patient's medical condition or advance directive.
13. Counsel and educate patients and their families of their medical conditions.
14. Develop awareness and facilitate the provision of health care within a team of health care providers.

#### **Practice-Based Learning and Improvement Competencies:**

6. Develop methods of analyzing the resident's own practice to improve quality of health care provided.
7. Develop a personal program of learning related to the requirements of the rotation in the context of an emergency medicine rotation.
8. To identify areas of weakness in medical knowledge and practice relevant to the current rotation, and develop a plan to address these weaknesses during the rotation and beyond.
9. To develop skills in the use of evidence from scientific studies to alter the resident's practice of medicine, with the goal of improving the health care provided.
10. To develop skills in the use of information technology, and in particular online Medline reference searching.

#### **Professionalism Competencies:**

1. To develop respectful and altruistic attitudes towards patients, their families, and other members of the health care team.
2. To incorporate principles of ethics into the practice of medicine.
3. To develop sensitivity to cultural, age, gender, and disability issues that may impede patient

care through disruption of physician-patient interaction.	
<b>Systems-Based Practice Competencies:</b>	
<ol style="list-style-type: none"> <li>1. Develop an understanding of the interaction of the practice of emergency medicine with that of the larger health care system as a whole.</li> <li>2. Develop knowledge of the practice and delivery of health care in different systems and environments</li> <li>3. Develop cost-effective strategies in the practice of emergency medicine.</li> <li>4. Develop an attitude of being an advocate for the patient within the health care system.</li> <li>5. Develop a willingness to become involved in a partnership to improve health care and system performance within the emergency department and hospital health care system.</li> </ol>	
<b>Description of Didactic Experience</b>	
Emergency medicine residents will participate in all didactic experiences available to the Ob/Gyn residents during their month on service. They will have access to all of the resources including an extensive library, ultrasound, medical records, and gynecologic subspecialists.	
<b>Evaluation Process:</b>	
Each resident will be assigned a nurse midwife "mentor" whom he/she will meet multiple times throughout the month to ensure appropriate exposure to both Obstetrical and Gynecologic issues. Additionally, the faculty coordinator will assess the resident's completion of the educational objectives outlined above on the Emergency Medicine Resident evaluation at the end of the rotation.	
<b>Feedback Mechanisms:</b>	
The resident in Emergency Medicine will receive continuous informal feedback from the supervising attending during their shifts. Formal feedback occurs on the end of month evaluation which will be discussed at the resident's semiannual evaluation with the residency director. Any situation in which a resident's performance is substandard will be brought to the Emergency Medicine Residency Program Director's attention directly.	
Have the service directors for all rotations outside the Emergency Department at the primary institution reviewed and agreed to the rotations as described?	YES (X) NO ( )

10. **ORIENTATION**

<b>Institution:</b> Rhode Island Hospital	<b>Duration in Months:</b> 1 month
	<b>Year of Training:</b> PGY-1
<b>Educational Objectives:</b>	
<p><b>Goal 1:</b> To expose incoming residents to several broad areas of emergency care as it applies to the Brown Medical School Program in Emergency Medicine.</p> <p>Objective: Review basic medical knowledge in the specialty of emergency medicine, specifically, the most common presenting chief complaints as outlined in the “Model of the Clinical Practice of Emergency Medicine” section 1.0 “Signs, symptoms and presentations”</p> <p>Objective: Review and learn basic procedural skills necessary for the daily practice of emergency medicine</p> <p>Objective: Introduce concepts of professionalism and systems based practice necessary for the daily practice of emergency medicine at our institution.</p> <p>Objective: Instill values and teach skills related to self directed learning and practice based learning</p> <p><b>Goal 2:</b> To ease the transition from medical school to postgraduate training.</p> <p>Objective: Meet fellow interns and develop lasting relationships</p> <p><b>Objective:</b> Settle into the local community in preparation for intern year</p>	
<b>Description of Clinical Experience</b>	
<p>Interns are expected to work 4-6 clinical shifts in the emergency department during orientation. During these shifts they are scheduled as extra personnel, however, are expected to participate fully in patient care under direct attending supervision. They are also to spend time orienting to the physical plant and the policies and procedures of the emergency department.</p>	
<b>Medical Knowledge and Patient Care Educational Objectives:</b>	
<b>Patient Care Competencies:</b>	
<b>Interpersonal and Communication Skill Competencies:</b>	
<b>Practice-Based Learning and Improvement Competencies:</b>	
<b>Professionalism Competencies:</b>	
<b>Systems-Based Practice Competencies:</b>	
<b>Description of Didactic Experience</b>	
<p>Intern orientation is primarily a didactic experience. It consists of several established workshops including ACLS, ATLS, and APLS. It incorporates several procedure based workshops including casting, suturing, a two-day cadaver lab. One day is spent participating in cases at our High Fidelity Medical Simulation Center, as well as, learning Teamwork training (MedTeams) and communication skills by way of a difficult patient workshop using actors from the local community. The rest of the month is made up of case based lectures on the most commonly encountered chief complaints in the emergency department, as well as, sessions on radiology and EKG interpretation. There is also a workshop on “Communication skills”, “Medical Error” and “Goal setting and planning”. There are several social events including a Teambuilding scavenger hunt and a Welcome beach party for all residents and faculty to welcome and meet the new interns.</p>	

<b>Evaluation Process:</b>	
<p>Interns take a simple multiple choice pre and post test to assess improvement in basic medical knowledge over the course of the month. Interns fill out an evaluation form after each session to provide formative feedback during the course of orientation and then complete a final evaluation at the completion of orientation. Each year this is reviewed by the Assistant Program Director when organizing the following year's orientation program. Interns are evaluated on their professionalism, attendance, participation and willingness to learn at the completion of the month.</p>	
<b>Feedback Mechanisms:</b>	
<p>Interns are given feedback as necessary during the course of the month. Any concerns are immediately brought to the attention of the Program Director and discussed with the intern involved.</p>	
<p>Have the service directors for all rotations outside the Emergency Department at the primary institution reviewed and agreed to the rotations as described?</p>	<p>YES (X ) NO ( )</p>

## 11. ORTHOPEDICS ROTATION

<b>Institution:</b> Rhode Island Hospital	<b>Duration in Months:</b> 1 month
	<b>Year of Training:</b> PGY-1
<b>Educational Objectives:</b>	
<ol style="list-style-type: none"> <li>1. Develop ability to correctly perform a history and physical in patients with musculoskeletal disorders (MK, PC, ICS).</li> <li>2. Develop a skillful, efficient, complete and problem driven examination technique directed by the history (MK, PC)</li> <li>3. Demonstrate ability to correctly order and interpret radiographs in patients with orthopedic injuries (MK, PC, SBP).</li> <li>4. Demonstrate knowledge of standard orthopedic nomenclature (MK, ICS).</li> <li>5. Develop a basic knowledge of musculoskeletal anatomy and pathology, as well as understanding of the healing characteristic of bone, muscle, and connective tissue (MK).</li> <li>6. Demonstrate knowledge of appropriate aftercare and rehabilitation of orthopedic injuries (MK, PC, SBP).</li> <li>7. Demonstrate knowledge of the difference in pediatric and adult anatomy and indicate how those differences are manifest in clinical and radiographic presentation (MK,PC).</li> <li>8. Demonstrate ability to apply orthopedic devices, including compressive dressings, splints and immobilizers (MK, PC).</li> <li>9. Demonstrate skill in performance of the following procedures: fracture/dislocation immobilization and reduction, arthrocentesis, and extensor tendon repair (MK, PC).</li> <li>10. Demonstrate ability to prioritize and manage the treatment of orthopedic injuries in multiple trauma patients (MK, PC, SBP).</li> <li>11. Describe the presentations of patients with inflammatory and infectious disorders and demonstrate ability to diagnose and treat them (MK, PC)</li> <li>12. Demonstrate the ability to diagnose and treat soft tissue foreign bodies (MK, PC)</li> <li>13. Describe the presentations, complications, diagnosis, management and prognosis of patients with human and animal bites (MK, PC, SBP)</li> <li>14. Describe the presentations, complications, diagnosis and management of compartment syndromes (MK, PC)</li> <li>15. Demonstrate ability to provide regional anesthesia, including hematoma blocks, Bier blocks, and radial, ulnar, median, axillary, posterior tibial and sural nerve blocks (MK, PC)</li> <li>16. Discuss the dosages, indications, contraindications, side effects and relative potency of standard oral analgesics used in the treatment of patients with musculoskeletal disorders (MK, PC)</li> <li>17. Discuss the dosages, indications, contraindications and side effects of standard analgesic and sedative agents used to treat patients with acute orthopedic trauma and demonstrate skills in their use (MK, PC)</li> <li>18. Discuss the differential diagnosis, historical features, physical and examination findings and management of patients with low back pain (MK, PC)</li> <li>19. Demonstrate ability to recognize and treat soft tissue infections involving muscle, fascia, and tendons (MK, PC).</li> <li>20. Describe diagnosis and treatment of overuse syndrome (MK, PC)</li> <li>21. Describe how to evaluate and preserve amputated limb parts (MK,PC)</li> <li>22. Demonstrate knowledge of joint injuries, evaluation and grading of joint injuries, treatment of joint injuries and prognosis (MK, PC)</li> <li>23. Discuss evaluation and treatment of soft tissue injuries such as strains, penetrating soft tissue injuries, crush injuries, and high pressure injection injuries (MK, PC)</li> </ol>	
<b>Medical Knowledge and Patient Care Educational Objectives:</b>	

**Patient Care Competencies:**

1. Demonstrate the use of information technology in order to promote patient care. Examples of this include the use of Lifelinks for retrieving laboratory and radiology reports and the use of the internet to facilitate patient care.
2. Develop competency in the performance of procedures required of emergency physicians, as well as performance of physical examination related to a patient's chief complaint.
3. To develop knowledge of preventive health aspects of patient care that may be incorporated into the practice of emergency medicine.

**Interpersonal and Communication Skill Competencies:**

1. Develop a physician-patient relationship model that creates a therapeutic relationship with patients.
2. Develop listening skills that will facilitate communication with patients, their families, and other members of the health care.
3. Demonstrate and observe caring and respectful behaviors through patient interactions and observations of more senior residents and attending staff
4. Develop interviewing skills that will facilitate patient interaction
5. Develop skills at facilitating informed decision-making by patients and their families. To learn of specific situations in which informed decision-making may not be possible due to a patient's medical condition or advance directive.
6. Counsel and educate patients and their families of their medical conditions.
7. Develop awareness and facilitate the provision of health care within a team of health care providers.

**Practice-Based Learning and Improvement Competencies:**

1. Develop methods of analyzing the resident's own practice to improve quality of health care provided.
2. Develop a personal program of learning related to the requirements of the rotation in the context of an emergency medicine rotation.
3. To identify areas of weakness in medical knowledge and practice relevant to the current rotation, and develop a plan to address these weaknesses during the rotation and beyond.
4. To develop skills in the use of evidence from scientific studies to alter the resident's practice of medicine, with the goal of improving the health care provided.
5. To develop skills in the use of information technology, and in particular online Medline reference searching.

**Professionalism Competencies:**

1. To develop respectful and altruistic attitudes towards patients, their families, and other members of the health care team.
2. To incorporate principles of ethics into the practice of medicine.
3. To develop sensitivity to cultural, age, gender, and disability issues that may impede patient care through disruption of physician-patient interaction.

**Systems-Based Practice Competencies:**

1. Develop an understanding of the interaction of the practice of emergency medicine with that of the larger health care system as a whole.
2. Develop knowledge of the practice and delivery of health care in different systems and environments
3. Develop cost-effective strategies in the practice of emergency medicine.
4. Develop an attitude of being an advocate for the patient within the health care system.
5. Develop a willingness to become involved in a partnership to improve health care and system

performance within the emergency department and hospital health care system.	
<b>Description of Clinical Experience</b>	
The PGY-1 resident will be assigned to rotate with a second year orthopedic resident for one month. With the orthopedic resident, they will manage ED consults in both the Bridge and Hasbro Emergency Departments.	
<b>Description of Didactic Experience</b>	
The resident should attend all orthopedic teaching conferences and morning radiology rounds. Residents are expected to attend the 5 hours of Emergency medicine didactic conference each week.	
<b>Evaluation Process:</b>	
The resident in Emergency Medicine will be evaluated monthly by the service attending with input from the second year orthopedic resident, utilizing evaluation forms provided by the Department of Emergency Medicine.	
<b>Feedback Mechanisms:</b>	
The resident in Emergency Medicine will receive continuous informal feedback from both the PGY-2 resident and orthopedic faculty with which he/she has contact. Formal feedback occurs on the end of month evaluation which will be discussed at the resident's semiannual evaluation with the residency director. Any situation in which a resident's performance is substandard will be brought to the Emergency Medicine Residency Program Director's attention directly.	
Have the service directors for all rotations outside the Emergency Department at the primary institution reviewed and agreed to the rotations as described?	YES (X ) NO ( )

## 12. PEDIATRIC WARDS (PEDS) ROTATION

<b>Institution:</b> Hasbro Childrens Hospital	<b>Duration in Months:</b> 1 month
	<b>Year of Training:</b> PGY-1
<b>Educational Objectives:</b>	
<p><b>1. Demonstrate competence in Patient Care:</b></p> <ul style="list-style-type: none"> <li>a) Obtain appropriate history prior to child's arrival on the floor from the referring physician</li> <li>b) Provide appropriate information and regular communications with other staff included in the patients care e.g. primary care physician, subspecialty consultants, ED, PICU staff, transfer hospital</li> <li>c) Recognize and respond to all urgent or emergent medical scenarios requiring immediate attention and intervention</li> <li>d) Show competence in running a ward team, with appropriate guidance, coordination of care, supervision, and teaching skill (senior level)</li> <li>e) Demonstrate appropriate guidance, supervision, and teaching for medical students (intern level)</li> </ul> <p><b>2. Demonstrate competence in Medical Knowledge:</b></p> <ul style="list-style-type: none"> <li>a) Perform a directed history and physical exam</li> <li>b) Create a differential diagnosis with attention to history, physical, age</li> <li>c) Formulate a plan for diagnosis, management, and discharge</li> <li>d) Have facility in the identification, assessment, stabilization, and initial treatment plans in the following areas           <ul style="list-style-type: none"> <li>i) <b>General:</b> Failure to thrive, weight loss, fever without localizing signs, constitutional symptoms</li> <li>ii) <b>Cardiovascular:</b> Hypotension, hypertension, arrhythmia, syncope, heart murmur, shock</li> <li>iii) <b>Dermatologic:</b> Rashes, petechiae, prupura, ecchymoses, urticaria, edema</li> <li>iv) <b>EENT:</b> Trauma, conjunctival injection, acute visual change, edema, epistaxis</li> <li>v) <b>Endocrine:</b> Polydipsia, polyuria</li> <li>vi) <b>GI/Nutrition/Fluid:</b> Diarrhea, vomiting, dehydration, malnutrition, dysphagia, regurgitation, abdominal pain, abdominal mass, hematemesis, rectal bleeding, jaundice, ascites</li> <li>vii) <b>GU/Renal:</b> Hematuria, edema, decreased urine output, scrotal masses, dysuria</li> <li>viii) <b>GYN:</b> genital trauma, sexual assault, pelvic pain, abnormal vaginal bleeding</li> <li>ix) <b>Heme/Onc:</b> Pallor, abnormal bleeding, lymphadenopathy, hepatosplenomegaly, masses</li> <li>x) <b>Musculoskeletal:</b> Bone and soft tissue trauma, limp, arthritis/arthralgia, limb pain</li> <li>xi) <b>Neurologic:</b> Seizure, headache, delirium, lethargy, weakness, ataxia, coma, head trauma, vertigo, irritability</li> <li>xii) <b>Psychiatric/Psychosocial:</b> Acute psychosis, suicide attempt, depression, conversion reaction, child abuse or neglect</li> <li>xiii) <b>Respiratory:</b> Increased work of breathing, cyanosis, apnea, dyspnea, tachypnea, wheezing, stridor, inadequate respiratory effort, cough hemoptysis, chest pain, respiratory failure.</li> </ul> </li> </ul> <p><b>3. Demonstrate skill in Patient Care:</b></p> <ul style="list-style-type: none"> <li>a. Explain the indications and limitations of medical tests and be aware of age appropriate values.</li> <li>b. Interpret abnormalities in the context of specific physiologic derangement.</li> <li>c. Discuss therapeutic options for correction of abnormalities when appropriate.</li> <li>d. Have an understanding of the relative costs</li> <li>e. Develop procedural skills needed for the management of the pediatric patient during the post-stabilization period of care, including lumbar puncture, arterial and venous puncture, umbilical vein catheterization, suprapubic and pleural paracentesis, and endotracheal intubation.</li> <li>f. Demonstrate familiarity and interpretation of common laboratory parameters with discussion of their impact relative to a patient's clinical condition including...           <ul style="list-style-type: none"> <li>i. CBC with differential, platelets, indices</li> </ul> </li> </ul>	

- ii. Blood chemistries
- iii. Renal function tests
- iv. Tests of hepatic function and damage
- v. Serologic tests for infection
- vi. Measures of inflammation
- vii. Drug levels
- viii. Assessment of immune function
- ix. Coagulation studies
- x. Arterial, capillary, and venous blood gasses
- xi. Microbiologic cultures
- xii. Urinalysis
- xiii. CSF analysis
- xiv. Gram stain
- xv. Stool studies
- xvi. Chest X-ray, abdominal, and lateral neck films

4. Demonstrate skill in **Professionalism:**

- a. Place patient needs paramount, and always act in the best interest of patients
- b. Apply principles of evidence based decision making and problem solving in the care of hospitalized children. Show capacity to support a care plan by discussion with others that may wish for alternative pathways
- c. Recognize the limits of one's own knowledge, skills, and tolerance for stress; ask for help as needed and appropriate.
- d. Demonstrate respect, compassion, empathy, and integrity
- e. Consistently act responsibly and adhere to professional standards for ethical and legal behavior.
- f. Demonstrate caring and respectful behaviors when interacting with patients, families, and medical staff.
- g. Demonstrate sensitivity to ethical principles, culture, age, gender, sexual preference, and disability.
- h. Be aware of quality control/quality improvement processes and when appropriate use the results to improve patient management.
- i. Acknowledge errors
- j. Demonstrate sensitivity and skills in dealing with death and dying in the hospital setting.

5. Demonstrate competence in **Interpersonal and Communication Skills:**

- a. Communicate well and work effectively with fellow residents, attendings, consultants, nurses, ancillary staff, and referring physicians.
- b. Demonstrate skills as a team participant and as a team manager,
- c. Work with the primary care provider to assure continuity of care; communicate with the primary care giver in an effective and timely manner.
- d. Demonstrate sensitivity to family, cultural, ethnic, and community issues when assessing patients and making health care plans.
- e. Consistently listen carefully to the concerns of patients and families, and provide appropriate information and support.
- f. Describe the role of managed care case managers; work with these individuals to optimize health outcome.
- g. Maintain appropriate communications with nursing staff caring for patient
- h. Maintain appropriate, comprehensive, and comprehensible communication with the patient and family throughout hospitalization
- i. Maintain appropriate communications with primary caregivers and subspecialists

**6. Demonstrate facility with Systems-Based Practice:**

- a. Demonstrate awareness of the unique problems involved in the care of children with multiple problems or chronic illness, and serve effectively as an advocate and case manager for such patients.
- b. Identify and attend to issues such as growth and nutrition, developmental stimulation, and schooling during extended hospitalizations.
- c. Identify problems and risk factors in the child and the family, even outside the scope of this admission (e.g., immunizations, social risks, developmental delay); appropriately intervene or refer.
- d. Facilitate the transition to home care by appropriate discharge planning and parental/child education.
- e. As the primary provider (e.g., for one's continuity patients) relate to the inpatient team and patient in a manner that results in continuity of management, family support, and appropriate discharge planning.
- f. Perform in the capacity of pediatric consultant for hospitalized patients managed by other providers (family physicians, surgeons, etc.).

**7. Demonstrate knowledge of Cost Control**

- a. Demonstrate familiarity with the common mechanisms of inpatient cost control in managed care settings, including pre-authorization, concurrent review, and discharge planning.
- b. Practice appropriate utilization of consultants and other resources
- c. Show concern for financial circumstances of the patient and refer for social service support as needed.

**Description of Clinical Experience**

All patients admitted to Hasbro Children's Hospital are on the teaching service and are covered by a resident team. There are four resident teams on the inpatient wards at all times with each team consisting of one senior resident (either a PGY-2 or a PGY-3 in pediatrics) and either two or three PGY-1 residents (more in the winter season). The ED resident is one of the PGY-1 residents on one of the four teams. Each team is supervised by a single "service attending" from the full time Brown University faculty and in that role is the physician of record that provides oversight for all service patients on that team. The service attending is also responsible for coordinating the teaching sessions for the residents and students on his or her teams. The teams admit patients that are ultimately assigned to either the "service attending", a private community-based attending, or a subspecialist pediatrician as appropriate to the diagnosis. Roughly a third of the patients are admitted to "service" and roughly half of the service attendings supervisors are general pediatricians. Another third of the pediatric inpatients are admitted by their personal community based general pediatric attending physicians, the last third are admitted to subspecialty services that oversee the resident based care.

Housestaff admit and write orders on all non surgical pediatric patient admissions. Patients under the supervision of community based general pediatricians have their care provided by residents which are overseen and critiqued by the patient's general pediatric attending physician. Residents are expected to be the focal point of care for their patients, maintaining themselves as the focal point of communications between primary care attending, subspecialists, nursing and therapists. Residents are also expected to present their care plans and learning at the daily morning report as well as the daily radiology rounds where they review in detail the outcome of studies they ordered and discuss the implications with input from pediatric radiologists. Residents are expected to follow their patients through significant procedures and all family meetings. PGY-1 residents are responsible for initial history, physical, and data management on all in house patients. The PGY-1 will review his/her plan with the senior resident who has oversight of the team. All patients are examined by an attending each and every day. Each patient has an attending of record that must examine the patient, interact with the

patient and/or family and write a note in the patient’s chart. The service attending is responsible for all the “service” patients on the team.

The inpatient service has a “day team” and a “night team” that shares in the patient’s care across a child’s hospitalization. The day team rotates on an every fourth night call rotation. The “on call” team begins to take admissions at 8:00 am and continues until 8:00 pm when team members hand off the admission pager to the night float team. The “on call” team ties up care responsibilities for the patients admitted prior to the hand off, sings out the night float team and goes home for the night. The night float teams admits all pediatric inpatients from 8:00pm to 8:00am. The following morning overnight admissions are divided among the fresh residents utilizing a formula that divides patients evenly across teams. There is no night float coverage on Friday or Saturday night. On those days the long call team admits new patients from 8:00am to 8:00 am the following morning. There is a detailed sign out to the oncoming admitting and cross cover team after which the post call team goes home mid morning. Sign out occurs from intern to intern and senior to senior with a face to face meeting at the end of each work day. There is a detailed compilation of each patient’s history, pertinent and active issues, and duties that require follow up and attention overnight. The verbal sign out is augmented by a protected electronic patient tracking database that maintains detailed information including laboratory and pharmacy details as a supplement and double check.

**Medical Knowledge and Patient Care Educational Objectives:**

**Patient Care Competencies:**

**Interpersonal and Communication Skill Competencies:**

**Practice-Based Learning and Improvement Competencies:**

**Professionalism Competencies:**

**Systems-Based Practice Competencies:**

**Description of Didactic Experience**

Faculty teaching rounds are expected to take place no less than three days per week. Many faculty do clinical work rounds on a daily basis. Rounds vary from walk rounds that include bedside history, physical examination, and evaluation of patients, to more pathophysiologic didactic oriented sessions. Faculty are given a description of the minimal teaching interactions expected of supervising faculty at the beginning of each year. Resident clinical work rounds take place on a daily basis with the senior resident managing the rounds that include junior residents and medical students. Resident teams interact daily with each attending pediatrician who has a patient under the care of that resident team.

**Evaluation Process:**

Residents receive daily feedback and evaluation by the supervising “service” attending as well as their senior resident regarding the care of individual patients. At the completion of the month their “service” attending fills in an ER off service evaluation form and returns it to the ER residency program director.

**Feedback Mechanisms:**

The end of month evaluation is reviewed with each individual resident at their semiannual evaluation with the program director or assistant program director. Any concerns brought to the attention of the program director are discussed immediately with the resident involved.

Have the service directors for all rotations outside the Emergency Department at the primary institution reviewed and agreed to the rotations as described?	YES ( X ) NO ( )



### 13. PEDIATRIC EMERGENCY ROOM (PER) ROTATION

<b>Institution:</b> Hasbro Children's Hospital	<b>Duration in Months:</b> 1 month PGY-1; 5 shifts every adult EM month in PGY-2-4 <b>Year of Training:</b> PGY-1, 2, 3, 4
<b>Educational Objectives:</b>	
<b>The objectives of the emergency medicine experience will include the development of the following skills:</b>	
<ol style="list-style-type: none"><li>1. Evaluation, care and prioritization of patients with acute illnesses or injuries of varying degrees of severity.</li><li>2. Resuscitation and stabilization of patients after their initial evaluation.</li><li>3. Interaction with other professionals involved in emergency care in the emergency department, including the trauma team, emergency physicians, specialists in surgery, anesthesia, radiology, and relevant pediatric and surgical subspecialties. Participation in the emergency medical system in the provision of prehospital care for acutely ill or injured patients, including access to appropriate transport systems and triage decision-making.</li><li>4. Participation in the admission, transfer or discharge planning of all evaluated patients, including communications with the primary physician.</li></ol>	
<b>The comprehensive experience for all emergency medicine residents will include but not be limited to the following disorders. The pathophysiologic correlates of these clinical situations will be emphasized.</b>	
<ol style="list-style-type: none"><li>1. Acute major and minor medical problems such as respiratory infection, respiratory failure, cardiopulmonary arrest, dehydration, coma, seizures, sepsis, shock, fever;</li><li>2. Acute major and minor surgical problems such as appendicitis, bowel obstruction, burns, foreign body ingestion, abscess drainage;</li><li>3. Poisonings and ingestions such as acetaminophen, anticholinergics, anti-hypertensives, iron, coins;</li><li>4. Major and minor trauma such as intracranial hemorrhage, hemothorax, splenic rupture, open and closed fractures, extremity dislocations and sprains, lacerations;</li><li>5. Physical and sexual abuse;</li><li>6. Acute psychiatric, behavioral and psychosocial problems.</li></ol>	
<b>All residents will be trained and overseen in the following procedural skills:</b>	
<ol style="list-style-type: none"><li>1. Basic and advanced life support</li><li>2. Endotracheal intubation</li><li>3. Nasogastric intubation</li><li>4. Arterial and venipuncture</li><li>5. Lumbar puncture</li><li>6. Bladder catheterization</li><li>7. Intravenous and intraosseous line placement</li></ol>	

8. Thoracentesis
9. Gastric lavage
10. Eye evaluations using the slit lamp
11. Gynecological evaluations of prepubertal and postpubertal females
12. Sexual abuse evaluations including the collection of forensic evidence
13. Wound care and suturing of lacerations
14. Splinting of simple extremity injuries
15. Removal of nasal and aural foreign bodies
16. Incision and drainage of superficial abscesses

**Description of Clinical Experience**

The pediatric emergency department is an extensively equipped and supervised facility dedicated entirely to the care of the acutely ill and injured children. The facility is a modern, spacious, functional design located on the ground floor of the children’s hospital. In addition to 24 hour staffing by attending physicians trained in pediatric emergency medicine, there are pediatric nurses and nurse practitioners with expertise in pediatric acute care present in the ED on a full time basis and respiratory therapy available 24 hours a day. Currently the ED cares for an average annual census of roughly 42,000 children and adolescents.

Critically ill patients are seen by residents in conjunction with an attending immediately upon patient arrival. Outside of that circumstance residents are universally the physicians of first contact for patients triaged into the ED. The attending staff in the pediatric ED consists entirely of board certified Pediatric Emergency Physicians. A pediatric emergency attending physician is on site in the emergency department 24 hours a day throughout the year. In addition, Brown University sponsors a fellowship in pediatric emergency medicine with a number of fellowship trainees present in the ED across all hours as well. The attendings see every patient in the department and write an attending note and cosign the resident’s charts prior to each patient’s admission or discharge.

As in the adult emergency department, residents in the pediatric emergency department function with a graduated level of responsibility corresponding to their level of training. PGY-3 and PGY-4 residents function as team leaders in critical resuscitations and manage conscious sedation for procedures and fracture management.

The pediatric ER is part of a large tertiary care hospital with in house pediatric services representing the majority of pediatric subspecialties, pediatric surgery, anesthesia, respiratory therapy, and nursing. It is part of the resident’s training and feedback to quickly and prudently obtain consultation from appropriate ancillary and subspecialty staff as appropriate. The pediatric radiology suite is located directly adjacent to the pediatric emergency department and films are read out directly with the assistance of full time pediatric radiology attendings when in house.

**Medical Knowledge and Patient Care Educational Objectives:**

**Patient Care Competencies:**

**Interpersonal and Communication Skill Competencies:**

<b>Practice-Based Learning and Improvement Competencies:</b>	
<b>Professionalism Competencies:</b>	
<b>Systems-Based Practice Competencies:</b>	
<b>Description of Didactic Experience</b>	
The pediatric emergency medicine curriculum didactics are incorporated on a monthly basis into the general EM didactic conferences and are given by both pediatric attending physicians and pediatric emergency medicine fellows.	
<b>Evaluation Process:</b>	
Residents are evaluated on a monthly basis. At the end of each rotation a consensus evaluation is completed by the Pediatric Emergency Medicine Division faculty and submitted to the Emergency Medicine residency program director. A faculty member from the Division of Pediatric Emergency Medicine Division is assigned to the residency curriculum committee where curricular goals and objectives are discussed and evaluated.	
<b>Feedback Mechanisms:</b>	
Feedback is given informally on a shift by shift basis by the pediatric attending faculty. They also receive feedback on patient outcomes from a periodic follow up conference held by the division of pediatric emergency medicine. The information gathered during these sessions is relayed to the residents who participated in that patient's care. The consensus evaluation is turned in at the completion of the month and reviewed with the resident at their semiannual meeting with the ER residency program director or assistant program director. Residents also participate in various pediatric high fidelity simulation scenarios incorporated into our residency conference curriculum.	
Have the service directors for all rotations outside the Emergency Department at the primary institution reviewed and agreed to the rotations as described?	YES (X) NO ( )

## 14. PEDIATRIC INTENSIVE CARE (PICU) ROTATION

<b>Institution:</b> Hasbro Children's Hospital	<b>Duration in Months:</b> 1 month
<b>Year of Training:</b> PGY-2	
<b>Educational Objectives:</b>	
<p>Goal 1) Gain competence in <b>pediatric resuscitation</b> (MK, PC, SBP)</p> <ol style="list-style-type: none"> <li>a. Demonstrate skills in PALS defined protocols</li> <li>b. Demonstrate skill in identification of children that require urgent or emergent intervention</li> <li>c. Demonstrate skill in resuscitation and stabilization of children while on transport or in outside referring hospitals</li> <li>d. Demonstrate skills in intubation and ventilation of infants and children</li> </ol> <p>Goal 2) Demonstrate ability to obtain and interpret <b>key history and medical data</b> surrounding critical illness (MK, PC, ICS).</p> <ol style="list-style-type: none"> <li>a. Demonstrate skill in obtaining focused and pertinent history to assist in determination of immediate intervention, followed by more detailed history when patient is stabilized</li> <li>b. Demonstrate ability to perform focused and valid physical examination with appropriate interpretation of physical findings.</li> <li>c. Demonstrate a knowledge of the selection and interpretation of laboratory data</li> <li>d. Demonstrate competence in the identification shock with appropriate supportive interventions</li> <li>e. Demonstrate competence in the identification of impending respiratory failure with the appropriate interventions</li> </ol> <p>Goal 3) Gain competence in the <b>management</b> of critically ill children (MK, PC)</p> <ol style="list-style-type: none"> <li>a. Demonstrate skill in effective physical examination of critically ill children</li> <li>b. Demonstrate competence in the fluid and electrolyte management of children with alterations in fluid homeostasis</li> <li>c. Demonstrate competence in ventilatory interventions and management of children with respiratory failure, paralysis, or lung disease</li> <li>d. To learn the psychological differences between infants, children and adults.</li> </ol> <p>Goal 4) Demonstrate knowledge of the clinical presentation, clinical features, pathophysiology, and treatment of children with the following <b>common disorders</b> (MK, PC)</p> <ol style="list-style-type: none"> <li>a) Infection:       <ol style="list-style-type: none"> <li>i) Sepsis (viral, bacterial, fungal)</li> <li>ii) Congenitally acquired infections</li> <li>iii) Localized infections (joint, skin, UTI, bone, etc.)</li> </ol> </li> <li>b) Metabolic: Demonstrate skill in the identification, evaluation, and intervention for children with       <ol style="list-style-type: none"> <li>i) hypoglycemia</li> <li>ii) hypo- or hyper-calcemia</li> <li>iii) hypo- or hyper-kalemia</li> <li>iv) hypo- or hyper- natremia</li> <li>v) acidosis with or without anion gap</li> <li>vi) inborn errors of metabolism</li> </ol> </li> <li>c) Gastrointestinal disorders:       <ol style="list-style-type: none"> <li>i) Severe diarrhea with dehydration</li> <li>ii) bowel obstruction</li> <li>iii) GI bleed</li> <li>iv) acute or fulminant hepatitis</li> </ol> </li> <li>d) Cardiovascular disorders:       <ol style="list-style-type: none"> <li>i) Discuss knowledge of presentation of cyanotic and noncyanotic congenital heart disease, and</li> </ol> </li> </ol>	

## PDA

- ii) Demonstrate knowledge of management of hypertension or hypotension
- iii) Demonstrate knowledge of interpretation of EKG findings in infants and children
- iv) Demonstrate skill in management of arrhythmia such as SVT

## e) Hematologic disorders:

- i) coagulopathy
- ii) anemia
- iii) sickle cell crisis/acute chest
- iv) tumor lysis syndrome

## f) Renal disorders:

- i) acute renal failure
- ii) electrolyte abnormalities
- iii) oliguria, anuria

## g) Neurologic disorders:

- i) seizure
- ii) hydrocephalus
- iii) post-operative neurosurgical care
- iv) hypoxic-ischemic injury
- v) intraventricular hemorrhage or stroke

## h) Endocrine disorders:

- i) overwhelming disorders of thyroid function
- ii) adrenal insufficiency
- iii) DKA/new onset diabetes
- iv) electrolyte or glucose abnormalities

Goal 5) Recognize the clinical presentation and provide appropriate management of **emergent medical** situations

Goal 6) To acquire practice in meeting the **emotional and communication needs** of critically ill children and their families (Prof, ICS).

### Description of Clinical Experience

The pediatric intensive care unit (PICU) is a modern, busy, 16 bed facility located within Hasbro's children's hospital. The PICU is the referral center for the state as well as the region. The PICU has two "pods" with eight private rooms located circumferentially around each of two central nursing statements. All physician orders are placed through a computer based Physician Order Management System (POM) system. All critical patients have residents assigned to them and residents are actively involved in their care and decision making. The PICU is supervised by five board certified pediatric intensivists on call 24 hours a day. Clinical teaching takes place during daily patient care rounds held at the bedside. Rounds are interdisciplinary and led by the Attending physician. Trainees are expected to present each patient's problems and formulate a treatment plan. Trainees are expected to outline anticipated events including short term problems and long term care plans for the patient's recovery.

Responsibilities of the resident involve learning the pathophysiology related to a variety of conditions encountered in pediatric critical care medicine and applying it to the care of his patients. Residents are expected to become skilled in the assessment of degree of patient illness. Residents are introduced to and allowed to advance their procedural skill such as intravenous and arterial cannulation, endotracheal intubation, central line placement and chest tube placement. They are responsible for preroounding on each patient assigned to themselves and to collect their laboratory, physical and monitoring data. The resident is then expected to present this data to the PICU team on rounds with integration of the information leading to an assessment and management plan for the patient. Under

the direct supervision of the pediatric PGY-3 residents and attending staff the resident learns to manage the critically ill patient using the team approach.

Residents on the PICU take call every fourth night. Residents who are post call may leave the unit to go home once morning work rounds are completed, hence they are often free to go home prior to the full 30 hours on the post call morning. They are in compliance with the required duty hours limits.

Residents are also expected to learn and develop a sense of autonomy in the care of the critically ill patient. In addition residents may participate in the regional transport system for children that require hospital or unit level of care necessitating transport to our hospital. While en route to the children's hospital the resident is the physician in charge of the immediate management and interventions on behalf of the patient with back up assistance from the PICU attending via phone.

**Medical Knowledge and Patient Care Educational Objectives:**

**Patient Care Competencies:**

**Interpersonal and Communication Skill Competencies:**

**Practice-Based Learning and Improvement Competencies:**

**Professionalism Competencies:**

**Systems-Based Practice Competencies:**

**Description of Didactic Experience**

Didactic teaching and lectures occur three to four times per week and are directed by the attending physician on service. Teaching also occurs informally at the bedside on teaching rounds daily.

**Evaluation Process:**

Residents are evaluated by the On service PICU attending using the Emergency medicine residency evaluation form for off service rotations at the completion of their month. They are also given daily feedback as needed

**Feedback Mechanisms:**

PICU attendings provide regular feedback during the course of the one month rotation. Any concerns are brought to the attention of the ER program director who addresses them immediately with the resident. Monthly evaluations are reviewed individually with residents during their semiannual evaluations with the program or assistant program director

Have the service directors for all rotations outside the Emergency Department at the primary institution reviewed and agreed to the rotations as described?	YES (X) NO ( )

16. **TRAUMA INTENSIVE CARE (TICU) ROTATION**

<b>Institution:</b> Rhode Island Hospital	<b>Duration in Months:</b> 3 months
	<b>Year of Training:</b> PGY-1, 2, and 3
<b>Educational Objectives:</b>	
<p>GOAL: The goal of this comprehensive training experience is to prepare the emergency medicine resident to rapidly evaluate and treat trauma patients.</p>	
<p><u>Upon completion of the PGY-I Trauma rotation, the resident will be able to:</u></p>	
<ol style="list-style-type: none"> <li>1. Develop facility in the monitoring and integration of care required by critically ill trauma patients (MK, PC, SBP).</li> <li>2. Experience the management of delayed post-operative complications, sepsis, and multiple organ failure (MK, PC).</li> <li>3. Reinforce prior exposure to nutritional support of the surgical patient, and experience the problems peculiar to the critically ill patient (MK, PC, SBP)</li> <li>4. Develop facility in the fluid and electrolyte management of the complicated critically ill patient (MK, PC)</li> <li>5. Participate in the management and monitoring of patients with closed head injury, subarachnoid hemorrhage, intracerebral hemorrhage, and spinal injury (MK, PC)</li> <li>6. Experience the specific problems in oxygenation and ventilatory support in systemic inflammatory syndromes including ARDS in trauma patients, patients with flail chest/pulmonary contusion and those with permeability pulmonary edema (MK, PC)</li> <li>7. Reinforce appropriate use of blood products and their alternatives (MK, PC, SBP)</li> <li>8. Reinforce facility with circulatory access and monitoring devices, thoracostomy tube and abdominal drain management, airway management, including surgical airways and mechanical ventilators. (MK, PC)</li> <li>9. Gain experience meeting the emotional and communication needs of critically ill patients and their families. (PC, ICS, Prof)</li> </ol>	
<p><u>Upon completion of the PGY II/III rotation, the resident will accomplish the following:</u></p>	
<p>I. Trauma Resuscitation: Priorities of acute care - residents will develop a contemporaneous approach to resuscitation, diagnosis, and treatment of life threatening traumatic injuries.</p> <ol style="list-style-type: none"> <li>1. "ABCDE" approach to trauma evaluation and management. Residents will learn the advantages and pitfalls of algorithms in the care of trauma patients</li> <li>2. The primary goal of airway management and shock therapy will be grasped.</li> <li>3. Pharmacology of airway control of the trauma patient will be stressed.</li> <li>4. Residents will become facile at all aspects of airway management, including: Intubation: orotracheal, nasotracheal intubation, Needle cricothyrotomy, Surgical airway</li> <li>5. Fluid resuscitation</li> <li>6. Use of clinical parameters, CVP, and urine output to assess volume status and response to therapy</li> <li>7. Use of blood products</li> <li>8. Invasive vascular access: Indications, risks, benefits, alternatives, Seldinger technique, Cut</li> </ol>	

downs

II. Physical exam of the trauma patient: Residents will be able to perform rapid physical exams of trauma patients. In addition, they will learn the definitions and utility of Trauma Scales, Injury Severity Scales and Glasgow Coma Scores.

III. Residents will understand the limits of diagnostic testing and the importance of serial physical exams in the trauma patient

IV. Residents will appreciate the differences between pediatric and adult trauma patients in assessment, resuscitation, spectrum of injuries, intervention options, and outcomes.

1. Knowledge of clinical signs of shock and pediatric fluid resuscitation
2. Pediatric physical exam
3. Abuse presenting as trauma

V. Definitive care of the trauma patient: Residents will learn the indications for emergent, urgent surgical exploration of thoracic, abdominal, CNS, vascular, and orthopedic injuries

VI. Management of specific organ system injuries

#### **Abdominal injuries**

- Blunt trauma - Residents will manage the entire spectrum of blunt abdominal traumatic injuries. Specific expertise will be obtained in the following areas:
- Use of CT ultrasound and peritoneal lavage for diagnosis. Residents will learn the limits of these diagnostic tests and the importance of longitudinal re- evaluation of these patients.
- Use of IVP/cystogram/RUG to assess GU injuries. Knowledge of Foley catheter contraindications
- Understanding of expectant vs interventional (operative) management of splenic, renal and hepatic injuries
- Postoperative and post-traumatic care of blunt abdominal injuries.
- Penetrating trauma: Residents will manage the entire spectrum of penetrating abdominal trauma. Specific expertise will be obtained in the following areas:
- Use of peritoneal lavage, CT and physical exam for assessment of penetrating abdominal trauma
- Knowledge of associated injuries: Diaphragmatic/thoracic, Great vessel, GU, Intestinal/pancreatic, Hepatic/splenic, Thoracic Injury

**Life-threatening conditions:** Residents will be able to recognize and emergently treat the following life-threatening conditions: Tension pneumothorax, Exsanguinating hemothorax, Flail chest, Sucking chest wounds, Pericardial tamponade,

Residents will manage the entire spectrum of blunt **thoracic trauma**. Specific expertise will be obtained in the following areas: Use of radiography, CT, arteriography, EKG, and clinical exam for the diagnosis of the following conditions: Great vessel injury, Pulmonary parenchymal injury, Cardiac injury, Chest wall injuries

- Indications for tube thoracostomy and evaluation of drainage as a guide to further intervention
- Indications for open thoracotomy in the Emergency Department and knowledge of

outcomes.

- Indications for needle pericardiocentesis
- The above procedures will be performed proficiently.
- Postoperative and post-traumatic care of the blunt thoracic trauma patient
- Knowledge of late complications, including pulmonary and cardiac contusions.
- Penetrating thoracic trauma
- Residents will manage the entire spectrum of penetrating thoracic trauma.
- Specific expertise will be obtained in the following: Use of clinical exam, radiography, CT, arteriography, and CVP assessment for the diagnosis of Hemothorax/great vessel injury, Cardiac tamponade/cardiac chamber disruption, Diaphragmatic penetration/abdominal injury, Knowledge of indications for emergent, urgent and expectant management of these injuries.

**CNS injuries:** Residents will become proficient in evaluation and initial treatment of head- injured patients. Expertise will be obtained in the following areas:

- Assessment - Residents will recognize the varying presentations of CNS injury in all ages of patients
- Knowledge of CNS injury scores, Age-appropriate neurologic exams, Importance of monitoring changes in CNS status, Use of CT, ultrasound in the evaluation of CNS injury
- Treatment
- Emergent CNS resuscitation via pharmacologic agents
- Emergent surgical interventions and respiratory approaches
- Burr holes - indications and performance of the procedure
- Neurosurgical intervention/indication for emergent craniotomy
- Outcome: Residents will follow these patients longitudinally in order to appreciate the recuperative potential of a variety of CNS injured patients.

### **Dermal Injuries**

Burns: Residents will care for the acute burn patient in the Emergency Department and learn the following:

- Burn severity assessment
- Emergency management
- Fluid resuscitation, including CVP line placement and CVP interpretation
- Treatment of pain
- Airway assessment and management in the burn patient
- Infectious considerations in burned patients
- Management of CO poisoning and inhalation injury

Wound care/Laceration repair: Residents will manage a broad spectrum of dermal disruptions and be able to provide expert care to both the dermal injury and assessment of underlying muscular, tendinous, neurologic, vascular and bony tissue.

### Description of Clinical Experience

These objectives will be achieved through one month rotations in the Division of Trauma during the first three years of the residency.

#### *Clinical Activities*

The Emergency Medicine Resident rotating on the Trauma Service will have the following duties and responsibilities:

1. Direct patient care.
2. Consultation under supervision.
3. Performance of procedures related to patient care
4. On-call responsibilities on par with other residents on the service at their level of training.
5. Maximum work week hours in compliance with ACGME guidelines.

During the PGY-I year, the intern will have primary patient care responsibilities in the Trauma ICU of Rhode Island Hospital and make daily rounds with the ICU. The PGY-I will take call in addition to one of the Trauma service ICU residents every third night. During the PGY-II and III years, the resident will have primary patient care responsibilities in the Rhode Island Hospital and Hasbro Emergency Departments, responding to clinical cases as a member of the hospital Trauma Team. The residents will be on call every other day. Residents will be expected to function as a mid level surgical resident (PGY 2-3) in every respect except for technical operative skills. The PGY II/III will participate in rounds as needed.

**RELATIONSHIP WITH OTHER RESIDENTS and FACULTY:** Emergency Medicine residents will have responsibilities on par with residents at the same level of training on the service and be supervised by other residents, fellows, and attending physicians in concert with this principle. Their hours will be in concert with the surgical residents on this service and not to exceed the maximums as set forth by the ACGME work hour requirements.

**SUPERVISION:** Resident supervision includes Emergency Medicine attendings, PGY-5 surgical residents and trauma surgeon attendings.

**RESOURCES and FACILITIES:** The services available to the Emergency Medicine Resident while on this rotation include the Peters Library and Brown University Libraries, Medical Records Department, service attendings and fellows, consultants in subspecialties, and regular conferences and case discussions.

### Medical Knowledge and Patient Care Educational Objectives:

#### Patient Care Competencies:

#### Interpersonal and Communication Skill Competencies:

#### Practice-Based Learning and Improvement Competencies:

#### Professionalism Competencies:

#### Systems-Based Practice Competencies:

### Description of Didactic Experience

When possible, the PGY I-III residents will participate in Trauma Conference every week from 8:00am

to 9:00am on Wednesday mornings. TICU walk rounds occur at 7am on Monday and PGY-1 residents on the TICU participate.

*Reading Assignments*

Trauma Handbook; Rhode Island Hospital and Hasbro Children’s Hospital Guidelines for trauma care.

*Recommended Reading*

**Rosen’s Textbook of Emergency Medicine**

**Evaluation Process:**

Residents in Emergency Medicine will be evaluated monthly by the service attending, utilizing evaluation forms provided by the Department of Emergency Medicine. Any situations in which a resident’s performance is substandard will be brought to the Emergency Medicine Residency Program Director’s attention.

**Feedback Mechanisms:**

The Program Director is responsible for notifying residents of any problems noted as soon as possible. Written evaluations are available for review during normal working hours. They are reviewed formally with the Program Director on a semi-annual basis.

Have the service directors for all rotations outside the Emergency Department at the primary institution reviewed and agreed to the rotations as described?	YES (X ) NO ( )

## 17. TOXICOLOGY ROTATION

<b>Institution:</b> Rhode Island Hospital	<b>Duration in Months:</b> 1 month
	<b>Year of Training:</b> PGY-3
<b>Educational Objectives:</b>	
<p>To gain a global picture of medical toxicology, including community health aspects, laboratory aspects, clinical aspects, and areas of current research interest.</p>	
<p><b>Objective 1:</b> Develop a comprehensive knowledge of common poisonings and management strategies and then to apply that understanding to the acute management of various common poisonings including the following (MK, PC):</p>	
<ul style="list-style-type: none"> <li>Analgesics: Acetaminophen, NSAIDS, Opiates and related narcotics, Salicylates</li> <li>Alcohols: Ethanol, Glycol, Isopropyl, Methanol</li> <li>Anesthetics</li> <li>Anticholinergics/Cholinergics</li> <li>Anticoagulants</li> <li>Anticonvulsants</li> <li>Antidepressants</li> <li>Antiparkinsonian drugs</li> <li>Antihistamines and antiemetics</li> <li>Antipsychotics</li> <li>Bronchodilators</li> <li>Carbon monoxide</li> <li>Cardiovascular drugs: Antiarrhythmics, Antihypertensives, Beta Blockers, Calcium channel blockers</li> <li>Caustic agents: Acids, Alkalis</li> <li>Cocaine</li> <li>Cyanides, hydrogen sulfide</li> <li>Hallucinogens</li> <li>Hazardous materials</li> <li>Heavy metals</li> <li>Herbicides, insecticides, and rodenticides</li> <li>Household/Industrial chemicals</li> <li>Hormones/Steroids</li> <li>Hydrocarbons</li> <li>Hypoglycemics/Insulin</li> <li>Inhaled Toxins</li> <li>Iron</li> <li>Isoniazid</li> <li>Marine toxins</li> <li>Methemoglobinemia</li> <li>Mushrooms/Poisonous plants</li> <li>Neuroleptics</li> <li>Non prescription drugs</li> <li>Organophosphates</li> <li>Recreational Drugs</li> <li>Sedatives/Hypnotics</li> <li>Stimulants/Sympathomimetics</li> <li>Strychnine</li> <li>Biochemical warfare agents</li> </ul>	
<p><b>Objective 2:</b> Recognize the following common toxidromes: opiate, anticholinergic, sedative/hypnotic,</p>	

cholinergic, anion gap acidosis (MK)

**Objective 3:** Understand and explain the principles and methods of decontamination; the various techniques, indications/contraindications, efficacy and specific uses (MK, PC)

**Objective 4:** Learn specific antidotes and antivenins and their indications (MK, PC)

**Objective 5:** Understand the methods, limitations and use of toxicologic laboratory testing  
Laboratory methods: 1. Colorimetric, Gas/liquid/thin layer chromatography, Mass spectroscopy, EMIT (MK, PC)

**Objective 6:** Understand the structure of and use of the Poison Control Center in acute ingestions/poisonings (PC, SBP)

#### Description of Clinical Experience

During the rotation the resident is assigned to work with one of the faculty who has expertise in toxicology. He/she will be first call the Emergency Department for questions related to toxicology. The attending will serve as direct backup in these cases. In complicated or interesting acute cases, the resident will be expected to personally assist in management, utilizing the ED attending on duty as backup. For patients admitted, the resident/attending will round on the floor/ICU for follow-up.

#### Medical Knowledge and Patient Care Educational Objectives:

#### Patient Care Competencies:

#### Interpersonal and Communication Skill Competencies:

#### Practice-Based Learning and Improvement Competencies:

#### Professionalism Competencies:

#### Systems-Based Practice Competencies:

#### Description of Didactic Experience

During the month the resident will spend several days in both the Poison Center and the toxicology laboratory to gain an understanding of how these parts of the hospital function and contribute to patient care. A core of basic readings will be completed by the resident during the month. Attendings with specific training in toxicology will present a set of core toxicology lectures to the residents. Residents will also participate in several toxicology cases at the High Fidelity Medical Simulation Center. At the end of the month, the resident will deliver a didactic presentation on a toxicologic subject for Toxicology Conference. The resident will also review an article of toxicology interest for Journal Club.

#### Evaluation Process:

A standard evaluation form will be completed for each rotating resident by the toxicologist in charge of the rotation and turned in to the EM residency program director. This will be reviewed by the program director.

#### Feedback Mechanisms:

Residents will receive daily feedback regarding participation in the didactic program and understanding of the material. Each resident's final evaluation will be reviewed with them at their semi annual evaluation with the Program Director or Assistant Program Director.

Have the service directors for all rotations outside the Emergency Department at the primary institution reviewed and agreed to the rotations as described?	YES (X) NO ( )

## 18. ULTRASOUND ROTATION

<b>Institution:</b> Rhode Island Hospital	<b>Duration in Months:</b> 1 month + (1 month experience during Ob/Gyn rotation as EM 1) <b>Year of Training:</b> PGY-2
<b>Educational Objectives:</b>	
<p>The goal of this comprehensive training experience is to train the emergency medicine resident to perform, interpret, and clinically practice emergency ultrasonography. Emergency ultrasonography encompasses focused, goal-directed ultrasound studies of limited scope.</p>	
<b>Objectives:</b>	
<u>Upon completion of the PGY-I year, the resident will be able to:</u>	
<ol style="list-style-type: none"> <li>1. Describe the essential physical principles of ultrasound (MK).</li> <li>2. Describe the practice and principles of emergency obstetrical ultrasonography (MK).</li> <li>3. Describe the practice of ultrasound-guided procedures (MK).</li> <li>4. Demonstrate facility with the technique of transvaginal pelvic ultrasonography (MK, PC).</li> <li>5. Obtain clinical experience with sonographic interpretation of obstetrical and gynecologic pathology (MK, PC).</li> <li>6. Demonstrate facility with the technique of ultrasound-guided central venous access (MK, PC).</li> <li>7. Demonstrate proficiency of a Level 1 Emergency Sonographer (MK, PC).</li> </ol>	
<u>Upon completion of the PGY-II year, the resident will be able to:</u>	
<ol style="list-style-type: none"> <li>1. Describe and perform the Focused Abdominal Sonography for Trauma (FAST) (MK, PC).</li> <li>2. Describe and perform emergency aortic ultrasonography (MK, PC).</li> <li>3. Describe and perform emergency echocardiography (MK, PC).</li> <li>4. Describe and perform emergency biliary ultrasonography (MK, PC).</li> <li>5. Describe and perform emergency ultrasound-guided procedures (MK, PC).</li> <li>6. Demonstrate proficiency of a Level 2 Emergency Sonographer (MK, PC).</li> </ol>	
<u>Upon completion of the PGY-III or IV year, the resident will be able to:</u>	
<ol style="list-style-type: none"> <li>1. Demonstrate proficiency in clinical performance and interpretation of emergent sonographic examinations (MK, PC, ICS).</li> <li>2. Demonstrate proficiency of a Level 3 Emergency Sonographer (MK, PC, ICS).</li> </ol>	
<b>Description of Clinical Experiences:</b>	
<ol style="list-style-type: none"> <li>1) Intern orientation (Site: RIH)           <ol style="list-style-type: none"> <li>a) Lectures               <ul style="list-style-type: none"> <li>• Ultrasound Physics and Principles</li> <li>• Obstetrical Emergency Ultrasound</li> <li>• Emergency Ultrasound Procedures</li> </ul> </li> <li>b) Orientation to ultrasound equipment and function</li> <li>c) Required for all PGY-I residents</li> </ol> </li> <li>2) Ob-Gyn clinical rotation (Site: Womens &amp; Infants)           <ol style="list-style-type: none"> <li>a) Ob/Gyn attending supervision of EM resident pelvic ultrasonography</li> </ol> </li> </ol>	

- b) Documentation of required transvaginal examinations
  - c) Completion designates resident as Level 1 sonographer
- 3) EUS rotation (Site: RIH & Miriam)
- a) Completion of the didactic module (20 hrs. didactics)
  - b) Completion of practice examinations (85 exams)
  - c) Required for PGY II residents
  - d) Completion designates resident as Level 2 sonographer
- 4) Emergency Department rotations
- a) Indicated ultrasound examinations
    - Clinically appropriate ultrasound examinations
    - Examinations performed independently or under faculty supervision
    - Examinations documented and submitted for review
  - b) Required for PGY II-IV residents
- 5) EUS elective rotation (Site: RIH & Miriam)
- a) Completion of ultrasound indicated examinations
  - b) May be required for PGY-III residents at the discretion of the Residency Director
  - c) Optional for PGY IV residents for advanced training in EUS and research

During the OB/Gyn rotation, PGY-I Emergency Medicine residents will have responsibilities on par with residents at the same level of training on the service and be supervised by other residents, fellows, and attending physicians in concert with this principle. Their hours will be in concert with the OB/Gyn residents on this service and not to exceed the maximums as set forth by the ACGME work hour requirements.

During the Emergency Ultrasound and Emergency Department rotations, residents will have responsibilities as designated above. Residents will be supervised by residents, fellows, and attending physicians. Their hours will be in concert with the residents on this service and not to exceed the maximums as set forth by the ACGME work hour requirements.

**Supervision:** Resident supervision includes the Director, Emergency Ultrasound, Emergency Ultrasound Instructors, Emergency Ultrasound fellows, and Level 3 emergency physician sonographers.

**Resources and facilities:** The services available to the Emergency Medicine Resident while on this rotation include the Peters Library and Brown University Libraries, Medical Records Department, service attendings and fellows and regular conferences and case discussions.

The resident will have complete access to departmental ultrasound equipment including:

- Sonosite Titan: RIH ED
- Sonosite 180: RIH ED

**Medison Mysono: The Miriam Hospital ED**

<b>Medical Knowledge and Patient Care Educational Objectives:</b>
<b>Patient Care Competencies:</b>
<b>Interpersonal and Communication Skill Competencies:</b>
<ol style="list-style-type: none"> <li>1. Develop a physician-patient relationship model that creates a therapeutic relationship with patients.</li> <li>2. Develop listening skills that will facilitate communication with patients, their families, and other members of the health care.</li> <li>3. Demonstrate and observe caring and respectful behaviors through patient interactions Develop interviewing skills that will facilitate patient interaction</li> <li>4. Develop skills at facilitating informed decision-making by patients and their families. To learn of specific situations in which informed decision-making may not be possible due to a patient's medical condition or advance directive.</li> <li>5. Counsel and educate patients and their families of their medical conditions.</li> <li>6. Develop awareness and facilitate the provision of health care within a team of health care providers.</li> </ol>
<b>Practice-Based Learning and Improvement Competencies:</b>
<ol style="list-style-type: none"> <li>1. Develop methods of analyzing the resident's own practice to improve quality of health care provided.</li> <li>2. Develop a personal program of learning related to the requirements of the rotation in the context of an emergency medicine rotation.</li> <li>3. To identify areas of weakness in medical knowledge and practice relevant to the current rotation, and develop a plan to address these weaknesses during the rotation and beyond.</li> <li>4. To develop skills in the use of evidence from scientific studies to alter the resident's practice of medicine, with the goal of improving the health care provided.</li> <li>5. To develop skills in the use of information technology, and in particular online Medline reference searching.</li> </ol>
<b>Professionalism Competencies:</b>
<ol style="list-style-type: none"> <li>1. To develop respectful and altruistic attitudes towards patients, their families, and other members of the health care team.</li> <li>2. To incorporate principles of ethics into the practice of medicine.</li> <li>3. To develop sensitivity to cultural, age, gender, and disability issues that may impede patient care through disruption of physician-patient interaction.</li> </ol>
<b>Systems-Based Practice Competencies:</b>
<b>Description of Didactic Experience</b>
Selected literature on primary Emergency Ultrasound indications will be distributed to the PGY-I and II residents by the Director, Emergency Ultrasound.
<b>Evaluation Process:</b>
Upon completing the Emergency Ultrasound didactics and practicum, residents will undergo a proficiency review examination by the Director, Emergency Ultrasound. Completion designates the

resident as a Level 3 sonographer. Having demonstrated practical and clinical proficiency, the resident will perform and provide oversight of ultrasound examinations in the Emergency Departments of Rhode Island Hospital and The Miriam Hospital.

Completion of the proficiency examination is a requirement for all residents as of 2004. Certification of completion is documented in the resident's record upon completion of the PGY-IV year. Residents in Emergency Medicine will be evaluated monthly by the Director, Emergency Ultrasound, utilizing evaluation forms provided by the Department of Emergency Medicine. Any situations in which a resident's performance is substandard will be brought to the Emergency Medicine Residency Program Director's attention.

**Feedback Mechanisms:**

The Program Director is responsible for notifying residents of any problems noted as soon as possible. Written evaluations are available for review during normal working hours. They are reviewed formally with the Program Director on a semi-annual basis.

Have the service directors for all rotations outside the Emergency Department at the primary institution reviewed and agreed to the rotations as described?	YES (X) NO ( )