Emergency Medicine Residency Program

Resident Physician Manual

Program Policies and Procedures

2017-2018

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Table of Contents

I. Overall Educational Goals pg. 3
II. ACGME Core Competencies pg. 4
III. Resident Supervision and Progressive Responsibilities pg. 6
IV. Documentation of Patient Records pg. 8
V. Patient Handovers pg. 9
VI. Conferences: Attendance Policy and Presentation Requirements pg. 11
VII. Journal Club pg. 12
VIII. Scholarly Activity and CQI Requirements pg. 13
IX. Research pg. 16
X. E*Value pg. 17
XI. Procedure Log Requirements pg. 17
XII. Duty Hours and Work Environment pg. 18
XIII. Moonlighting Policy and Request Form pg. 19-20
XIV. Annual/Sick/Maternal/Paternal Leave pg. 21
XV. Shift Scheduling pg. 22
XVI. CME Allowance pg. 24
XVII. Requirements for Reimbursement pg. 24
XVIII. Educational Resources pg. 26
XIX. Policy for Promotion pg. 26
XX. Academic Deficiencies and Corrective Action pg. 29
XXI. Clinical Rotation Summaries pg. 31
XXII. ACGME Emergency Medicine Milestones pg. 61
XXIII. The Alphabet Soup of EM pg. 62
XXIV. Clinical Competency Committee pg. 63
XXV. Program Evaluation Committee pg. 65
XXVI. In-Training Exam Policy pg. 66
XXVII. Social Media Policy pg. 66
I. Overall Educational Goals

The overall educational goals, as well as goals and objectives for each assignment at each educational level, are distributed by e-mail annually to all residents and faculty. This is in the form of the Resident Physician Manual. The primary goal of the residency program is to teach residents how to be outstanding emergency medicine clinicians and to provide efficient emergency medical care in a compassionate manner.

The other goals of our program are:

1. To promote excellence in academic and administrative aspects of emergency medicine.

2. To provide the necessary tools to develop research and teaching skills for a career in academic emergency medicine.

To achieve these goals, we will provide a supervised clinical experience and well-planned didactic teaching of the highest quality. The residents will be given progressive responsibility for patient care throughout their three-year residency. Residents will be taught procedural skills by means of skill labs and direct patient encounters.

Our clinical schedule will be designed to provide the educational experience necessary to achieve clinical competency in the field of Emergency Medicine. Residents will be offered ample opportunities to teach junior residents and medical students. We will provide research opportunities to residents with guidance from our faculty members. At the end of the three-year training program, our residents will have gained the necessary knowledge and confidence to independently practice Emergency Medicine.
II. ACGME Core Competencies

The residency program must require its residents to develop the competencies in the six areas below to the level expected of a new practitioner. Toward this end, programs must define the specific knowledge, skills, and attitudes required and provide educational experiences as needed in order for their residents to demonstrate the competencies.

1. PATIENT CARE

Residents must be able to provide patient care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health. Residents are expected to:

- Communicate effectively and demonstrate caring and respectful behaviors when interacting with patients and their families.
- Gather essential and accurate information about their patients.
- Make informed decisions about diagnostic and therapeutic interventions based on patient information and preferences, up-to-date scientific evidence, and clinical judgment.
- Develop and carry out patient management plans.
- Counsel and educate patients and their families.
- Use information technology to support patient care decisions and patient education perform competently all medical and invasive procedures considered essential for the area of practice.
- Provide health care aimed at preventing health problems or maintaining health work with health care professionals, including those from other disciplines, to provide patient-focused care.

2. MEDICAL KNOWLEDGE

Residents must demonstrate knowledge about established and evolving biomedical, clinical, and cognate (e.g. epidemiological and social-behavioral) sciences and the application of this knowledge to patient care. Residents are expected to:

- Demonstrate an investigatory and analytic thinking approach to clinical situations.
- Know and apply the basic and clinically supportive sciences which are appropriate to their discipline.
3. PRACTICE-BASED LEARNING AND IMPROVEMENT
Residents must be able to investigate and evaluate their patient care practices, appraise and assimilate scientific evidence, and improve their patient care practices. Residents are expected to:

- Analyze practice experience and perform practice-based improvement activities using a systematic methodology.
- Locate, appraise, and assimilate evidence from scientific studies related to their patients’ health problems.
- Obtain and use information about their own population of patients and the larger population from which their patients are drawn.
- Apply knowledge of study designs and statistical methods to the appraisal of clinical studies and other information on diagnostic and therapeutic effectiveness.
- Use information technology to manage information, access on-line medical information; and support their own education.
- Facilitate the learning of students and other health care professionals.

4. INTERPERSONAL AND COMMUNICATION SKILLS
Residents must be able to demonstrate interpersonal and communication skills that result in effective information exchange and teaming with patients, their patients’ families, and professional associates. Residents are expected to:

- Create and sustain a therapeutic and ethically sound relationship with patients.
- Use effective listening skills and elicit and provide information using effective nonverbal, explanatory, questioning, and writing skills.
- Work effectively with others as a member or leader of a health care team or other professional group.

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

- Demonstrate respect, compassion, and integrity; a responsiveness to the needs of patients and society that supersedes self-interest; accountability to patients, society, and the profession; and a commitment to excellence and on-going professional development.
- Demonstrate a commitment to ethical principles pertaining to provision or withholding of clinical care, confidentiality of patient information, informed consent, and business practices.
- Demonstrate sensitivity and responsiveness to patients’ culture, age, gender, and disabilities.
6. SYSTEMS-BASED PRACTICE
Residents must demonstrate an awareness of and responsiveness to the larger context and system of health care and the ability to effectively call on system resources to provide care that is of optimal value. Residents are expected to:

- Understand how their patient care and other professional practices affect other health care professionals, the health care organization, and the larger society and how these elements of the system affect their own practice.
- Know how types of medical practice and delivery systems differ from one another, including methods of controlling health care costs and allocating resources.
- Practice cost-effective health care and resource allocation that does not compromise quality of care.
- Advocate for quality patient care and assist patients in dealing with system complexities.
- Know how to partner with health care managers and health care providers to assess, coordinate, and improve health care and know how these activities can affect system performance.

III. Resident Supervision and Progressive Responsibilities

Clinical care provided by any EM resident always takes place under the supervision of the EM attending physician. Faculty supervision can either be direct (with the supervising physician physically present with the resident and patient) or indirect (the supervising physician is physically within the Emergency Department and is immediately available to provide direct supervision). The degree of professional responsibility accorded to the resident is progressively increased throughout the course of training according to individual capabilities and the PGY level as outlined.

The PGY-1 EM resident is responsible for the initial evaluation, stabilization, and disposition of individual acutely ill or injured patients. PGY-1 residents are responsible for a fewer number of ED patients while learning the basic EM clinical skills and approach to the patient. The resident manages patients with the supervision of the EM attending and occasionally a senior EM resident. PGY-1 residents are expected to gradually contribute toward patient flow as their skill level and knowledge base expand throughout the academic year. They are not expected to assume any type of supervision of other learners, although occasionally they do informally supervise medical students. Off-service rotations provide a broad foundation upon which to build knowledge. Teaching responsibilities are in the form of interacting clinically with medical students, giving one core lecture and participating in Journal Club and trauma conference. PGY-1 residents have no direct administrative role to perform but are exposed to various administrative issues during orientation sessions and at residency conference. They are active in recruiting future residency applicants. Residents are required to become ACLS, BLS, and PALS providers during the PGY-1 year.
The PGY-2 EM resident assumes increased responsibility in the initial evaluation, stabilization, and disposition of acutely ill or injured patients. They are expected to carry the majority of critical patients in the ED at any given time, thus developing the ability to care for multiple patients simultaneously. Based upon the clinical situation, the PGY-2 resident is encouraged to initiate the appropriate workup and treatment while discussing care with the EM attending at some point during that patient’s ED stay. This experience allows the PGY-2 resident to develop and improve procedural skills, clinical judgment, patient flow capabilities, and decision-making skills. The PGY-2 resident will assist PGY-1 off-service residents or students in initiating patient work-ups. Off-service rotations focus on critical care. As the year progresses, the resident will continue to assume more responsibility for team leadership, supervision, and administration in the clinical and didactic arenas. These residents will be able to provide direct medical control of EMS calls. They also are active in recruiting for future residency applicants by assuming leadership in the organization of the associated social events and the interview day. Annual teaching responsibilities include one Core Content and one Evidence-Based Medicine Clinical Answers lecture at the weekly EM didactic session, participation in Journal Club and trauma conference presentations. These residents are encouraged to obtain ACLS, PALS instructor status or certified in ATLS.

At the PGY-3 level, there will be advanced clinical, administrative, supervisory, and educational functions within the ED. PGY-3 residents will continue to develop their expertise in patient care and procedural skills, team leadership, supervising resuscitations and managing multiple patients simultaneously. The resident will focus on managing the entire ED, becoming more autonomous, and learning to delegate and refine triage skills. They are expected to supervise their juniors, off-service rotators and students and to lead by example. The PGY-3 resident will continue to direct medical control for EMS calls. PGY-3 residents will be supervised exclusively by the EM attending physician. Residents will be expected to teach on all clinical shifts and to actively participate in conferences. They are expected to give a total of three didactic lectures, (including one with a Pediatric EM focus), present at trauma conference, and supervise Journal Club. All PGY-3 residents will complete their CQI project and Scholarly Activity which both began at the PGY 1 level. They are active in recruiting for future residency applicants.

**Responsibilities and Surveillance**

All faculty and residents have the responsibility for patient safety. To that end, all will be held accountable for safe, effective, and appropriate resident supervision and progression of responsibilities in the Emergency Department. All critical decisions (e.g. DNR or other end-of-life decision, ICU transfer, care of a complex patient, need for invasive procedures) are made with real-time input from attending physicians. Decisions for patient admission can be done with indirect supervision during the PGY-3 year as long as the attending physician has been made aware of this decision at some point during the patient’s ED stay.

The Residency Director is responsible for dissemination and implementation of this policy to the faculty and residents of the program. The Residency Director will periodically review the implementation and effectiveness of the policy and associated guidelines in consultation with department faculty and residents, including strategies for improvement. On-going surveillance of the policy will be undertaken by the Residency Director, Department Chief, and the Medical Director.
IV. Documentation of Patient Records

**HPI** – A complete HPI should have four of the following eight details:

1. **Timing** – how long each episode lasted or time of day  
   Ex: every 10 minutes, at night, seldom, frequently
2. **Duration** – length of time illness has been present or ongoing  
   Ex: since 3 weeks ago, for the past 2 hours, since last night
3. **Quality** – characteristics of the chief complaint  
   Ex: throbbing, color
4. **Severity** – measurement of discomfort or pain  
   Ex: scale of 0 – 10, temperature (101.5)
5. **Location** – where it hurts.  
   Ex: pancreas, abdominal pain, left hip
6. **Signs/Symptoms** – any other problem that can be identified with the chief complaint  
   Ex: feels sick to stomach, bleeding, LOC, SOB
7. **Context** – how it happened.  
   Ex: fell off bike, MVA, fall, assaulted
8. **Modifying Factors** – any influence that has made the problem better or worse  
   Ex: took Advil, rest

**ROS** – You need to have ten positives, negatives, or both or one positive or one negative and mark the box all other systems reviewed and negative. All ten systems must be complete.

**History** – You need two of the three:

- **PMH** – patient’s medical history
- **FH** – family history
- **SH** – social history

**PE** – You need to have eight marked to have a complete exam:

- Constitutional: vital signs, appearance Psychic:  
  appropriate, inappropriate, combative  
  normal, cool, warm to touch  
  Eyes: normal, red  
  ENT: normal, throat red and scratchy CV:  
  normal, palpations  
  Resp: normal, SOB GI:  
  normal, tender  
  GU: normal, discharge  
  MS: Includes neck and back: normal, tenderness  
  Heme/Lymph: normal, edema  
  Neuro: normal, lethargic
Medical Decision Making (MDM) – Document everything you do: IVF, EKG, labs, x-ray’s, CT’s, MRI’s and consults. Record the results.

If you have a patient from whom you cannot get information (e.g. intoxicated, unresponsive, intubated, confused), then mark the box that states: “Unable to obtain additional information from patient. Reason: ____________.”

If you do not state the reason, then the coding office cannot caveat the HPI, ROS and History. You still have to complete a PE.

Make sure that you always sign, date, and time the chart and all procedure notes, then review the chart with the attending.

V. Policy Statement on Safe Handover of Patients

Policy Statement

1. Effective clinical handover is an essential team process and a critical component in the delivery of safe quality health care to the patient across the entire spectrum of health care providers.

2. Clinical handover processes must be timely, patient-centered, structured and contribute to safe patient care. Clinical handover formalizes the transfer of accountability and responsibility of some or all relevant aspects of patient care.

3. The Department is committed to implementing systems that ensure effective, consistent and agreed upon processes to support clinical handovers. This ensures timely clinical handover processes free from significant distractions other than emergent patient interventions, utilizing an appropriate environment and systems to deliver continuous safe quality clinical care.

Policy Rationale

The purpose of this policy is to enhance patient safety by improving clinical handover, ensure a consistent approach to clinical handover across healthcare teams, and to ensure processes and practices are in place to enable continuity of care to occur within and across healthcare services provided in the Emergency Department.
Standards

1. Participation in clinical handovers by all relevant staff during rounds are directly supervised by the attending physician.

2. Clinical handover processes and procedures are supported by appropriate documentation (including clinical notes, labs, and imaging follow-up and interpretation, etc.).

3. Shift to shift clinical handover occurs as a regular, consistent, and mandatory event, and the fundamentals of effective teamwork and communication are demonstrated in the process of clinical handovers during rounds.

4. Policies of confidentiality, privacy, patient identification, and medical records are appropriately applied to clinical handovers and transfers.

5. An acknowledged transfer of clinical accountability and responsibility must occur through documentation in the medical record in addition to verbal confirmation during rounds.

6. Included in faculty development and resident training, educational walk rounds are also included in the process of patient handover.

7. Sufficient resources are in place to enable effective clinical handover, including staff training in clinical handover.

8. Incidents relating to clinical handovers are reported to the Medical Director.

Responsibilities and Surveillance

All faculty and residents have the responsibility for patient safety. To that end, all will be held accountable for safe and effective transitions of care of all patients in the Emergency Department. The Medical Director is responsible for dissemination and implementation of this policy to the faculty and residents of the program. The Medical Director will periodically review the implementation and effectiveness of the policy and associated guidelines in consultation with department faculty and residents, including strategies for improvement. In addition, in an effort to provide on-going training in safe and effective hand-offs, lessons learned from the management of clinical handover issues will be discussed during relevant conferences including Morbidity and Mortality Conference, resident meetings, faculty meetings, multi-disciplinary conferences, simulation labs, etc. On-going surveillance of the handover policy and other patient safety initiatives in the ED will be undertaken by the Department Chief, Medical Director, and the Residency Director.
VI. Conference: Attendance Policy and Presentation Requirements

Attendance Policy and Presentation Requirements

Emergency medicine residents are expected to attend all scheduled didactic lectures including simulation lab, Journal Club, and other scheduled educational conferences unless on vacation or excused with a minimum of 24-hour notice prior to conference. A minimum conference attendance of 70% of Thursday morning didactics is required for promotion to each subsequent year of residency as outlined in the Residency Advancement Criteria. Late arrival to the conference by more than 10 minutes is equal to a missed conference hour.

To ensure compliance each EM resident is expected to do the following:
1. Approach your attending physician on the first day of each off-service rotation.
2. Introduce yourself and the program. You are the Emergency Medicine ambassador.
3. Professionally explain the didactic/simulation lab policy, present a hardcopy of the month’s conference schedule, and inform the attending and senior resident that you will be absent during those times as outlined but would like to make this least disruptive as possible for patient care and team rounding. For example:
   a. Offer to present your patients first in order to get to conference on time.
   b. Offer to come early or stay late in order to finish required work as long as it does not interfere with residency duty hours.
4. If for any reason you are denied the opportunity to attend your mandatory educational didactics, page your Chief Residents first. If no response, then page the PD immediately so that she may speak to the off-service attending or resident involved.

Conference Presentation Requirements:
PGY-1: One lecture covering a basic core content topic, one Journal Club, 30 minutes Radiology presentation following clinical rotation.
PGY-2: Two lectures: One covering core content, one addressing a specific Evidence-Based Medicine question with literature discussion; one Journal Club, one Trauma conference.
PGY-3: Three lectures: One covering a pediatric topic in depth, the remaining two may be chosen to cover M and M, core content, EBM, or other at the approval of the Curriculum Director (CD), one Journal Club, one Trauma Conference, one CQI presentation.
All presentations must adequately cover the topic at the appropriate level of training.

1. Time of presentation is to be 45-50 minutes, with 10 minutes of a question and answer period to follow. If the resident fails to deliver an adequate lecture as determined by the core faculty, CD, and/or PD, he/she will be required to deliver an additional lecture that academic year.

2. Topics will be chosen by the resident and must be approved by the CD. Lecture topic must be chosen 30 days prior to the first day of the month in which the lecture occurs. For example, an October 30th lecture topic must be approved by September 1st. The resident may not repeat a lecture topic in the course of his/her residency, with the exception of a remediation lecture.

3. Lecture should be designed with the help of the mentor and/or other faculty.

4. Month of presentation will be assigned by the CD at the beginning of the year. Every attempt will be made to schedule it during an EM rotation month. Residents may trade assignment dates with their colleagues with prior approval from the CD.

5. Dress for the presentation must be professional as the speaker is representing the department and the university. At a minimum, shorts, baseball caps, jeans should not be worn.

VII. Journal Club

Journal Club is held one Thursday, every other month. All residents are required to attend.

Journal Club Attendance Policy:

1. PGY-1 residents will be assigned a month in which to present a journal article in depth, with review of the statistics. The resident will select the article from the ACEP website: http://www.annemergmed.com/content/journalclub.

2. PGY-2 residents will be assigned a month in which to lead the discussion/questions/answers.

3. PGY-3 residents will be assigned a month in which to coordinate the above.
VIII. Scholarly Activity and CQI Requirements

Scholarly Activity Requirement: One scholarly project must be completed during residency. There must be a component of research within your scholarly activity. Obtain approval and guidance from a mentor and the Program Director.

Suggestions for your scholarly project:

1. Participate in a research project. You can initiate one, participate in one with any faculty member, or participate in one in a different Department/department. You can use your elective in your third year for this if desired. Select a relevant focused clinical question that you care about.
2. Write a publishable journal article or an original textbook chapter with a faculty member.
3. Create an educational project. Examples: Establish a lecture series, a radiology case series, EBM series, or teaching portfolios. Create medical student teaching files or simulation cases. Design a module to be included in the EM curriculum. Develop a course, e.g., for non-physicians.
4. Develop an administration project. Develop an evaluation project.

Goal: The overall goal is to create a substantive, useful product involving aspects of research that can be described in a sentence and presented in a brief lecture.

Deadlines are as follows:

**PGY-1**
Establish a mentor within the first 6 months
Project idea proposal completed within 12 months

**PGY-2**
Update to mentor and Program Director

**PGY-3**
Completion of project and didactic presentation by spring
Lecture and product filed in residency office by graduation
Emergency Medicine Continuous Quality Improvement Training

Physicians in Emergency Medicine are being asked to demonstrate quality and safety-related behavior. The purpose of the MUSC CQI program is to educate at the resident level how quality in emergency medicine can be determined and why quality improvement projects can positively affect the care of emergency patients. Methods and tools for quantifying these measures will be examined, as well as their accuracy in assessing quality by adjusting for differences in environment and patient populations. The program will focus on two of the six ACGME general competencies: practice-based learning and improvement, and systems-based practice. Fundamental to these competencies is the principle of improving patient care by examining current practices and applying a systematic, evidence-based approach for improvement. The curriculum is as follows:

**Year 1**
The residents will review the monthly CQI report. They will be expected to understand the quantitative and qualitative measures being detailed. Additionally, they will understand that it is their responsibility to report to the CQI director any cases for which potential improvements in care may have been possible. Those cases felt to be of specific interest to the residents will be discussed further either at monthly morbidity and mortality conference or by separate e-mail.

The residents will complete two online modules [approximately 2 hours] on “Introduction to Health Care Improvement” and “How to Improve with the Model for Improvement” as developed by the Institute for Healthcare Improvement. This free online learning resource (http://app.ihi.org/lms/mycatalogs.aspx) provides a consistent framework and vocabulary for addressing quality assessment and improvement in the clinical setting. The resident will learn about the elements of quality from different stakeholders’ perspectives, and a systems orientation that recognizes the inter-relationships among structure, process, and outcomes. After you have completed the modules, print-out the completion certificate and give to the program coordinator.

**Deadline for completion of the modules is December 31 of Intern Year.**

**Year 2**
Each resident will be required to choose and implement a quality improvement project. He/she will identify a clinical management issue, develop a plan to improve patient care, implement the plan with faculty and institutional support, and present the project to peers, faculty, and administrators by inclusion in the monthly CQI report. The project will be supervised by the resident’s faculty advisor (mentor) along with input from the CQI director. The resident is expected to select a topic, perform a root cause analysis or develop assessment markers, and propose a solution. The project is not to start until the completion of year one and is due by the end of year two.
Examples of projects are:
Follow-up of labs or x-rays, patient satisfaction issues, asthma or other disease management, compliance with CMS quality initiatives, optimal utilization of clinical guidelines, information sharing between the ED and follow-up care providers, and communication between ED staff and other services. Many of the previous projects were chosen based on first identifying something that was a source of frustration, then doing a root cause analysis, and finally proposing a solution. A list of suggested topics is at the end of this document. The suggested format for project write-up is the following:

- Introduction
- Methods
- Results
- Discussion/limitations
- Conclusions

**Deadline for completion of the project is June 1.**

In addition, residents will continue to review the monthly CQI report. It is also their responsibility to report to the CQI director any cases in which improvements in care may have been possible. Those cases felt to be of specific interest to the residents will be discussed at monthly Morbidity and Mortality conference or by separate e-mail.

**Year 3**
Each resident will prepare one monthly CQI report encompassing both statistical and case review presentation. This will be submitted in a timely fashion to the CQI Director for final review prior to group distribution. Additionally, he/she will present one case at monthly M&M.

In addition, the resident will continue to review the monthly CQI report. It is also his/her responsibility to report to the CQI director any cases in which improvements in care may have been possible. Those cases felt to be of specific interest to the residents will be discussed further either at monthly Morbidity and Mortality conference or by separate e-mail.

**Possible CQI Projects**

- EMS run sheets being available for review
- Procedural sedation – best practice
- Improved communication with private MDs – ED chart copy
- Ultrasound-guided peripheral IV access – survival & complications
- Acute pain protocol – Morphine weight based dose every 7 minutes prn
- Abnormal vital signs – recognized, repeated, repeat visit with bad outcome
- Utilization of SWATs for sepsis
- Hemolyzed lab specimens – frequency, reasons, solutions
- Documentation of screening for intimate partner violence
- Time to EKG for men v. women
- Use of AFFIRM test to replace wet preps
- Documentation of pregnancy status on radiology requests
- Follow-up of positive blood cultures
• Radiology discrepancies
• FFP & platelet utilization in trauma patients

IX. Research

Research in the Department of Emergency Medicine is a growing portfolio of a variety of basic science, translational and clinical trials experimentation. There is a wide variety of opportunities for residents. As part of a vibrant academic medical center, Emergency Medicine has access to considerable resources for investigation. There are outstanding opportunities for collaboration in research for residents.

Any research project should begin with a thorough review of the existing literature. After this analysis a mentor should be identified. This can be anyone from the faculty at MUSC. Sources of funding should be considered early and proposals directed at these sources of funding. Intramural proposals for preliminary data leading to further submission will be reviewed by the research director and Department chief. Upon project review, some funds may be available through the Emergency Medicine Resident Research Fund. Scope of the project is also very important to resident projects. They should be designed with reasonable expectations as to performance in a busy clinical schedule. Resources are available for assistance to projects reviewed on a competitive basis.

Both ACEP and SAEM have resident research awards presented on an annual basis. In addition, there are a number of venues for presentation of research including the SAEM, ACEP, NAEMSP and other meetings.

A research elective is available for students and residents. Goals and a research plan should be identified and planned well in advance of the elective rotation. Research Fellowships are a possibility with work in MUSC’s Masters of Science in Clinical Research Program. If interested in a research fellowship, please contact the research director for further discussion.
X. E*Value

MUSC’s electronic system of managing its residents is known as “E*Value”, which was developed by Advanced Informatics in Minneapolis, Minnesota.

E*Value tracks all details relevant to resident training, including biographic data, training records, rotations, conferences, evaluations, procedures, follow-up logs, and duty hours logged.

During orientation, residents will receive a password and basic instructions for use. Technical support is provided by Advanced Informatics and MUSC’s office of Graduate Medical Education.

This system provides very important documentation that is required by the ACGME during site visits. Accuracy and continual data entry is critically important.

XI. Procedure Log Requirements

Residents are required to maintain a procedure log in the E*Value system. Resident competency in the listed procedure is to be appropriately certified and documented in a timely fashion. When logging into E*Value, record whether the procedure was done on a patient or in a simulation setting.

Do not stop logging procedures once you have completed the required number.

Number of procedures required over three years for graduation:

- Adult medical resuscitations: 45
- Adult trauma resuscitations: 35
- Cardiac pacing: 06
- Central venous access: 20
- Chest tubes: 10
- Procedural sedations: 15
- Cricothyrotomies: 03
- Disclocation reductions: 10
- Intubations: 35
- Lumbar punctures: 15
- Pediatric medical resuscitations: 15
- Pediatric trauma resuscitations: 10
- Pericardiocentesis: 03
- Vaginal deliveries: 10
XII. Duty Hours and Work Environment

MUSC Emergency Medicine residents on any clinical rotation other than Adult or Pediatric Emergency Medicine rotations, follow the MUSC institutional policy in regards to duty hours and the work environment without exception. Please refer to the MUSC GME website for this policy at:

http://academicdepartments.musc.edu/gmehandbook/policies/res_duty_hours.html

MUSC Emergency Medicine residents rotating in the Adult or Pediatric Emergency Medicine rotations follow the more stringent Emergency Medicine specific duty hour standards as outlined below, in addition to the common Program requirements as outlined by the ACGME.

- As a minimum, residents shall be allowed an average of one full day in seven days away from the institution and free of any clinical or academic responsibilities, including planned educational experiences.
- While on duty in the emergency department, residents may not work longer than 12 continuous scheduled hours. There must be at least an equivalent period of continuous time off between scheduled work periods.
- A resident should not work more than 60 scheduled hours per week seeing patients in the emergency department and no more than 72 duty hours per week. Duty hours comprise all clinical duty time and conferences, whether spent within or outside the educational program, including all on-call hours.
- There must at least an equivalent period of continuous time off between scheduled work periods. Residents may attend educational activities between work periods, but at some point in the 24-hour period must have an equivalent period of continuous time off between the end of one activity (work or educational) and the start of another activity (work or educational).

Protocols for Duty Hour Violations

A. Scheduled Duty Hour Violations

In conjunction with the MUSC GME policy on Resident Duty Hours, no resident should be scheduled prospectively for any clinical or academic duties that would violate the duty hour policy. If this were to occur, the resident is to notify the Chief and/or responsible faculty member of the scheduling service to amend the schedule appropriately. If the resident meets any resistance, he/she is to notify the EM Program Director immediately. The Program Director will then intervene for immediate adjustment and ensure there will be no scheduled duty hour violations. It is the resident physicians’ responsibility to review their clinical schedule prior to the start of the rotation to enact this protocol in a timely fashion.

B. Unscheduled Duty Hour Violations

In the unusual event a resident is not scheduled, but subsequently remains on duty beyond scheduled hours, it must only be based on his/her own initiative as outlined in the GME policy. Under these circumstances the resident must notify the Program
Director and a written record of the event will be maintained. In the unlikely event the resident physician is asked to remain beyond duty hours by a senior resident or faculty member, the resident physician is to notify the Program Director immediately for intervention and avoidance of a duty hour violation.

C. Duty Hour Violations Logged
Duty hours are to be logged by every resident physician in accordance with the MUSC GME policy in E*Value. The Program Director receives an instant notification via e-mail if a duty hour violation has been logged by any Emergency Medicine resident. This would only occur if the protocols were not followed as outlined above. In this instance the Program Director will contact the resident immediately to clarify the violation and again review the policies and protocols in place to avoid any further future violations. The Program Director will track both individual resident and program-wide episodes of additional duty.

XIII. Moonlighting Policy and Request Form

Moonlighting privileges may be granted by the Program Director to PGY-3 Emergency Medicine resident physicians. The resident must first obtain permission to moonlight from the GME office by completing the form located on the GME website at:

http://academicdepartments.musc.edu/gmehandbook/appendix3/MoonlightingApprovalForm16-17.pdf

The EM residency program adheres to the MUSC GME policy which can be found at:
http://academicdepartments.musc.edu/gmehandbook/policies/moonlighting.html

In addition to following the MUSC GME Moonlighting policy, all EM residents requesting moonlight privileges must also adhere to the following EM specific criteria. This activity may not interfere with the residency training. Moonlighting residents are also required to complete the EM residency form below, which outlines the following policies:

- The resident may not moonlight on shifts that are back to back with scheduled ED shifts, or that are back to back with didactics.
- If the resident does not obey these rules or in any way falsifies compliance information, moonlighting privileges can and will be revoked for a minimum of 6 months.
- The hours spent moonlighting will be considered part of residency program duty hours. On non-ED rotations, the total number of hours worked must not exceed 80/week on the average. On ED rotations, total clinical hours must not exceed an average 60/week, and overall work hours must not exceed an average of 72/week. Outside employment should not cause undue fatigue nor detract from any aspect of resident education and responsibilities.
Moonlighting Request Form and Policy
(to be completed quarterly)

To: Jeffrey Bush, MD
Residency Program Director

Resident Name: __________________________ Date: __________

I wish to inform you that I request to moonlight effective __________. The estimated average number of hours per month that I will be moonlighting is _____. I plan to moonlight at the following hospitals:

I verify that I am in and will stay in full compliance with all residency program requirements which are necessary to moonlight including the following:

- No incomplete clinical rotations ______ (Initial)
- Medical records complete ______ (Initial)
- Follow-up logs complete and submitted ______ (Initial)
- Procedure log complete and submitted ______ (Initial)
- Conference Attendance minimum 70% ______ (Initial)
- Not currently active in any remediation ______ (Initial)
- Completion of 2 years EM Residency ______ (Initial)
- Satisfactory performance in all 6 Core Competencies ______ (Initial)

I acknowledge that moonlighting may enhance my training, but I also recognize that it is a privilege and not a right. This activity will not interfere with my residency training in regards to clinical rotations or didactic experience. I will not moonlight on shifts that are back to back with clinical duties or didactic conferences. If I do not obey these rules, or in any way falsify compliance information, I understand that my moonlighting privileges can and will be revoked for a minimum of six (6) months.

Furthermore, I understand the hours spent engaging in moonlighting activities will be considered part of my residency program duty hours. Outside employment should not cause me undue fatigue. Residents’ duty hours as outlined by the Graduate Medical Education office at http://academicdepartments.musc.edu/gmehandbook/policies/res_duty_hours.html must be maintained and monitored. A moonlighting approval form must also be completed for the Office of GME at http://academicdepartments.musc.edu/gmehandbook/appendix3/Moonlighting%20Approval%202011%20to%202012.pdf

I understand that the MUSC malpractice insurance, DEA registration, and my limited SC license do not cover me while moonlighting.

_________________________________________   ________________________________
(Signature and Date)                        (PD Signature and Date)
XIV. Annual/Sick/Maternal/Paternal Leave

The Emergency Medicine Residency Program’s policy for leave is the same as the policy of the Graduate Medical Education office, which is as follows:

- Annual leave is three weeks per year. Residents may take 15 weekdays (Monday through Friday) and six (6) weekend days (Saturday and Sunday) per year. Leave not taken in an academic year (July 1 – June 30) is not carried over.
- Annual leave is granted at the discretion of the shift scheduler and the Program Director and must be approved in writing by the scheduler.
- Time away from MUSC for job interviews and board exams must be taken as annual leave unless other arrangements are approved by the Program Director.
- Residents must obtain approval for annual and family leave no later than 60 days before the first day of the month that begins the affected rotation. All vacation requests must first be submitted to the Residency Program Coordinator.
- The maximum number of consecutive annual leave days allowed is seven, unless the Program Director gives special permission for more.
- In keeping with the ABEM Policy on Resident Leave Time, our program policy states that a resident cannot exceed more than six weeks of leave time each academic year. Any time over that will need to be "made up" prior to certification eligibility.
- Sick leave is three weeks (21 days, including Saturdays and Sundays) per year. A resident who is absent from the residency program for four or more consecutive days due to illness must present a clearance letter from the principal treating physician or receive written approval from the Program Director before returning to the program. Under certain circumstances, additional sick leave without pay may be granted. Any shifts missed due to sick leave or any other reason must be made up.
- Maternity leave will be granted to the mother at the time of birth or adoption in conjunction with FMLA policy. The mother will be granted a maximum of six weeks of maternity leave. For more information go to:
- Paternity leave will be granted to the father after the birth or adoption in conjunction with the FMLA policy. The father will be granted a maximum of six weeks of paid leave (three weeks annual leave, three weeks sick leave). For more specific details go to:

Resident Initial ____________
XV. Shift Scheduling Policy

These guidelines apply for resident physicians of all specialties when creating the ED schedule. EMS shifts are included for EM resident physicians. For details specifically regarding vacations please refer to the MUSC GME Annual Leave Policy. Requests for more than seven consecutive days are not accepted. All vacation requests must be submitted to the EM Program Coordinator. **No vacation is approved for any resident physician from any service until it is logged by the Program Coordinator and then approved by the EM Chief Residents.** Although these guidelines apply to all, specific circumstances will be reviewed individually by the EM Chief Residents and Dr. Jeff Bush.

**Off-Service PGY-1 Residents**
- 21 shifts per month
- 19 shifts if 1-2 days off
- 18 shifts if 3-4 days off
- 17 shifts if 5-6 days off
- 16 shifts if 7 days off
**If in the ED for 32-33 days, then 22 shifts If in the ED for 34-35 days, then 23 shifts**

**Emergency Medicine Residents**

**PGY-1**
- 21 shifts (19 ED or EMS, 2 PED)
  - 20 shifts if 1-2 days off
  - 19 shifts if 3-4 days off
  - 18 shifts if 5-6 days off
  - 17 shifts if 7 days off

**PGY-2**
- 20 shifts (18 ED or EMS, 2 PED)
  - 19 shifts if 1-2 days off
  - 18 shifts if 3-4 days off
  - 17 shifts if 5-6 days off
  - 16 shifts if 7 days off

**PGY-3**
- 19 shifts (17 ED or EMS, 2 PED)
  - 18 shifts if 1-2 days off
  - 17 shifts if 3-4 days off
  - 16 shifts if 5-6 days off
  - 15 shifts if 7 days off
VACATION RESTRICTIONS

Feb: No vacation requests will be accepted for the last Wednesday of the month from EM residents unless confirmation of taking In-Training examination elsewhere.

June (first two weeks): No vacation requests accepted from PGY-3 residents.

June (last two weeks): No vacation requests accepted from PGY-1 or PGY-2 residents.

ACEP (date varies yearly): No vacation requests accepted during the timeframe of conference, usually end of October.

Thanksgiving/Christmas/New Year: No vacation requests accepted.

The following rotations do not allow vacations:

PGY-1: Cardiology, MSICU
PGY-2: PICU, NSICU, Trauma

SICK CALL POLICY ON EMERGENCY MEDICINE ROTATIONS

The Department of Emergency Medicine has the following policy regarding absences from scheduled Emergency Department duties:

• All absences from scheduled ED shifts must be approved by the Emergency Medicine Chief Residents and ultimately the Program Director. All Emergency Medicine residents, rotating residents, and medical students must contact one of the Chief Residents (even at an unseemly hour) for approval and arrangement of alternative coverage for our Emergency Department patients. If the Chief Residents are not available, the Program Director should be contacted directly.

  • Dr. Russell Allinder (Chief Resident): 205-999-0415, Pager 15405
  • Dr. Alexandra Monroe (Chief Resident): 404-245-4216, Pager 15419
  • Dr. Jeffrey Bush (Residency Director): 843-860-6055, Pager 14306
  • Dr. Simon Watson (Associate Residency Director): 828-773-2001, Pager 14347
  • Dr. Lindsey Jennings (Assistant Residency Director): 248-535-6108, Pager 14786
  • Melanie Pigott (Residency Coordinator): 843-834-0101

• All absences by Emergency Medicine residents, rotating residents, or medical students must be made up. Make-up shifts will need to be scheduled with the Chief Residents as soon as possible. If absences occur late in the month, make-ups may have to be scheduled the following month, even if during a non-emergency medicine rotation. However, make-ups must not interfere with expected duties or responsibilities on other rotations. Successful credit for the EM rotation will not be granted until make-ups occur.

Resident Initial _______
DECEMBER VACATION POLICY
The Emergency Medicine program has a standard policy regarding resident scheduling and vacations during the month of December.

- We will divide the last 10 days of December into two, five-day blocks. All residents rotating on Emergency Medicine will be assigned to one of the blocks. They will be scheduled to work one five-day block, and will have the other block off. Thus, all residents will enjoy a five-day stretch of time off, including one of the holidays, and no official vacation time will be used.
- Of course, for this to work, the policy will have to apply to both Emergency Medicine and rotating residents, and no official vacations will be allowed during December. Obviously, this policy only applies to those residents rotating on Emergency Medicine.
- All time off is subject to the Program Director’s approval, the above notwithstanding.

XVI. CME Allowance
Residents receive an allowance of $750.00 each year (maximum of three years) for continuing medical educational items. These may include items such as books, journals, e-newsletters, and conferences including travel expenses. CME funds are not permitted to be used for any type of equipment, e.g. computers, laptops, iPads. All requests to use CME funds are ultimately approved at the program director’s discretion. If you have any questions at all, please ask PRIOR to purchasing. Unused funds can carry into the next academic year. CME funds are to be used to enhance your education while you are in the residency program. Funds cannot be used during your third year for items that correlate with your permanent job and requests intended to “clear your account” (example: purchasing $750 of books as you are graduating) will be denied. The CME fund allowance amount is subject to change.

XVII. REQUIREMENTS FOR REIMBURSEMENT
General Expense Reimbursement Guidelines
1. All reimbursement requests must be an approved Resident expense. A Reimbursement Form with Program Director’s signature must be submitted along with required supporting documentation.
2. Original receipt must be submitted with Reimbursement Approval Form, along with required supporting documentation. Supporting documentation for any reimbursement must include the following:
   - Proof of amount due: an original invoice, order form, or bill.
   - Proof of payment: MUST include partial information of payment method such as a copy of cashed check, part of a credit card number and expiration date, and must show the payment amount.
   - Copy of certificate or license, if applicable.
3. All subscriptions can only be for a 12-month period and no promotional gift card can be associated with any subscription.
4. Mobile phones, wireless hot spots, cameras, video recorders, laptop computers and tablets for home use are not reimbursable.
5. It is the Resident’s responsibility to provide all reimbursement documentation for submission to Accounts Payable.
Travel Guidelines
The following guidelines have been adopted to support EM Resident Travel Reimbursement:

1. Resident must first obtain written approval from the Residency Program Director, then the Department Director. Approval must specify the budgeted amount that is approved to be reimbursed. Any expenses incurred over this amount will be the responsibility of the resident, or may be covered by available CME funds.

2. All reimbursable travel must be domestic travel only within the United States.

3. Registration fees, airfare (for the original ticketing), lodgings, meals, parking and transportation are reimbursable when required for participation in a preapproved workshop, seminar, convention, or conference, which the Resident is authorized to attend.

4. Payment for all travel, registration, lodging, meals, transportation and parking and associated expenses will only be reimbursed for travel only after travel has been completed, provided documentation of approval by the Program Director and all supporting documentation is attached to receipts (i.e., program of event, certificate of completion of training, invitation to speak at conference, etc.) as appropriate for the event.

5. Meals will be reimbursed at the current State Approved rate. A meal allowance cannot be claimed or covered if any meals are included as part of the registration fee per MUSC Accounting Guidelines. All meal receipts must be itemized.

6. Mileage will be reimbursed at the current State Approved rate.

7. Fees for optional activities such as sight-seeing, movies, minibar purchases in rooms, golf, tennis, or field trips, and any and all expenses incurred for personal use are not reimbursable.

8. Expenses for alcoholic beverages are not reimbursable.

   It is the responsibility of the Resident to obtain appropriate approval and submit all travel reimbursement documentation.

   Resident Initial __________  Date: __________
XVIII. Educational Resources

1. **EMRAP:**
   Accessible through your EMRA account. Combined, the audio and written summaries are the most effective CME resources.

2. **EMedhome.com:**
   Username is your MUSC email address; password is “emedhome.” Great resource, especially for the lectures, which are a compilation of the last 10 years of EBM conferences, including ACEP Scientific Assembly. Access to EMCast audio resource by Amal Mattu is available through Emedhome.com.

3. **EMCrit.org:**
   A great resource for stabilization and management of critically ill patients.

4. **ERCAST.com:**
   A great resource from the perspective of a community EM doctor with lots of good clinical pearls/curbside consults.

5. **Emlitofnote.com:**
   Good EBM site with recent articles posted.

XIX. Policy for Promotion

The following are considered the resident physician advancement criteria. These are the requirements for successful promotion within the Emergency Medicine residency between PGY years as well as graduation from the residency.

**PGY-1 to PGY-2 Level**

- Attend June/July EM-1 Orientation.
- Complete BLS/ACLS provider certification.
- Complete PALS provider certification.
- Successfully complete all clinical rotations.
- Attend 100% of weekly EM conferences unless excused 24 hours in advance of conference. *In no circumstances should the total be less than 70%.* These include Simulation and Procedure Lab, and Mock Oral Examinations.
- Consistently complete all medical charts prior to the end of the shift.
- Consistently respond within 48 hours to all e-mails requiring a response unless on vacation.
- Submit rotation evaluations monthly.
- Meet GME’s duty hours’ entry requirements.
- Complete bi-annual evaluation session with Residency Directors.
- Submit current Procedure Log for bi-annual evaluation with Residency Directors.
- Submit patient follow-up log using E*Value (5 patients/ED and PED month with equal mix of admitted and discharged patients) for bi-annual evaluation with Residency Directors.
- Complete In-Training Examination in February.
- Submit annual faculty evaluations.
- Submit annual peer evaluations.
- Submit annual residency program evaluations.
- Take USMLE Step 3.
- Complete the CQI project portion for PGY1, present one core lecture, and present at Journal Club.
- Demonstrate competency in patient care for appropriate level of training.
• Demonstrate competency in medical knowledge for appropriate level of training.
• Demonstrate competency in practice-based learning and improvement for appropriate level of training.
• Demonstrate competency in professionalism for appropriate level of training.
• Demonstrate competency in interpersonal and communication skills for appropriate level of training.
• Demonstrate competency in systems-based practice for appropriate level of training.
• Log total of 150 certified ED bedside ultrasound studies and become “ultrasound certified”.

**PGY-2 to PGY-3 Level**
• Successfully complete all clinical rotations.
• Complete Pediatric Resuscitation course.
• Attend 100% of weekly EM conferences unless excused 24 hours in advance of conference. *In no circumstances should the total be less than 70%.* These include Simulation and Procedure Lab, and Mock Oral Examinations.
• Consistently complete all medical charts prior to the end of the shift.
• Consistently respond within 48 hours to all e-mails requiring a response unless on vacation.
• Submit rotation evaluations monthly.
• Meet GME’s duty hours’ entry requirements.
• Complete bi-annual evaluation Log for bi-annual evaluation with Residency Directors.
• Submit current Procedure Log for bi-annual evaluation with Residency Directors.
• Submit patient follow-up log using E*Value (5 patients/ED and PED month with equal mix of admitted and discharged patients) for bi-annual evaluation with Residency Directors.
• Complete In-Training Examination in February.
• Submit annual faculty evaluations.
• Submit annual peer evaluations.
• Submit annual residency program evaluations.
• Pass USMLE Step 3.
• Present two lectures (one of which is EBM), facilitate at one Journal Club and participate in trauma case presentation.
• Demonstrate competency in patient care for appropriate level of training.
• Demonstrate competency in medical knowledge for appropriate level of training.
• Demonstrate competency in practice-based learning and improvement for appropriate level of training.
• Demonstrate competency in professionalism for appropriate level of training.
• Demonstrate competency in interpersonal and communication skills for appropriate level of training.
• Demonstrate competency in systems-based practice for appropriate level of training.
PGY-3 to Graduation

- Complete BLS/ACLS provider re-certification or instructor certification.
- Complete PALS provider re-certification or instructor certification.
- Successfully complete all clinical rotations.
- Attend 100% of weekly EM conferences unless excused 24 hours in advance of conference. **In no circumstances should the total be less than 70%**. These include Simulation and Procedure Lab, and Mock Oral Examinations.
- Consistently complete all medical charts prior to the end of the shift.
- Consistently respond within 48 hours to all e-mails requiring a response unless on vacation.
- Submit rotation evaluations monthly.
- Meet GME’s duty hours’ entry requirements.
- Submit monthly moonlighting shift sheets.
- Complete bi-annual evaluation session with Residency Directors.
- Submit current Procedure Log for bi-annual evaluation with Residency Directors. Procedure Log numbers must meet minimum RRC Guidelines for Procedures and Resuscitations prior to graduation.
- Submit patient follow-up log using E*Value (5 patients/ED and PED month with equal mix of admitted and discharged patients) for bi-annual evaluation with Residency Directors.
- Complete In-Training Examination in February.
- Submit annual faculty evaluations.
- Submit annual peer evaluations.
- Submit annual residency program evaluations.
- Complete CQI project as outlined by CQI Director.
- Complete scholarly project as outlined by Research Director.
- Present three conference lectures (one with a Peds EM focus), make a trauma conference case presentation, and supervise at least one Journal Club.
- Demonstrate competency in patient care for appropriate level of training.
- Demonstrate competency in medical knowledge for appropriate level of training.
- Demonstrate competency in practice-based learning and improvement for appropriate level of training.
- Demonstrate competency in professionalism for appropriate level of training.
- Demonstrate competency in interpersonal and communication skills for appropriate level of training.
- Demonstrate competency in systems-based practice for appropriate level of training.
- Demonstrate the capability of the independent practice of Emergency Medicine as agreed upon by the EM Residency Administration prior to graduation.
- Complete exit interview with Dr. Bush.
XX. Academic Deficiencies and Corrective Action

STATEMENT OF POLICY

Each Residency Program Director is responsible for assessing and monitoring each resident’s academic and professional progress including knowledge, skills and professional behavior as well as adherence to departmental policies and procedures concerning resident education and the hospital’s graduate medical education policies. If a Program Director determines that a resident should undergo a mental health assessment as part of an educational consultation, the cost for this will be split evenly between the Department and the Office of GME. Failure to meet the established academic standards will result in corrective action(s) up to and including dismissal from the program.

PROCEDURES

1. Each Residency Program Director will devise written guidelines concerning resident accountability, monitoring and disciplinary actions, all of which are subject to the initial approval and annual review of the GMEC.

2. Policies regarding academic deficiencies will be generally uniform throughout all residency programs and will include the following categories of corrective actions:

   2.1 Oral Reprimands (OR) or Written Warnings may occur for deficiencies for which some corrective action is necessary. The resident will have the opportunity to correct the deficiency. If the deficiency is corrected, no further action will be taken. If the deficiency is not corrected, the resident may be placed on "formal academic remediation", suspended or dismissed from the program.

   2.2 Formal Academic Remediation (FAR) will be imposed for more serious and/or prolonged deficiencies. The resident will have the opportunity to remediate the deficiency within a defined period of time, as set forth in the "learning contract" established by the Program Director. The resident will receive a written document describing remediation measures to be corrected, the specific time period in which improvement must be demonstrated, and the possible consequences if no improvement is made. The resident will be required to sign this document.

   2.3 Suspension (S) may be imposed. During suspension, the resident will be removed from his/her clinical rotations and will not receive credit for training during this time period. Suspension will be for a specified period of time and specific corrective measures will be required. Following successful completion of the terms of the suspension, the resident will be placed on "formal academic remediation" upon reinstatement into the residency program as outlined in 2.2.

   2.4 Dismissal (D) of a resident may occur for academic reasons, disciplinary reasons, or if s/he is deemed to be an immediate threat to patient safety. (See Resident Dismissal Policy)

3. Prior to the imposition of any action that may result in formal academic remediation, suspension or
dismissal, the Residency Program Director must submit the recommendation to the Designation Institutional Official.

4. A resident who does not report to work for three (3) consecutively scheduled work days without speaking directly to his/her Program Director will be dismissed from the residency program and his/her Resident Agreement will be terminated. The resident will have five (5) business days from the date of dismissal to contact the Designated Institutional Official for GME and explain the reason(s) for the failure to contact the Program Director. If the Designated Institutional Official for GME accepts the explanation, the resident will be reinstated. If the Designated Institutional Official for GME does not accept the explanation, the dismissal will be upheld.

RESIDENT DISMISSAL -- STATEMENT OF POLICY
A resident may be dismissed from his/her residency program. The resident has the right to appeal the decision through the Resident Grievance Procedure.

PROCEDURES

1. Each Department will have regular evaluations of residents and will define specific criteria to recommend dismissal based upon these evaluations and/or other material(s) which document the reason for dismissal.

2. The Program Director will recommend dismissal by notifying the Designated Institutional Official for GME. The Designated Institutional Official for GME will conduct a thorough review of the resident's situation and share the results with the Program Director. In the event the Designated Institutional Official concurs with the department's recommendation, the DIO will notify the resident via certified mail and outline a specific time-frame for dismissal. The resident will be informed of the right to appeal the decision.

3. Reasons for dismissal include, but are not limited to, the following:

3.1 Incapacitating illness, which, in the judgment of the Program Director and faculty, precludes the resident from participation in the graduate medical education program and patient care activities.

3.2 Failure of the resident to abide by MUSC policies, GMEC policies, resident- related provisions of the hospital's Medical and Dental Staff Bylaws/Rules and Regulations, and/or any applicable federal and state laws.

3.3 Failure of the resident to maintain satisfactory levels of academic and clinical performance as determined through periodic evaluations and a formal academic remediation plan.

3.4 Actions which directly violate any of the terms of the Resident Agreement.

4. In the event of dismissal, the resident has the right to appeal the decision through the appropriate Resident Grievance Procedure, academic or disciplinary.

4.1 In the event the resident's dismissal is upheld after a formal grievance hearing, the Designated Institutional Official for GME will notify the South Carolina Board of Medical Examiners, the ECFMG when necessary, and when appropriate, the ACGME.
### XXI. CLINICAL ROTATION SUMMARIES

<table>
<thead>
<tr>
<th>Rotation</th>
<th>Emergency Medicine</th>
</tr>
</thead>
<tbody>
<tr>
<td>Institution</td>
<td>MUSC Hospital</td>
</tr>
<tr>
<td>Year of training</td>
<td>PGY-1</td>
</tr>
<tr>
<td>Duration in Months:</td>
<td>6</td>
</tr>
</tbody>
</table>

**Educational objectives:**

Although time will be spent in the ED during each year of the residency, the focus of the first year is on quality in relation to patient care. The resident will develop the fundamental skills of the practice of emergency medicine by completion of the rotation should be able to:

**PATIENT CARE**

- Perform a complaint directed history and physical on patients presenting to the ED and discuss the importance of obtaining information from the family and pre-hospital care providers on arrival of the patient.
- Rapidly identify patients with acute injuries or illnesses which pose a risk to life or limb.
- Appropriately order and interpret ancillary studies based on clinical presentation.
- Formulate a comprehensive differential diagnosis.
- Achieve technical proficiency in procedural skills consistent with level of training.

**MEDICAL KNOWLEDGE**

- Demonstrate basic fund of medical knowledge including the etiology, presentation, pathophysiology and treatment for diseases and injuries encountered.
- Formulate scientific basis for patient care decisions.

**PRACTICE-BASED LEARNING AND IMPROVEMENT**

- Become familiar with the educational resources available in the Emergency Department, including the textbooks, computer based program and internet resources.
- Demonstrate ability to form a clinical question and identify available resources to resolve them.

**INTERPERSONAL AND COMMUNICATIONSKILLS**

- Present a case succinctly and accurately to colleagues.
- Effectively and confidently relay all pertinent information to patient and family.
- Demonstrate appropriate conflict resolution skills.

**PROFESSIONALISM**

- Demonstrate the ability to act as a patient advocate at all times.
- Demonstrate respect, compassion, and integrity with patients, family, and all staff.
- Demonstrate respect of patient’s privacy and confidentiality.

**Description of clinical experiences:**

The resident is responsible for the initial evaluation of their patients, the formulation of a differential diagnosis, and the planning of an appropriate diagnostic and therapeutic regimen under the direct supervision of the faculty. The resident performs or assists in any procedures required by their patients as appropriate for level of training and experience. If a consultation is required, the resident discusses the case with the appropriate consultant and a plan is decided upon. If the patient can be discharged, the resident is responsible for ensuring a comprehensive discharge plan which the patient understands.

The resident begins to become more efficient seeing an increased number of patients per hour. They also act as a role model for more junior members of the team.
Description of didactic experiences:

The resident is excused from duties one half day per week to attend all regularly scheduled Emergency Medicine conferences while on the EM rotation. Attendance is mandatory. The conference series is structured to encompass the entire core curriculum and provide the resident with a broad fund of knowledge.

Evaluation process:

1. Daily feedback by supervising emergency medicine faculty.
2. Direct observation of patient care by faculty.
3. Formal written evaluation at end of rotation by emergency medicine faculty.
4. Quarterly written Emergency Medicine Residency Exams will be administered and results tracked.
5. Annual participation in the ABEM in-service examination
6. The resident will keep a procedure log that is reviewed by the Program Directors semiannually.
7. Simulated oral board examinations quarterly.
8. Any problems which occur during the rotation or any circumstance which interfere with the resident’s successful completion of a rotation are immediately communicated by the supervising physician to the program director. This is brought to the attention of the resident and an appropriate course of action is discussed.

The resident will complete a rotation evaluation form at the end of each rotation which is forwarded to the Program Director for review and action.
Rotation | Obstetrics / Gynecology
--- | ---
Institution | MUSC Hospital
Year of training | PGY-1 X PGY-2 PGY-3
Duration in Months: | 1

Educational objectives:

During this rotation the resident is expected to gain exposure to both normal, abnormal, and high-risk pregnancies and deliveries and by completion of the rotation should be able to:

**PATIENT CARE**
- Demonstrate competency in the evaluation and management of a pregnant woman with various medical complaints.
- Demonstrate competency in the evaluation and management of labor in a pregnant woman.
- Demonstrate competency in the skills and the techniques necessary to manage a NSVD.
- Describe techniques used to assist in any complicated vaginal deliveries and complications.
- Demonstrate competency in the evaluation and management of women in the immediate post-partum period.
- Identify patients with acute OB/GYN emergencies that pose a risk to the patient and/or fetus, and perform a rapid assessment and institute appropriate initial therapeutic interventions.

**MEDICAL KNOWLEDGE**
- Understand normal labor and delivery, common perinatal complications, and their management.
- Display a thorough understanding of the etiology and evaluation of bleeding during pregnancy.
- Understand the laws that pertain to emancipated minors, sexually transmitted diseases and obstetrical issues.

**PRACTICE-BASED LEARNING AND IMPROVEMENT**
- Utilize educational resources available in the hospital pertaining to L&D patients.
- Demonstrate the ability to form and answer a clinical question using the available resources.

**INTERPERSONAL AND COMMUNICATION SKILLS**
- Be able to present a case succinctly and accurately to other physicians.
- Effectively and professionally interact with other members of the OB/GYN team.
- Learn to develop a professional relationship with patients and their families in order to maximize information exchange and trust in the plan of care.
- Develop a working relationship with residents and faculty of the OB/GYN service and learn the style of communication among Obstetricians and Gynecologists.

**PROFESSIONALISM**
- Demonstrate the ability to clearly and timely document the patient record.
- Demonstrate the ability to act as advocate for the patient at all times.

**SYSTEMS-BASED PRACTICE**
- Function as an integral part of OB/GYN team.
- Discuss the indications for admission and discharge of OB patients including medical and social considerations.
- Understand the role of the obstetrician/gynecologist in the care of the emergency department patient.

Description of clinical experiences:

The resident will function as junior house officers on the labor and delivery team and have the same duties and responsibilities as other residents on the service. Residents perform a complete obstetrical history and physical and manage patients in active labor. It is expected that each resident perform and/or assists in a minimum of 10 uncomplicated vaginal deliveries under supervision of senior residents and faculty and assist in several complicated deliveries and caesarian sections. In addition, the resident will attend out-patient clinic as required for OB/GYN residents at the equivalent level of training.

Description of didactic experiences:
The resident is excused from duties one half day per week to attend all regularly scheduled Emergency Medicine conferences while on the OB rotation. Attendance is mandatory. In addition, the following didactic sessions are provided for the residents while they are on this rotation:

- OB/GYN review conference.
- Maternal fetal medicine conference.
- OB/GYN grand rounds.

**Evaluation process:**

1. Written evaluations will be completed by the supervising OB faculty. These evaluations are available for resident review after completion of the rotation.
2. Any problems which occur during the rotation or any circumstance which interfere with the resident’s successful completion of a rotation are immediately communicated by the supervising faculty to the program director. This is brought to the attention of the resident and an appropriate course of action is discussed.

The resident will complete a rotation evaluation form at the end of each rotation which is forwarded to the Program Director for review and action.
During this rotation the resident is expected to gain exposure to both normal and abnormal studies in radiology and by completion of the rotation should be able to:

**PATIENT CARE**
- Master a systematic approach to the chest x-ray taken for the evaluation of traumatic and non-traumatic conditions.
- Master a systematic approach to abdominal radiographs.
- Master a systematic approach to pelvis and extremity radiographs.
- Master a systematic approach to the interpretation of radiographs of the spine, including the cervical, thoracic, and lumbar spine.
- Be familiar with indications for CT, MRI, and ultrasound studies.

**MEDICAL KNOWLEDGE**
- Understand indications for ordering various radiologic studies.
- Understand any potential risks to the patient, clinician, and/or fetus if applicable with ordering such studies.

**PRACTICE-BASED LEARNING AND IMPROVEMENT**
- Utilize educational resources available in the hospital pertaining to radiographic studies.
- Demonstrate the ability to handle any radiographic read discrepancies following termination of patient care in the ED.

**INTERPERSONAL AND COMMUNICATION SKILLS**
- Be able to accurately describe any potential pathology of interest to the Radiologist interpreting the study.
- Effectively and professionally interact with all members of the Radiology team.

**PROFESSIONALISM**
- Demonstrate the ability to act as an advocate for the patient at all times.

**SYSTEMS-BASED PRACTICE**
- Function as an integral part of the radiology team.
- Understand the role of the radiologist in the care of the emergency department patient.
### Description of clinical experiences:

- One calendar month rotation
- Initial meeting with Claudia Richey, Radiology Coordinator, (2-2473) to receive assignment (resident specific) for each week
- 1 week each of Chest, MSK, CT (Neuro and Body), Night Float
- 8:00 am – 4:00 pm Mon-Fri starting every day with Peds ED board
- **Night Float Week**
  - 3:00 pm-11:00 pm Sat-Tues
  - 1:00 pm-9:00 pm Wed (to meet Duty Hours for Thurs EM conferences)
  - Off after EM conference until Tues at 8:00 am the following week
- **Requirements:**
  - Documented attendance
  - End of Rotation Power Point Presentation (30 minutes at EM conference)
    - Rapid review of interesting studies
    - Utilization of ACR Appropriateness Criteria to instruct residents on most appropriate/effective imaging modality for a common emergency room clinical scenario
- Consideration of interdisciplinary CQI project if resident identifies an opportunity. This would be acceptable to fulfill the EM residency CQI project requirement.

### Description of didactic experiences:

The resident is excused from duties one half day per week to attend all regularly scheduled Emergency Medicine conferences while on the Radiology rotation. Attendance is mandatory. In addition residents attend weekday daily afternoon Radiology conferences.

### Evaluation process:

1. Written evaluations will be completed by the supervising Radiology faculty. These evaluations are available for resident review after completion of the rotation.
2. Any problems which occur during the rotation or any circumstance which interfere with the resident’s successful completion of a rotation are immediately communicated by the supervising faculty to the program director. This is brought to the attention of the resident and an appropriate course of action is discussed.

The resident will complete a rotation evaluation form at the end of each rotation which is forwarded to the Program Director for review and action.
Rotation | Pediatric Emergency Medicine
---|---
Institution | MUSC Hospital
Duration in Months: | 1
Year of training | PGY-1 | X | PGY-2 | PGY-3

Educational objectives:

Although time will be spent in the Pediatric ED during each year of the residency, the focus of the first year is on quality in relation to pediatric patient care. The resident will develop the fundamental skills of the practice of pediatric emergency medicine and by completion of the rotation should be able to:

**PATIENT CARE**
- Perform a complaint directed history and physical on pediatric patients presenting to the ED and discuss the importance of obtaining information from the family and pre-hospital care providers on arrival of the patient.
- Discuss the importance of gathering a clinical database including all past medical information.
- Rapidly identify pediatric patients with acute injuries or illnesses which pose a risk to life or limb.
- Appropriately order and interpret ancillary studies based on clinical presentation.
- Formulate a comprehensive differential diagnosis.
- Achieve technical proficiency in procedural skills consistent with level of training.

**MEDICAL KNOWLEDGE**
- Demonstrate basic fund of medical knowledge including the etiology, presentation, pathophysiology and treatment for diseases and injuries encountered.

**PRACTICE-BASED LEARNING AND IMPROVEMENT**
- Become familiar with the educational resources available in the Pediatric Emergency Department, including the textbooks, computer based program and internet resources.
- Demonstrate the ability to form a clinical question and identify available resources to resolve them.

**INTERPERSONAL AND COMMUNICATION SKILLS**
- Present a case succinctly and accurately to colleagues.
- Effectively and professionally interact with all members of the pediatric emergency medical team.
- Develop a professional relationship with pediatric patients and their families in order to maximize information exchange and trust in the plan of care.
- Demonstrate the ability to clearly and timely document the patient record.

**PROFESSIONALISM**
- Demonstrate the ability to act as a patient advocate in the current medical environment.
- Demonstrate respect, compassion, and integrity with patients, family, and all staff.
- Demonstrate respect of patient’s privacy and confidentiality.

**SYSTEMS-BASED PRACTICE**
- Understand basic resources available for care of the emergency department patient.
- Discuss the indications for admission or discharge of each patient including medical and social considerations for optimal care.

Description of clinical experiences:

The resident is responsible for the initial evaluation of their patients, the formulation of a differential diagnosis, and the planning of an appropriate diagnostic and therapeutic regimen under the direct supervision of the pediatric emergency medicine faculty. The resident performs or assists in any procedures required by their patients as appropriate for level of training and experience. If a consultation is required, the resident discusses the case with the appropriate consultant and a plan is decided upon. If the patient can be discharged, the resident is responsible for ensuring a comprehensive discharge plan which the patient understands.
**Description of didactic experiences:**

The resident is excused from duties one half day per week to attend all regularly scheduled Emergency Medicine conferences while on the EM rotation. Attendance is mandatory. The conference series is structured to encompass the entire core curriculum and provide the resident with a broad fund of knowledge.

**Evaluation process:**

1. Daily feedback by supervising pediatric emergency medicine faculty.
2. Direct observation of patient care by faculty.
3. Formal written evaluation at end of rotation by emergency medicine faculty.
4. Quarterly written Emergency Medicine Residency Exams will be administered and results tracked.
5. Annual participation in the ABEM in-service examination
6. The resident will keep a procedure log that is reviewed by the Program Directors semiannually.
7. Simulated oral board examinations quarterly.
8. Any problems which occur during the rotation or any circumstance which interfere with the resident’s successful completion of a rotation are immediately communicated by the supervising physician to the program director. This is brought to the attention of the resident and an appropriate course of action is discussed.

The resident will complete a rotation evaluation form at the end of each rotation which is forwarded to the Program Director for review and action.
### Rotation

<table>
<thead>
<tr>
<th>Ultrasound</th>
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</thead>
<tbody>
<tr>
<td>Institution: MUSC Hospital</td>
</tr>
<tr>
<td>Duration: 1 Month</td>
</tr>
<tr>
<td>Year of training: PGY-1</td>
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</tbody>
</table>

#### Educational objectives:

During this four-week rotation, the resident will focus on Emergency Ultrasound (EUS) skills in the Emergency Department (ED). The resident will complete a minimum of 120 ultrasound studies, which include a minimum of: 20 trauma scans, 20 aorta studies, 20 biliary studies, 20 cardiac studies, 10 renal, 10 IUP studies, and at least 20 other diagnostic and procedural studies. Common applications of EUS to be discussed and performed during the rotation include: Trauma, Aorta, Cardiac, Biliary, Renal, DVT, Soft Tissue/Musculoskeletal, Thoracic, Ocular, Obstetric, and Procedural. By completion of the rotation the resident should be able to:

**PATIENT CARE**
- Become familiar with clinical indications for which bedside ultrasound
- Develop skills in utilization of EUS for diagnosis in appropriate ED patients
- Develop skills for ultrasound guidance of ED procedures
- Develop skills for any non-EUS related procedures (e.g. intubations, joint reductions) that arise during scanning shifts in the ED, as per the request of the ED staff working clinically

**MEDICAL KNOWLEDGE**
- Become familiar with all features of the core applications of Emergency Medicine (EM) Ultrasound, including study indications and scope of practice, appropriate probe choice, image and video acquisition, study interpretation, imaging guidelines, technical limitations, and documentation

**PRACTICE-BASED LEARNING AND IMPROVEMENT**
- Become familiar with the educational resources available regarding EM US, including textbooks, computer-based programs, and internet resources
- Demonstrate the ability to perform and properly interpret diagnostic and procedural EUS with one-on-one guidance and instruction
- Participate in a weekly EUS review
- Over the course of the month, the resident will present a total of two (2) brief ultrasound cases during residency conference

**INTERPERSONAL AND COMMUNICATION SKILLS**
- Be able to present pertinent clinical information to the supervising physician succinctly and accurately
- Effectively and professionally interact with other members of the ED team
- Maintain a professional relationship with patients and their families

**PROFESSIONALISM**
- Demonstrate respect, compassion, and integrity to all patients, family members, and team members

**SYSTEMS-BASED PRACTICE**
- Function as an adjunct part of the ED team
- Understand the role of EUS in the ED
- Recognize clinical situations in which a more formal US examination may be needed by Radiology, OB/Gyn, and Cardiology
Description of clinical experiences:

Emphasis during the four-week rotation will be on performing all of the core EUS studies and reporting any pertinent findings to the appropriate clinical team caring for the patient. The resident will not have any on-call responsibilities but is expected to keep an up-to-date procedure log and duty hour record. The resident is supervised by the Ultrasound Director and Assistant Director, although individual scans performed in the ED can be supervised by any faculty member privileged to perform EUS.

Description of didactic experiences:

The resident is excused from duties one half day per week to attend all regularly scheduled Emergency Medicine conferences while on the US rotation. Attendance is mandatory. The resident is expected to participate in one-on-one bedside supervision as deemed appropriate by the Ultrasound Director. The resident will participate in a weekly EUS review with the Ultrasound Director and Assistant Director, in which relevant ultrasound studies will be discussed and critiqued. The resident will take a pre-test and post-test administered by the EUS Director.

Evaluation process:

1. Written evaluations will be completed by the Ultrasound Director and Assistant Director following the completion of the rotation. These evaluations are available for resident review.
2. Any problems that occur during the rotation or any circumstances that interfere with the resident’s successful completion of a rotation are immediately communicated by the supervising faculty to the Program Director. This is brought to the attention of the resident and an appropriate course of action is discussed.

The resident will complete a rotation evaluation form at the end of each rotation that is forwarded to the Program Director for review and action.
<table>
<thead>
<tr>
<th>Rotation</th>
<th>Coronary Care Unit</th>
<th>Institution</th>
<th>MUSC Hospital</th>
<th>Duration in Months: 1</th>
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</thead>
<tbody>
<tr>
<td>Year of training</td>
<td>PGY-1  X  PGY-2  PGY-3</td>
<td></td>
<td></td>
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</tbody>
</table>

**Educational objectives:**

During this rotation the resident will function as a member of the CCU team caring for patients in the CCU. and by completion of the rotation should be able to:

**PATIENT CARE**
- Develop skills in the initial evaluation, diagnosis, stabilization, and treatment of critically ill cardiac patients.
- Develop a problem oriented approach to patients with complex cardiac problems
- Manage the medical care of several patients in the CCU simultaneously.
- Learn the appropriate use of laboratory tests, imaging procedures and nuclear medicine tests in the diagnostic evaluation of cardiac patients.
- Be familiar with the placement of arterial, central venous, Swan-Ganz and pacing catheters, their indications, contraindications, maintenance and the interpretation of results of these procedures.
- Refine skills of dysrhythmia management and cardioversion.

**MEDICAL KNOWLEDGE**
- Develop an understanding of the natural history of cardiac illnesses.
- Develop a more thorough understanding of acute myocardial infarction, dysrhythmia management, and resuscitation of critically ill cardiac patients.
- Improve their knowledge of assessment and management of hemodynamically unstable patients, including indications and use of hemodynamic monitoring.

**PRACTICE-BASED LEARNING AND IMPROVEMENT**
- Become familiar with the educational resources available in the CCU, including textbooks, computer based program and internet resources.
- Demonstrate the ability to form a clinical question and use the available resources to resolve the patient care issues.

**INTERPERSONAL AND COMMUNICATION SKILLS**
- Be able to present pertinent clinical information to the supervising cardiologist succinctly and accurately.
- Effectively and professionally interact with other members of the CCU team.
- Develop a professional relationship with patients and their families.

**PROFESSIONALISM**
- Demonstrate the ability to clearly and accurately document in the patient record.
- Demonstrate respect, compassion, and integrity to all patients, family members, and team members.

**SYSTEMS-BASED PRACTICE**
- Function as an integral part of the CCU and medical resuscitation team.
- Be familiar with indications for admission to a Cardiac Care Unit.
- Be familiar with the goals of inpatient CCU treatment and appropriate criteria for discharge of CCU patients to a lower level of care.
- Understand the role of the CCU consultant within the ED setting.
Description of clinical experiences:
The intern will have all of the same responsibilities as an intern from the Department of Internal Medicine on the CCU team. Daily responsibilities include pre-rounds on each of the house officer’s patients and formal work rounds with the entire team. Emphasis should be on the initial work-up of patients admitted to the service with development of a differential diagnosis and therapeutic plan and then following the patient through the entire course of their hospitalization. The intern will have on-call responsibilities and is expected to keep and up to date procedure log and duty hour record. The residents are supervised by cardiology fellows, attending cardiologists, and the director of the CCU.

Description of didactic experiences:
The resident is excused from duties one half day per week to attend all regularly scheduled Emergency Medicine conferences while on the CCU rotation. Attendance is mandatory. In addition, residents participate in daily patient teaching rounds with the team as well as daily morning report with the Department of Internal Medicine focusing on a specific patient presentation and details of appropriate management.

Evaluation process:
1. Written evaluations will be completed by the supervising cardiologist following the completion of the rotation. These evaluations are available for resident review.
2. Any problems which occur during the rotation or any circumstance which interfere with the resident’s successful completion of a rotation are immediately communicated by the supervising faculty to the program director. This is brought to the attention of the resident and an appropriate course of action is discussed.

The resident will complete a rotation evaluation form at the end of each rotation which is forwarded to the Program Director for review and action.
Rotation Medical Intensive Care Unit (MICU)

<table>
<thead>
<tr>
<th>Institution</th>
<th>Year of training</th>
</tr>
</thead>
<tbody>
<tr>
<td>MUSC Hospital</td>
<td>EM1</td>
</tr>
</tbody>
</table>

Duration in Months: 1

Educational objectives:
During this rotation the resident will function as a member of the MICU team caring for patients in the MICU and by completion of the rotation should be able to:

**PATIENT CARE**
- Be able to perform the initial evaluation, stabilization and definitive management of critically ill patients.
- Discuss the importance of gathering a clinical database on all patients being evaluated including the following:
  - Information: allergies, PMH, current medications, past hospitalizations ongoing medical problems and assessment of potential pregnancy.
- Identify patients with acute injuries or illnesses, which pose a risk to life of limb and perform a rapid assessment and institute appropriate initial therapeutic interventions.
- Perform the initial evaluation and resuscitation of the critically ill patient in an orderly and comprehensive fashion as part of the critical care team.
- Manage the medical care of several serious ill patients admitted to the MICU.
- Learn to interpret X-rays, EKGS, lab results and their relationship to the patients’ clinical presentation as well as the limitations of basic labs and radiographic studies.
- Be able to arrive at a final diagnosis for the patient, based on the integration of history, physical exam, lab and X-ray results.
- Refine skills of airway management and the use of mechanical ventilators
- Become familiar with the placement of arterial, central venous and pacing catheters, their indications, contraindications, maintenance, and interpretation of the results of these procedures.

**MEDICAL KNOWLEDGE**
- Be able to describe the etiology, presentation, pathophysiology and treatment for the diseases that have been encountered during this rotation and be able to discuss each of these as appropriate for the resident’s level of training.
- Develop and understand of the natural history of critical illnesses and multisystem failure.

**PRACTICE-BASED LEARNING AND IMPROVEMENT**
- Become familiar with the educational resources available in the MICU, including textbooks, computer based program and internet resources.
- Demonstrate the ability to form a clinical question and use the available resources to resolve the patient care issues.

**INTERPERSONAL AND COMMUNICATION SKILLS**
- Be able to present pertinent clinical information to the supervising surgical faculty succinctly and accurately.
- Effectively and professionally interact with other members of the MICU team.
- Develop a professional relationship with patients and their families.

**PROFESSIONALISM**
- Demonstrate the ability to clearly and accurately document in the patient record.
- Demonstrate respect, compassion, and integrity to all patients, family members, and team members.

**SYSTEMS-BASED PRACTICE**
- Function as an integral part of the MICU and medical resuscitation team.
- Understand the role of the MICU consult in the emergency department.
- Be familiar with indications for admission to the MICU.
- Understand the basic resources available for the care of the MICU patient.
- Be familiar with the goals of MICU treatment and appropriate criteria for discharge to a lower level of care.

**Description of clinical experiences:**
The resident will have all of the same responsibilities and function as a PGY-2 resident from the Department of Medicine on the MICU team. Daily responsibilities include pre-rounds on each of the house officer’s patients and formal work rounds with the entire team. Emphasis should be on the initial work-up of patients admitted to the service with development of a differential diagnosis and therapeutic plan and then following the patient through the entire course of their hospitalization. The resident will have on-call responsibilities and is expected to keep and up to date procedure log and duty hour record. The residents are supervised by critical care fellows and attendings.
Description of didactic experiences:

The resident is excused from duties one half day per week to attend all regularly scheduled Emergency Medicine conferences while on the MICU rotation. Attendance is mandatory. However, if patient care and safety were in jeopardy then the resident is expected to stay in the unit to continue patient care.

- Daily rounds that reviews the care of patients currently on the resident’s service.
- Medical grand rounds- This is a one-hour weekly conference that provides a comprehensive and current review of a selected topic often by a guest speaker.
- Simulation lab- residents will go to the simulation lab to run codes with a fellow and attending to refresh and enhance knowledge and abilities in running a code.

Evaluation process:

1. Written evaluations will be completed by the supervising faculty member following the completion of the rotation. These evaluations are available for resident review.

2. Any problems which occur during the rotation or any circumstance which interfere with the resident’s successful completion of a rotation are immediately communicated by the supervising faculty to the program director. This is brought to the attention of the resident and an appropriate course of action is discussed.

The resident will complete a rotation evaluation form at the end of each rotation which is forwarded to the Program Director for his review and action.
<table>
<thead>
<tr>
<th>Rotation</th>
<th>Emergency Medicine 2</th>
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</thead>
<tbody>
<tr>
<td>Institution</td>
<td>MUSC Hospital</td>
</tr>
<tr>
<td>Year of training</td>
<td>PGY-1</td>
</tr>
<tr>
<td>Duration in Months:</td>
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</tbody>
</table>

Educational objectives:

Although time will be spent in the ED during each year of the residency, the focus of the second year is on quality and quantity in relation to patient care. The resident will further develop the fundamental skills of the practice of emergency medicine while also developing skills in efficiency. By completion of the rotation should be able to continue to meet all objectives for the EM1 rotation while also being able to:

**PATIENT CARE**
- Perform an efficient complaint directed history and physical on patients presenting to the ED.
- Have prompt recognition and appropriate emergency stabilization of the unstable patient.
- Formulate a comprehensive differential diagnosis.
- Achieve technical proficiency in procedural skills consistent with level of training.
- Manage multiple patients simultaneously.

**MEDICAL KNOWLEDGE**
- Demonstrate a more advanced fund of medical knowledge within emergency medicine.
- Formulate scientific basis for patient care decisions.

**PRACTICE-BASED LEARNING AND IMPROVEMENT**
- Demonstrate ability to provide evidence-based medicine to patient care decisions.

**INTERPERSONAL AND COMMUNICATION SKILLS**
- Present a case succinctly and accurately to colleagues.
- Effectively and confidently relay all pertinent information to patient and family.
- Demonstrate appropriate conflict resolution skills.

**PROFESSIONALISM**
- Demonstrate the ability to act as a patient advocate at all times.
- Demonstrate respect, compassion, and integrity with patients, family, and all staff.
- Demonstrate respect of patient’s privacy and confidentiality.

**SYSTEMS-BASED PRACTICE**
- Utilize the consultation process appropriately.
- Provides appropriate medical command to pre-hospital providers.

Description of clinical experiences:

The resident is responsible for the initial evaluation of their patients, the formulation of a differential diagnosis, and the planning of an appropriate diagnostic and therapeutic regimen under the direct supervision of the faculty. The resident performs or assists in any procedures required by their patients as appropriate for level of training and experience. If a consultation is required, the resident discusses the case with the appropriate consultant and a plan is decided upon. If the patient can be discharged, the resident is responsible for ensuring a comprehensive discharge plan which the patient understands. The resident begins to become more efficient seeing an increased number of patients per hour. They also act as a role model for more junior members of the team.
### Description of didactic experiences:

The resident is excused from duties one half day per week to attend all regularly scheduled Emergency Medicine conferences while on the EM rotation. Attendance is mandatory. The conference series is structured to encompass the entire core curriculum and provide the resident with a broad fund of knowledge.

### Evaluation process:

1. Daily feedback by supervising emergency medicine faculty.
2. Direct observation of patient care by faculty.
3. Formal written evaluation at end of rotation by emergency medicine faculty.
4. Quarterly written Emergency Medicine Residency Exams will be administered and results tracked.
5. Annual participation in the ABEM in-service examination
6. The resident will keep a procedure log that is reviewed by the Program Directors semiannually.
7. Simulated oral board examinations monthly.
8. Any problems which occur during the rotation or any circumstance which interfere with the resident’s successful completion of a rotation are immediately communicated by the supervising physician to the program director. This is brought to the attention of the resident and an appropriate course of action is discussed.

The resident will complete a rotation evaluation form at the end of each rotation which is forwarded to the Program Director for review and action.
<table>
<thead>
<tr>
<th>Rotation</th>
<th>Trauma</th>
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<tbody>
<tr>
<td>Institution</td>
<td>MUSC Hospital</td>
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<tr>
<td>Year of training</td>
<td>PGY-1</td>
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<tr>
<td>Duration in Months:</td>
<td>1</td>
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Educational objectives:

During this rotation the resident is expected to be an integral part of the trauma night float team as described in the complete rotation curriculum and by completion of the rotation should be able to:

**PATIENT CARE**
- Develop the ability to evaluate, diagnose, and treat both adult and pediatric trauma patients.
- Understand the management and resuscitation of the multiple injured trauma patient.
- Understand the pathophysiology and management of thoracic and abdominal injuries.
- Understanding the pathophysiology and management of closed head injuries and spinal cord injuries.
- Understand the pathophysiology and management of musculoskeletal trauma.
- Gain an understanding of maxillofacial, neck, extremity, and genitourinary trauma.

**MEDICAL KNOWLEDGE**
- Demonstrate knowledge of wound ballistics and forensics related to trauma care.
- Have an understanding of injury control and prevention.
- Have an understanding of practical application and diagnostic modalities used in trauma patients.

**PRACTICE-BASED LEARNING AND IMPROVEMENT**
- Become familiar with the educational resources available in the hospital for care of the trauma patient including the textbooks, computer based programs, and internet resources
- Demonstrate the ability to form a clinical question and use the available resources to resolve the patient care issues.

**INTERPERSONAL AND COMMUNICATION SKILLS**
- Be able to present pertinent clinical information to the supervising trauma physician succinctly and accurately.
- Effectively and professionally interact with other members of the trauma team.
- Develop a professional relationship with patients and their families.

**PROFESSIONALISM**
- Demonstrate the ability to clearly and accurately document in the patient record.
- Demonstrate respect, compassion, and integrity to all patients, family members, and team members.

**SYSTEMS-BASED PRACTICE**
- Function as an integral part of the trauma team.
- Understand the role of the trauma consult and trauma team in the emergency department.
- Understand the basic resources available for the care of the pediatric and adult trauma patient.

**Description of clinical experiences:**

The resident will have all of the same responsibilities as an equal level of training resident from the Department of Surgery on night float. Emphasis should be on the initial work-up of patients admitted to the service with development of a differential diagnosis and therapeutic plan and then following the patient through the entire course of their hospitalization. The resident will have night float responsibilities and is expected to keep and up to date procedure log and duty hours record.
### Description of didactic experiences:

The resident is excused from duties one half day per week to attend all regularly scheduled Emergency Medicine conferences while on the Trauma rotation. Attendance is mandatory. In addition, residents participate in daily patient teaching rounds with the team as well as daily morning report focusing on a specific patient presentation and details of appropriate management. They are also required to attend monthly Trauma Grand Rounds and Morbidity and Mortality conference.

### Evaluation process:

1. Written evaluations will be completed by the supervising trauma surgeon following the completion of the rotation. These evaluations are available for resident review.

2. Any problems which occur during the rotation or any circumstance which interfere with the resident’s successful completion of a rotation are immediately communicated by the supervising faculty to the program director. This is brought to the attention of the resident and an appropriate course of action is discussed.

The resident will complete a rotation evaluation form at the end of each rotation which is forwarded to the Program Director for review and action.
During this rotation the resident is expected to gain exposure to the initial evaluation and subsequent inpatient management of patients with acute neurological conditions as described in the complete rotation curriculum and by completion of the rotation should be able to:

**PATIENT CARE**
- Discuss the importance of gathering a clinical database on all patients being evaluated for acuteneurological complaints.
- Skillfully perform a screening and detailed neurological evaluation for neurological presentations.

**MEDICAL KNOWLEDGE**
- Describe the anatomy, pathophysiology, presentation, and management of common nervous system disorders.
- Develop skill in the use and performance of diagnostic procedures in the evaluation of acute neurological disorders.
- Discuss the indications and contraindications for the administration of various interventions for acute cerebral vascular events.

**PRACTICE-BASED LEARNING AND IMPROVEMENT**
- Become familiar with the educational resources available in the hospital for neurological disorders including the textbooks, computer based programs, and internet resources
- Demonstrate the ability to form a clinical question and use the available resources to resolve the patient care issues.

**INTERPERSONAL AND COMMUNICATION SKILLS**
- Be able to present pertinent clinical information to the supervising neurologist succinctly and accurately.
- Effectively and professionally interact with other members of the neurology team.
- Develop a professional relationship with patients and their families.

**PROFESSIONALISM**
- Demonstrate the ability to clearly and accurately document in the patient record.
- Develop an understanding of the ethical principles pertaining to provision or withholding of clinical care, confidentiality of patient information, informed consent, and business practices.
- Provide patient care that incorporates sensitivity to the patient's age, ethnic, and social background and how these factors influence the plan of care.

**SYSTEMS-BASED PRACTICE**
- Function as an integral part of the neurology team.
- Understand the role of the consult neurologist in the emergency department.

**Description of clinical experiences:**

The resident will work closely with the attending neurologist supervising each patient case. The resident is expected to participate in all emergent neurological consults included but not limited to any BAT (Brain Attack Team) page both in the ED and on the inpatient floors. The resident will also be responsible for daily rounding and progressive management of these patients throughout their hospital course.
### Description of didactic experiences:

The resident is excused from duties one half day per week to attend all regularly scheduled Emergency Medicine conferences while on the Neurology rotation. Attendance is mandatory. In addition residents participate in daily patient teaching rounds with the team.

### Evaluation process:

1. Written evaluations will be completed by the supervising Neurology faculty following the completion of the rotation. These evaluations are available for resident review.

2. Any problems which occur during the rotation or any circumstance which interfere with the resident’s successful completion of a rotation are immediately communicated by the supervising faculty to the program director. This is brought to the attention of the resident and an appropriate course of action is discussed.

The resident will complete a rotation evaluation form at the end of each rotation which is forwarded to the Program Director for review and action.
During this rotation the resident will function as a member of the PICU team caring for pediatric patients in the PICU and by completion of the rotation should be able to:

**PATIENT CARE**
- Develop skills in the initial evaluation, diagnosis, stabilization, and treatment of critically ill and injured pediatric patients.
- Manage the medical care of several pediatric patients in the PICU simultaneously.
- Be familiar with the placement and management of various invasive devices needed in the monitoring of the acutely ill or injured child.

**MEDICAL KNOWLEDGE**
- Recognize the child in respiratory distress.
- State the indications for endotracheal intubation and perform endotracheal intubation in children.
- Select appropriate settings for mechanical ventilation in children.
- Compare and contrast clinical presentations and management of different types of congenital heart disease.

**PRACTICE-BASED LEARNING AND IMPROVEMENT**
- Become familiar with the educational resources available in the PICU, including textbooks, computer based program and internet resources.
- Demonstrate the ability to form a clinical question and use the available resources to resolve the patient care issues.

**INTERPERSONAL AND COMMUNICATION SKILLS**
- Be able to present pertinent clinical information to the supervising physician succinctly and accurately.
- Effectively and professionally interact with other members of the PICU team.
- Develop a professional relationship with patients and their families.

**PROFESSIONALISM**
- Demonstrate the ability to clearly and accurately document in the patient record.
- Demonstrate respect, compassion, and integrity to all patients, family members, and team members.

**SYSTEMS-BASED PRACTICE**
- Function as an integral part of the PICU and pediatric resuscitation team.
- Understand the role of the PICU consult in the emergency department.
- Understand the basic resources available for the care of the hospitalized pediatric patient.
- Be familiar with indications for admission to a PICU.
- Be familiar with the goals of PICU treatment and appropriate criteria for discharge of patients to a lower level of care.
**Description of clinical experiences:**

The resident will have all of the same responsibilities as a resident from the Department of Pediatrics on the PICU team. Daily responsibilities include pre-rounds on each of the house officer’s patients and formal work rounds with the entire team. Emphasis should be on the initial work-up of patients admitted to the service with development of a differential diagnosis and therapeutic plan and then following the patient through the entire course of their hospitalization. The resident will have on-call responsibilities and is expected to keep and up to date procedure log and duty hours’ record. The residents are supervised by attending pediatric intensivists and the director of the PICU.

**Description of didactic experiences:**

The resident is excused from duties one half day per week to attend all regularly scheduled Emergency Medicine conferences while on the PICU rotation. Attendance is mandatory. In addition, residents participate in daily patient teaching rounds with the team as well as daily morning report with the entire department of Pediatrics focusing on a specific patient presentation and details of appropriate management.

**Evaluation process:**

1. Written evaluations will be completed by the supervising PICU attending following the completion of the rotation. These evaluations are available for resident review.
2. Any problems which occur during the rotation or any circumstance which interfere with the resident’s successful completion of a rotation are immediately communicated by the supervising faculty to the program director. This is brought to the attention of the resident and an appropriate course of action is discussed.

The resident will complete a rotation evaluation form at the end of each rotation which is forwarded to the Program Director for review and action.
<table>
<thead>
<tr>
<th>Rotation</th>
<th>Emergency Medicine 3</th>
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</thead>
<tbody>
<tr>
<td>Institution</td>
<td>MUSC Hospital</td>
</tr>
<tr>
<td>Duration in Months:</td>
<td>9</td>
</tr>
<tr>
<td>Year of training</td>
<td>PGY-1</td>
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<tr>
<td></td>
<td>PGY-2</td>
</tr>
<tr>
<td></td>
<td>PGY-3</td>
</tr>
</tbody>
</table>

Educational objectives:

Although time will be spent in the ED during each year of the residency, the focus of the third year is on achieving clinical competence by exhibiting the ability to practice emergency medicine independently while still having continual faculty supervision. The resident will demonstrate competency in the fundamental skills of the practice of emergency medicine while also being efficient and managing the departmental patient flow. By completion of the rotation the resident should, in addition to meeting all objectives of the EM2 rotation, be able to:

**PATIENT CARE**
- Institute appropriate advanced treatment plans autonomously.
- Achieve technical proficiency in all procedural skills appropriate for emergency medicine.
- Be continually aware of not only his/her individual patients, but of all patients in the department including the waiting room and patients en route.

**MEDICAL KNOWLEDGE**
- Demonstrate an advanced fund of medical knowledge within emergency medicine
- Achieve scientific basis for patient care decisions.

**PRACTICE-BASED LEARNING AND IMPROVEMENT**
- Facilitate the learning of professional associates.

**INTERPERSONAL AND COMMUNICATION SKILLS**
- Demonstrate appropriate conflict resolution skills
- Work effectively with others in the role as a team leader

**PROFESSIONALISM**
- Demonstrate the ability to act as a patient advocate at all times.
- Demonstrate respect, compassion, and integrity with patients, family, and all staff.
- Demonstrate respect of patient’s privacy and confidentiality.
- Demonstrate confidence in being the team leader

**SYSTEMS-BASED PRACTICE**
- Provide appropriate medical command to pre-hospital providers.
- Provide appropriate support and supervision for all nursing staff in assisting with patient flow and difficult situations.
- Demonstrate integral knowledge of all ancillary services and supports within the hospital and community at large and can easily access these resources.
Description of clinical experiences:

The resident is responsible for the initial evaluation of multiple patients, the formulation of a differential diagnosis, and the planning of an appropriate diagnostic and therapeutic regimen under the direct supervision of the faculty. The resident performs or teaches junior residents and students any procedures required by their patients. If a consultation is required, the resident discusses the case with the appropriate consultant and a plan is decided upon. If the patient can be discharged, the resident is responsible for ensuring a comprehensive discharge plan which the patient understands. The resident is very efficient seeing an increased number of patients an hour. They also act as a role model for more junior members of the team and assist in their patient care plans while maintaining patient flow within the department as a whole.

Description of didactic experiences:

The resident is excused from duties one half day per week to attend all regularly scheduled Emergency Medicine conferences while on the EM rotation. Attendance is mandatory. The conference series is structured to encompass the entire core curriculum and provide the resident with a broad fund of knowledge.

Evaluation process:

1. Daily feedback by supervising emergency medicine faculty.
2. Direct observation of patient care by faculty.
3. Formal written evaluation at end of rotation by emergency medicine faculty.
4. Annual participation in the ABEM in-service examination
5. The resident will keep a procedure log that is reviewed by the Program Directors semiannually.
7. Any problems which occur during the rotation or any circumstance which interfere with the resident’s successful completion of a rotation are immediately communicated by the supervising physician to the program director. This is brought to the attention of the resident and an appropriate course of action is discussed.

The resident will complete a rotation evaluation form at the end of each rotation which is forwarded to the Program Director for review and action.
### Pediatric Emergency Medicine

<table>
<thead>
<tr>
<th>Rotation</th>
<th>Pediatric Emergency Medicine</th>
</tr>
</thead>
<tbody>
<tr>
<td>Institution</td>
<td>MUSC Hospital</td>
</tr>
<tr>
<td>Year of training</td>
<td>PGY-1 PGY-2 PGY-3 X</td>
</tr>
<tr>
<td>Duration in Months</td>
<td>1</td>
</tr>
</tbody>
</table>

**Educational objectives:**

Although time will be spent in the Pediatric ED during each year of the residency, the focus of the third year is on management of the entire department. The resident will refine the fundamental skills of the practice of pediatric emergency medicine and develop all administrative and teaching components inherent in leading a Pediatric ED. By the completion of the rotation her or she should be able to:

**PATIENT CARE**
- Perform a complaint directed history and physical on pediatric patients presenting to the ED and discuss the importance of obtaining information from the family and pre-hospital care providers on arrival of the patient.
- Discuss the importance of gathering a clinical database including all past medical information.
- Rapidly identify pediatric patients with acute injuries or illnesses which pose a risk to life or limb.
- Appropriately order and interpret ancillary studies based on clinical presentation.
- Formulate a comprehensive differential diagnosis.
- Achieve technical proficiency in procedural skills consistent with level of training.
- Oversee patient care of all junior residents and medical students.
- Assist in patient flow within the ED

**MEDICAL KNOWLEDGE**
- Demonstrate advanced fund of medical knowledge including the etiology, presentation, pathophysiology and treatment for diseases and injuries encountered.

**PRACTICE-BASED LEARNING AND IMPROVEMENT**
- Have complete familiarity with the educational resources available in the Pediatric Emergency Department, including the textbooks, computer based program and internet resources.
- Demonstrate the ability to form a clinical question and identify available resources to resolve them.

**INTERPERSONAL AND COMMUNICATION SKILLS**
- Present a case succinctly and accurately to colleagues.
- Effectively and professionally interact with all members of the pediatric emergency medical team.
- Develop a professional relationship with pediatric patients and their families in order to maximize information exchange and trust in the plan of care.
- Demonstrate the ability to clearly and timely document the patient record.
- Demonstrate the ability to coach all junior learners in patient presentations and patient and family interactions

**PROFESSIONALISM**
- Demonstrate the ability to act as a patient advocate in the current medical environment.
- Demonstrate respect, compassion, and integrity with patients, family, and all staff.
- Demonstrate respect of patient’s privacy and confidentiality.

**SYSTEMS-BASED PRACTICE**
- Understand basic resources available for care of the emergency department patient.
- Discuss the indications for admission or discharge of each patient including medical and social considerations for optimal care.

**Description of clinical experiences:**
The resident is responsible for the initial evaluation of patients, the formulation of a differential diagnosis, and the planning of an appropriate diagnostic and therapeutic regimen under the direct supervision of the pediatric emergency medicine faculty. The resident performs or assists in any procedures required by their patients as appropriate for level of training and experience. If a consultation is required, the resident discusses the case with the appropriate consultant and a plan is decided upon. If the patient can be discharged, the resident is responsible for ensuring a comprehensive discharge plan which the patient understands. The resident is also responsible for managing the flow of the entire Pediatric ED as well as providing guidance for junior learners.

<table>
<thead>
<tr>
<th>Description of didactic experiences:</th>
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</thead>
<tbody>
<tr>
<td>The resident is excused from duties one half day per week to attend all regularly scheduled Emergency Medicine conferences while on the EM rotation. Attendance is mandatory. The conference series is structured to encompass the entire core curriculum and provide the resident with a broad fund of knowledge.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Evaluation process:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Daily feedback by supervising pediatric emergency medicine faculty.</td>
</tr>
<tr>
<td>2. Direct observation of patient care by faculty.</td>
</tr>
<tr>
<td>3. Formal written evaluation at end of rotation by emergency medicine faculty.</td>
</tr>
<tr>
<td>4. Quarterly written Emergency Medicine Residency Exams will be administered and results tracked.</td>
</tr>
<tr>
<td>5. Annual participation in the ABEM in-service examination</td>
</tr>
<tr>
<td>6. The resident will keep a procedure log that is reviewed by the Program Directors semiannually.</td>
</tr>
<tr>
<td>7. Simulated oral board examinations quarterly.</td>
</tr>
<tr>
<td>8. Any problems which occur during the rotation or any circumstance which interfere with the resident’s successful completion of a rotation are immediately communicated by the supervising physician to the program director. This is brought to the attention of the resident and an appropriate course of action is discussed.</td>
</tr>
</tbody>
</table>

The resident will complete a rotation evaluation form at the end of each rotation which is forwarded to the Program Director for review and action.
<table>
<thead>
<tr>
<th>Rotation</th>
<th>Emergency Medical Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Institution</td>
<td>MUSC Hospital</td>
</tr>
<tr>
<td>Duration in Months: Longitudinal</td>
<td></td>
</tr>
</tbody>
</table>

| Year of training | PGY-1 | X | PGY-2 | X | PGY-3 | X |

**Educational objectives:**

During this rotation the resident is expected to learn the objectives and skills as described and by completion of the rotation should:

**PATIENT CARE**
- Be able to obtain a complaint directed history and physical through the EMS provider and learn the limitations of the history and physical examination as obtained in the pre-hospital environment.
- Discuss the importance of gathering information about the patient presentation and environmental factors that may only be available from the pre-hospital care provider.
- Be able to use information from the pre-hospital provider to initiate urgent treatment in a patient prior to hospital arrival.
- Become familiar with the Charleston County Advanced Life Support and Basic Life Support Protocols and the procedures that are the basis of their function by observing on Charleston County Ambulance Units.

**MEDICAL KNOWLEDGE**
- Be able to describe the role of pre-hospital care providers and the difference between ALS and BLS providers.
- Describe the role of the administrators and committees in the local system.
- Describe the role of each component of the system in a mass casualty incident.
- Demonstrate an understanding of CQI/PI in the pre-hospital care environment.
- Demonstrate an understanding of the differences in medical care in the pre-hospital setting in comparison to the ED setting.

**PRACTICE-BASED LEARNING AND IMPROVEMENT**
- Become familiar with the educational resources available and be able to locate resources pertaining to pre-hospital care and governmental regulations.
- Demonstrate the ability to form a clinical question and use the available resources to develop a pre-hospital CQI /PI project.

**INTERPERSONAL AND COMMUNICATION SKILLS**
- Be able to gather information efficiently from pre-hospital care providers and patients.
- Effectively and professionally interact with other members of the pre-hospital care team.
- Learn to develop a professional relationship with pre-hospital providers in order to maximize information exchange and provide a smooth transition of patient care from the pre-hospital to the hospital environment.

**PROFESSIONALISM**
- Demonstrate the ability to act as a patient advocate in all situations.
- Develop an understanding of the ethical principles pertaining to provision of clinical care, confidentiality of patient information, informed consent, and business practices in the pre-hospital environment.
- Provide patient care that incorporates sensitivity to the patient's age, ethnic, and social background and understand how these factors influence the plan of care.

**SYSTEMS-BASED PRACTICE**
- Function as an integral part of both the pre-hospital and hospital care system.
- Learn the basic elements of disaster and multiple casualty incident planning, drills and emergency response by attending classes, administrative meetings, drills, incidents and incident evaluation sessions under the supervision of the appropriate CFD/EMS personnel and MUSC EM faculty.
- Learn about the organization and administration of EMS systems by attending Medical Advisory Committee and Regional Emergency Medicine Advisory Board meetings with the EMS Medical Director and/or EM faculty.
### Description of clinical experiences:

During the course of the residency the resident will complete a longitudinal rotation with EMS. Residents are supervised by appropriate EMS personnel. The library of the Charleston EMS and ambulance call reports (as appropriate) are made available for the educational or research use of the rotating residents upon approval of the Medical Director of Training.

The resident will be required to ride on the ground ambulance for approximately 7 to 10 shifts. During this experience the resident will function as part of the pre-hospital care team and learn the difficulties and approach to history, physical examination, and treatment in the pre-hospital environment.

During this rotation the residents will also become familiar with the local Charleston County and South Carolina City EMS Systems by working with several faculty members who are integral members of this system. This involvement includes attending system meetings, performing in a PI/CQI project, and participating in the management of local agencies.

### Description of didactic experiences:

Emergency Medicine residents are excused from duties one half day per week to attend all regularly scheduled Emergency Medicine conferences while on the EMS rotation.

The MUSC EMS rotation offers an additional 4 hours of conference each week. These lectures cover an overview of topics related to EMS including disasters and other mass casualty incidents, EMS organization, communication, staffing, quality assurance, regulatory agencies, and legal aspects of Emergency Medical Services.

### Evaluation process:

1. EMS providers are instructed and expected to provide residents with formative evaluation data routinely during their clinical rotations with the residents.
2. Written evaluations will be completed by the supervising EMS provider. These evaluations are available for resident review after completion of the rotation.
3. Any problems which occur during the rotation or any circumstance which interfere with the resident’s successful completion of a rotation are immediately communicated by the supervising EMS provider to the program director. This is brought to the attention of the resident and an appropriate course of action is discussed.
4. Residents maintain a portfolio of their teaching, educational, research and CQI/PI EMS activities that will be reviewed with the program director.

The resident will complete a rotation evaluation form at the end of each rotation which is forwarded to the Program Director for review and action.
XXII. Emergency Medicine Milestones

1. Milestone Reporting

This document presents milestones designed for programs to use in semi-annual review of resident performance and reporting to the ACGME. Milestones are knowledge, skills, attitudes, and other attributes for each of the ACGME competencies organized in a developmental framework from less to more advanced. They are descriptors and targets for resident performance as a resident moves from entry into residency through graduation. In the initial years of implementation, the Review Committee will examine milestone performance data for each program’s residents as one element in the Next Accreditation System (NAS) to determine whether residents overall are progressing.

For each reporting period, review and reporting will involve selecting the level of milestones that best describes a resident’s current performance level in relation to milestones, using evidence from multiple methods, such as direct observation, multi-source feedback, tests, and record reviews, etc. Milestones are arranged into numbered levels. These levels do not correspond with post-graduate year of education.

Selection of a level implies that the resident substantially demonstrates the milestones in that level, as well as those in lower levels (See the diagram on page v). A general interpretation of levels for emergency medicine is below:

**Level 1:** The resident demonstrates milestones expected of an incoming resident.

**Level 2:** The resident is advancing and demonstrates additional milestones, but is not yet performing at a mid-residency level.

**Level 3:** The resident continues to advance and demonstrate additional milestones; the resident demonstrates the majority of milestones targeted for residency in this sub-competency.

**Level 4:** The resident has advanced so that he or she now substantially demonstrates the milestones targeted for residency. This level is designed as the graduation target.

**Level 5:** The resident has advanced beyond performance targets set for residency and is demonstrating “aspirational” goals which might describe the performance of someone who has been in practice for several years. It is expected that only a few exceptional residents will reach this level.
XXIII. The Alphabet Soup of EM

AAEM: American Academy of Emergency Medicine
ABEM: American Board of Emergency Medicine
ACEP: American College of Emergency Physicians
ACGME: Accreditation Council for Graduate Medical Education
AMA: American Medical Association
CORD: Council of Residency Directors (Emergency Medicine)
EMRA: Emergency Medicine Residents’ Association
NRMP: National Resident Matching Program
RRC: Residency Review Committee
SAEM: Society for Academic Emergency Medicine
SCACEP: South Carolina Chapter of the American College of Emergency Physicians
XXV. Clinical Competency Committee

Purposes

- To implement Milestones reporting
- To review resident performance across all competency domains
- To complete documentation as required by the Accreditation Council for Graduate Medical Education and the American Board of Emergency Medicine
- To provide input to the Residency Leadership to facilitate curriculum development, evaluation effectiveness, and program improvement
- To make consensus recommendations for promotion and remediation
- To identify residents needing additional resources for advancement

Membership

Members include the Associate Program Director, and key faculty appointed by the Residency Leadership. The Program Director will be excluded from chairing the Clinical Competence Committee.

Functions

- Make recommendations to the Program Director with regard to:
  - Advancement
  - Remediation
  - Dismissal

- Synthesize multiple different types of assessments into an evaluative statement about each resident’s performance. The CCC will use data garnered from assessment tools and faculty observations to assess resident progress in achieving the Educational Milestones.

- Areas of assessment will include:
  - Milestones summary
  - In-training exam scores
  - Rotation written evaluations
  - Multi-source evaluations (360)
  - Patient evaluations
  - Simulation participation and performance
  - Oral boards participation and performance
  - Ultrasound performance
  - Clinical efficiency

- Provide assessment of resident performance as required by the ACGME and ABEM.

- Fairly, consistently, and indiscriminately apply the residency’s Evaluation and Promotion policies.
• Identify residents who are not progressing with their peers in one or more areas. The CCC provides a group perspective on resident progress in the residency program and will assist in early identification of areas of needed improvement. When a resident is deemed in need of remediation, the resident will be referred to the Program Director for specific remediation plan and follow-up assessment.

• The CCC will make recommendations to the Residency Leadership regarding effective Milestones assessment.

• Provide the Program Director and individual Residents with documentation of biannual global assessment and CCC recommendations for advancement or remediation.

Format

• Each resident’s performance will be reviewed at least twice yearly (December and June) by the CCC.

• The CCC will create a biannual Performance Review for each resident, which summarizes the CCC’s assessment and recommendation for advancement or remediation. Copies of this letter will be provided to the Program Director.

• The Remediation Subcommittee works with the program director to develop appropriate remediation plans, as necessary.

• Milestones Subcommittee meetings will focus on development and improvement of training and evaluation in specific core competency areas.

• All members of the Committee agree to keep the information discussed confidential, and documentation will be classified as peer-review.

Emergency Medicine CCC Members for 2017-2018:

Dr. Simon Watson
Dr. Lindsey Jennings
Dr. Pauline Meekins
XXV. Program Evaluation Committee (PEC)

Membership

Members will include a minimum of two program faculty members and at least one EM resident physician. The Program Director (PD) will appoint the Chair of the PEC. The PD and the Chair will jointly appoint all PEC members. The PD will be excluded from chairing the PEC effective 7/1/2013 but can be a member of the committee.

Responsibilities

- Must participate actively in
  - Planning, developing, implementing, and evaluating educational activities of the program
  - Reviewing and making recommendations for revision of competency-based curriculum goals and objectives
  - Addressing areas of non-compliance with ACGME standards
  - Reviewing the program annually using evaluations of faculty, residents, and others as specified below

- The PEC must document a formal, systematic evaluation of the curriculum at least annually, and is responsible for rendering a written Annual Program Evaluation (APE)

- The program must monitor and track each of the following areas:
  - Resident performance
  - Faculty development
  - Graduate performance including performance of program graduates on the certification exam
  - Program quality
    - Residents and faculty must have the opportunity to evaluate the program confidentially and in writing at least annually, and
• The program must use the results of the residents’ and faculty members’ assessments of the program together with other program evaluation results to improve the program
  o Progress on the previous year’s action plan(s)

• The PEC must prepare a written plan of action to document initiatives to improve performance in one or more of the areas listed above, as well as delineate how they will be measured and monitored
  o The action plan should be reviewed and approved by the teaching faculty and documented in the minutes

2017 – 2018 EM PEC Members:

TBD (Chair)
Dr. Simon Watson
Dr. Jeffrey Bush (ad hoc) TBD

XXVI. In-Training Exam Policy (ITE)

In-Training Exam: The end goal is to demonstrate the capacity to pass your ABEM written examination. As the ITE scores are representative of this end goal, residents at all levels of training are encouraged to achieve a 90% chance or higher prediction pass rate of the real ABEM written exam at his/her respective level of training. We follow residents' progress each year as well as correlate ITE scores with USMLE scores. If a resident scores below the 80% cutoff (RRC standard), medical knowledge (MK) Departmental Remediation may be instituted. If placed on MK Departmental Remediation, the resident must meet with the residency leadership and faculty mentor and develop a study plan with timeline. The resident will meet with the assigned faculty mentor on a monthly basis to monitor progression. Study options will be provided and tailored to the resident; as this will be a very individualized approach. While on remediation, no moonlighting is permitted, leadership positions will be curtailed, and CME time/funds may be redirected towards board preparation activities at the discretion of the program director. If the resident fails to show substantial improvement in their MK, and subsequent ITEs, then Intuitionial Remediation will be initiated.

XXVII. Social Media Policy

Please visit MUSC’s Social Media Standards page for information regarding guidelines.
I have read and acknowledge the 2017-2018 Residency Orientation Manual.

Resident Signature:  
Date: