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Residency Manual

July 1, 2013
Residency in Emergency Medicine

St. Luke's - Roosevelt Hospital Center

Goals of Education

At the completion of thirty-six months of postgraduate training in Emergency Medicine, graduates will be outstanding emergency physicians with the professional ability to practice competently and independently, and will have the expertise to:

1. Resuscitate, stabilize, evaluate, and manage an undifferentiated population of acutely ill and injured patients of all ages who present to the ED on a 24hr a day basis.

2. Gain mastery over the essential components of the core content of the EM curriculum as outlined in the model of the practice of emergency medicine and demonstrate this by translating concepts into effective patient care as well as by superior performance on the annual in-training exams and the board certification exam for EM.


4. Skillfully perform all EM procedures. Demonstrate superior ability to teach EM procedures to junior faculty and residents.

5. Utilize appropriate emergency consultation.

6. Understand the social issues and use of community resources involved in the care of patients in the ED including addiction, violence/abuse of all ages, and sexual assault.

7. Understand the importance of follow-up and continuity of care and make appropriate referrals after completing the patient's emergency medical care.

8. Understand the organization and role of pre-hospital care services.

9. Appropriately direct pre-hospital care of the acutely ill and injured of all ages, and participate in medical control of pre-hospital care via telemetry.


11. Learn administrative and teaching skills necessary for a successful career in academic and community based emergency medicine.

12. Understand research methodologies and acquire skills in critically appraised scientific and scholarly publications and presentations and mastery over evidence-
based evaluation of the medical literature. Further, be skillful at the integration of new and evolving evidence into daily clinical practice.

13. Possess a thorough working knowledge surrounding the evaluation and management of a wide array of toxicological emergencies.

14. Understand the principles of ultrasonography in EM and utilize it as part of the daily practice and further to gain mastery in all of the approved ultrasound applications for emergency medicine. To be effective teachers of ultrasound skills.

15. Utilize effective communication, team-building skills, and appreciation of diversity with appropriate levels of cultural competency in the ED to enhance patient, staff, and personal satisfaction.

16. Possess critical tools for developing a balanced life and career a commitment to principles of self-care and overall well being necessary to support a productive career in emergency medicine.

17. Be familiar and conversant with basic principles of ethical practice of medicine and be able to apply these principles to the complex situations, which arise daily in the ED.

18. Gain mastery in TEACHING emergency medicine procedures, concepts and practice to junior faculty, residents and medical students.

19. Possess working knowledge of fundamental principles of global health and appreciation of the opportunities to use EM training and skills set in humanitarian international efforts throughout the world.

20. Be skillful advocates for all ED patients, become exemplary representatives of the specialty of Emergency Medicine.

**ACGME Core Competencies, EM Milestones, and the training and evaluation process at SLR**

The following is a brief description of the ACGME core competencies and how they are integrated into the EM training at St. Luke's/Roosevelt. Residents will be taught and demonstrate mastery in the following critical outcome areas:

- **Patient Care (PC):** 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.

- **Medical Knowledge (MK):** Residents must demonstrate knowledge of established and evolving biomedical, clinical, epidemiological and social-behavioral sciences, as well as the application of this knowledge to patient care.

- **Professionalism (P):** Residents must demonstrate a commitment to carrying out professional responsibilities and adherence to ethical principles. Residents are expected to demonstrate: compassion, integrity and respect for others; responsiveness to patients needs that supersedes self-interest; respect for patient privacy and autonomy; accountability to patients, society and the profession; and, sensitivity and responsiveness to a diverse patient population,
including but not limited to diversity of gender, age, culture, race, religion, disabilities and sexual orientation.

- **Practice Based Learning and Improvement (PBLI):** Residents must demonstrate the ability to investigate and evaluate their care of patients, to appraise and assimilate scientific evidence, and to continuously improve patient care based on constant self-evaluation and life-long learning. Residents are expected to develop skills and habits to be able to meet the following goals: identify strengths, deficiencies and limits in one’s knowledge and expertise; set learning and improvement goals; identify and perform appropriate learning activities; systematically analyze practice using quality improvement methods, and implement changes with the goal of practice improvement; incorporate formative evaluation feedback into daily practice.

- **Interpersonal and Communication Skills (ICS):** Residents must demonstrate interpersonal and communication skills that result in the effective exchange of information and collaboration with patients, their families and health professionals.

- **Systems-Based Practice (SBS):** Residents must demonstrate an awareness of and responsiveness to the larger context and system of health care, as well as the ability to call effectively on other resources in the system to provide optimal health care; incorporate considerations of cost awareness and risk-benefit analysis in patient care; advocate for quality patient care and optimal patient care systems; work in inter-professional teams to enhance patient safety and improve patient care quality and participate in identifying systems errors and implementing potential solutions.
Progressive Responsibility in Emergency Medicine Training at SLR

Our residency curriculum is designed to provide progressive clinical, teaching and administrative responsibility each year, with the expectation that EM3 residents will be able to provide clinical and administrative leadership to the ED at both Roosevelt and St. Luke's, 24 hours a day, seven days a week.

EM-1 Progressive Responsibility

EM-1 residents provide direct care to patients under the supervision of an emergency medicine attending and EM-3 resident. We encourage the EM-1’s to formulate a comprehensive differential diagnosis and plan prior to case presentation to the senior resident or attending.

EM-1 Clinical Educational Objectives and Responsibilities

As an EM-1 you will be taught and evaluated on the ability to do the following:

- Perform an accurate history and physical examination. (PC)
- Generate a thorough differential diagnosis, assessment and plan. (PC)
- Become proficient at all important ED procedures. (PC)
- Present patients to the attending in an accurate and concise manner. (PC, SBP)
- Demonstrate ability to interact with patients and their families in a professional and compassionate manner. (PC, P, ICS)
- Function comfortably as a member of the entire ED team that includes attending physicians, co-residents, nurses, physician assistants, clerks and other ancillary staff. (SBP, ICS, P)
- Communicate effectively and collegially with residents and attending physicians from other specialties. (P, ICS, SBP)
- Demonstrate the ability to clearly and completely document the history, physical exam, clinical course, assessment and plan of each patient. (PC, SBP, ICS, P)
- Formulate appropriate discharge plans and communicate them to patients and family. (PC, SBP, ICS, P)
- **Routinely follow-up on selected admitted and discharged patients, analyzing the care delivered and areas for improvement. (SBP, PBL)

EM-1 Supervisory responsibilities: None

EM-1 Didactic Goals, Objectives and Responsibilities

- Attend 100% of ED weekly conferences and monthly trauma conferences unless excused. Absence from conference during ICU, CCU rotations, post overnight, away elective and while on vacation are excused. (MK)
• Present the pre-hospital course and ED management of trauma cases at the joint EM/Surgery Trauma conference as requested. (SBP, PC, MK, ICS)
• Teach medical students. (SBP, MK, ICS)
• Obtain ACLS, ATLS and PALS certification. (MK)

EM-1 Administrative Goals and Objectives:
• Become familiar with the physical structure, equipment locations and patient flow patterns of the ED. Learn functions and names of all personnel assigned to the ED.
• Complete death certificates and discuss cases with the New York City Medical Examiner.

EM-1 Research and Evidence Based Practice Goals and Objectives:
• Attend journal club and present summaries of assigned articles. Demonstrate grasp of research methodology, statistical analysis, and critical assessment of the medical literature as presented in journal club didactics. (MK, SBP, PBLI)
• Actively participate in evidence base analysis of the medical literature. (MK, SBP, PBLI)
• Participate in ongoing research projects while on duty in the ED. (MK, PBLI, SBP)
• Formulate a plan for a scholarly activity project. (MK, SBP, PBLI) (See research section of residency manual.)

EM-2 Progressive Responsibility
The EM-2 residents perform an initial evaluation of ill and injured patients. They are expected to institute initial treatment and diagnostic plans independently. They present their findings in a clear and concise manner and articulate a comprehensive diagnostic and therapeutic plan. They perform the majority of critical interventions, such as intubations, and manage the majority of critically ill patients. EM-2 residents focus on the essential emergency medicine art and skill of multi-tasking and learning to care for multiple sick and injured patients simultaneously.

EM-2 Clinical Educational Goals, Objectives and Responsibilities:
As an EM-2 you will be taught, and evaluated on the ability to do, the following:
• Perform a complaint directed work-up of emergency department patients. (PC, MK)
• Establish a differential diagnosis for each patient chief complaint, reflecting the EM approach to problem solving. (PC, SBP, MK)
• Evaluate and treat patients independently; perform the indicated work-up prior to presentation to the EM-3 or attending. (PC, MK, SBP)
• Manage multiple patients simultaneously. (PC, SBP)
• Present comprehensive treatment and disposition plans. (PC, SBP)
• Demonstrate cost-effective laboratory and ancillary test ordering. (PC, SBP)
• Be able to give the rationale for, and complications of, any ED procedure undertaken. (PC, MK, SBP)
• Assume a “team captain” role in moderate trauma and cardiac arrest patients when the EM-3 is unavailable. Demonstrate effective skills in leading the team during resuscitations. (MK, ICS, SBP)
• Assume management of airway emergencies in the ED under the supervision of the EM-3 and attending. The EM-2 has primary airway responsibility and as such must demonstrate thorough knowledge of the concepts and pharmacology of emergency airway management including adjuncts and algorithms for the difficult or failed airway. All EM-2 must demonstrate adequate background knowledge by superior performance on the airway credentialing written and practical exams prior to commencement of year 2 in order to be eligible to advance to the airway responsibilities of year 2. (MK, ICS, SBP, PBLI)

**EM-2 Supervisory Responsibilities**
Provide clinical supervision to EM-1’s and medical students in the performance of minor procedures.

**EM-2 Didactic Education Goals, Objectives and Responsibilities:**
- Attend 100% of emergency department weekly conferences unless excused.
- Attend 100% of monthly trauma conferences unless excused.
- Prepare and present Follow-up Case at Wednesday Conference under the direction of Associate PD, or faculty mentor.
- Present the pre-hospital and ED management of trauma case at the Joint EM/Surgery conference as requested.
- Prepare and present a didactic session for the pre-hospital care personnel under the direction of Dr. Redlener.
- Teach EM-1’s and medical students.

**EM-2 Administrative Responsibilities**
- Become aware of basic policies and procedures governing patient care and flow in the emergency department.
- Active participation in a residency CQI/Patient Safety project.

**EM-2 Research/Critical Analysis of Medical Literature Goals, Objectives and Responsibilities:**
- Attend journal club and present summaries of assigned articles. Learn research methodology, statistical analysis, and critical assessment of the medical literature. (MK, PBLI)
• Participate in ongoing research projects while on duty in the ED. (MK, PBLI)
• Complete planning and begin implementation of a scholarly activity project (see Research section)

**EM-3 Progressive Responsibility**

- The focus of the EM-3 year is to develop efficient team management, supervisory, and teaching skills. In addition, the EM-3 resident must learn to appropriately utilize consultation services appropriately, and master the communication skills essential for independent practice.
- At both sites, the EM-3 resident is the team leader of their own clinical team which includes a junior resident, nurses and an ED technician.
- The EM-3 is responsible for supervising medical students and junior residents, managing the flow of patients assigned to the team, directing all major medical and traumatic resuscitations, and evaluating patients independently.
- After the EM-3 precepts the cases of the junior resident, they discuss the management and final disposition of all patients on their team with an attending physician.
- The attending physician is present during all resuscitations and intervenes only as required to ensure optimal patient care. Following the initial resuscitation, the EM-3 and attending discuss the case and develop a diagnostic and therapeutic strategy.

**EM-3 Clinical Education Goals, Objectives and Responsibilities:**

As an EM-3 you will be taught, and evaluated on the ability to do, the following:

- Direct all aspects of patient care including all pediatric, adult medical and trauma resuscitations under the supervision of the EM Attending. (PC, MK, ICS, PBL, P, SBP)
- Supervise airway management by EM2 residents, and serve as a back up if they are unable to successfully intubate the patient. (PC, MK, SBP, ICS, P.)
- **Screen all initial ECG's of ED patients assigned to the Red Team.** (PC, MK, SBP) **prior to assuming this responsibility, EM-3's must demonstrate clinical competence and medical knowledge by satisfactory performance on the ECG credentialing exam.
- Appropriately and effectively, consult other services as needed. (PC, ICS, SBP, MK)

**EM-3 Supervisory Responsibilities**

- Manage Red Team operations under the supervision of the charge attending physician, including, overall patient flow, and cases being evaluated by the junior resident. (PC, SBP, ICS, P, PBLI, MK)
- Assess ED readiness (e.g. adequate staff, supplies, monitors, and stretchers) to ensure that patient needs are being met. (PC, SBP, MK, ICS, P)
• Work with the charge nurse to deal with factors that impede the swift transfer of admitted patients to in-hospital teams. (PC, PBLI, SBP, P, MK, ICS)
• Supervise cases presented by medical students and junior residents, and then present these cases directly to the attending. (PC, MK, ICS, P, SBP)

**EM-3 Didactic Education Goals, Objectives and Responsibilities**

- Attend 100% of emergency department weekly conferences unless excused.
- Attend 100% of trauma conferences unless excused.
- Clinical teaching while on duty in the emergency department.
- Lead Morning Report on Tuesdays, Thursdays, Fridays, and Saturdays. EM-3’s may present a didactic topic or a case and lead a discussion.
- Present a senior topic lecture working with the associate PD and/or your faculty mentor.
- Lead a small group for Wednesday morning Board Review when applicable.
- Participate in a CQI meeting and write up a case for presentation at morbidity and mortality conference. (see CQI Requirement section)
- Participate in all aspects of your assigned group’s Residency CQI/Patient Safety Project including implementation of project, study if results and presentation at conference.

**Research**

1. Complete scholarly activity project. Completion of a scholarly project such as research project or case report to final submission to peer review journal or acceptance for presentation at a national or regional meeting is a requirement for graduation from the SLR residency and should be done under the immediate supervision of a faculty member.
2. Participate in ongoing research projects while on duty in the emergency department
Rules of the Road for Interns

Fundamentals:
• Bring your highest level of enthusiasm and your “A-Game” to your shifts, conference and all residency related activities. Take responsibility for your education and the quality of our program from day one. You will get out of it what you put into it.

Relationships:
• Every relationship counts. Every task and achievement takes place in the context of relationships. Make respectful, professional and enthusiastic communication your signature and you will have many friends and your ability to take care of patients and enjoy your job will increase. Some specifics:
  • Colleagues. Be proactive about supporting and befriending your classmates. Pay attention to what you can do to help out someone else and it will come back to you.
  • Seniors and faculty—all practice differently and all have something to teach you. Communicate your openness and desire to learn what they have to offer.
  • Nurses. Introduce yourself over and over. Learn the names of the nurses. Be respectful and interested. Many of them have years of experience and will save you from getting into trouble in multiple ways. When you write an order, also communicate it verbally. Explain your rationale. Ask their professional opinion about patients. You will be often surprised by how much they have to offer.
  • Staff, admin staff, BA’s and especially the SA’s. Learn all their names. Know who the shift managers are—you may need them and they are very helpful.
  • other services)
  • Medical students. We have 10-14 Columbia students monthly. Include them whenever possible. You won’t have direct teaching roles involving the students until later.
  • AA’s. We have an academic associate program here and the AA’s are undergrads in the department helping to collect our research data. Include them. Be friendly to them. They look up to you and are aspiring to do what you already do.

Conference:
• It’s the heart of the program and we expect 100% attendance, always on-time and maximal participation and enthusiasm. This includes journal club and trauma conference.
• More than 30 minutes late counts as an absence. On your 3rd unexcused absence you will be assigned an extra clinical shift and for each further unexcused absence an additional extra shift. Excused absences are when you are on CCU, ICU, Vacation, away elective, Shock-Trauma, and post overnight. ED-AC resident is expected to be at conference.
• Interns are expected to sit in the front rows.

ER Shifts
• On time. Period.
• Rested, fit for duty, not hung over. enthusiastic.
• Pace: Intern year is about learning from each patient. Speed comes later.
• Consults and Imaging studies: Initially only with attending/senior.
• Chaperones. For EVERY pelvic and GU exam
• Patient privacy. No rectal exams in the hallway. Be sensitive to patient’s privacy and dignity and comfort during history and physical. (challenging—the ED gets very crowded, but make the effort)
• Do a complete PE when appropriate and make sure patients are undressed. You need to see the feet and feel the abdomen…
• Seniors will likely order things on your patients and may work around you.
• Interns do their own lines and labs for first 6 months. This is not to torture you but to make sure you are skilled so you can get the line in the trauma patient who really needs it.

Off Service:
• Simple—be where you are supposed to be all the time and give your best. You are an ambassador for yourself and for the residency.

Sick Call:
Available and reachable. Get paid for night and weekend sick call. Failure to be available and reachable is considered serious breech of professionalism and regardless of cause can result in extra assigned shifts and letter in file.

Dress Code:
ED—Scrub top and bottom—preferable the ones with your name on them. White coat optional. ALWAYS WITH VISIBLE HOSPITAL ID.
No t-shirt tops. Appropriate grooming and hygiene.

Self Care, Fitness for Duty
Is considered primary professional responsibility. This includes sleep before shifts, not arriving overtired or hung over, recognizing when you need rest; engaging in regular exercise and eating well as well as taking the appropriate breaks during shift.
Professionalism

- Dress/ personal hygiene
- Fit for duty
- Timeliness
- Food in the ED
- Travel before shifts—do not schedule your red-eye flight prior to your shift…
- Jitney time—do not rush out to catch the jitney. Patient care and thorough sign out comes first. This is NY. There are subways.
- Chart completion. Complete your charts at the end of every shift.
- Real Estate/housing: Be a good citizen. Pay your electric bill on time. Respect the real-estate staff.

Non-Negotiable

COMMUNICATION:
Always reachable during business hours. If you sign your beeper out to your phone, make sure you answer it. (PC, Risk management, PD…) Check your email every day and respond in a timely way to residency and administrative emails. It is impossible to run the program when communication fails.

Procedures:
Appropriate supervision for all procedures and document procedures in emstat or New-Innovations. This is non negotiable. You must keep an accurate track of your procedures.

Follow ups:
Routine follow up of your patients (see section on follow up) is a required part of training.

Travel
- Do not arrange travel such that you may be late for clinical responsibilities. Travel often involves delays. Plan your travel time to allow buffer time for unanticipated delays. Similarly don’t plan to travel on the red eye the night prior to clinical responsibility.

Drugs and Alcohol
- Recreational drug use is not condoned by the residency. Do not arrive to work hung over. Be mindful of alcohol use. As doctors we are not immune to substance abuse and addiction. There is help should this become a problem for
you. Treatment programs are available. Speak to the PD for more information. As residents you would be fully supported through the treatment process.

**Counseling services**

- Are available in and out of the hospital system. Many residents before you have availed themselves of counseling during the intensely stressful period of professional development which is residency. Speak to the PD if you think you may be interested in counseling.
Rotation Descriptions

EM-1 Rotations

July EM Didactic Course

Year: PGY-1

Duration: 2 weeks

Faculty Liaison: Tommy Wong, MD

Location: Roosevelt Hospital

Description:
This is an introductory two-week rotation for EM-1 residents. It consists of lectures, procedure labs, and courses given by our faculty on the essential topics of Emergency Medicine.

Goals, Objectives and Responsibilities:
Become acquainted with the EM faculty and fellow SLR residents
Re-introduction to basic EM principles and common chief complaints that include headache, chest pain, airway emergencies, trauma, obstetric and gynecologic issues
Learn aseptic technique in placing central venous access
Gain skills in basic procedures such as splinting and suturing
Become familiar with introductory ultrasound
Certification in ATLS
Learn EMSTAT, PACS and Prism
Become familiar with the “Rules of the Road” for EM Residents at SLR.

Schedule
The didactic portion will run generally from 8am to 5pm. Most days will consist of lectures in the morning and modules / procedure labs in the afternoon.
You are provided with the two-week lecture schedule on day one of the residency.

Tips
This first month can be overwhelming because the lectures cover a tremendous amount of material. Personal schedules are busy with moving-related issues. However, remember to relax, immerse yourself in the lectures, and enjoy getting to know your peers.

Useful texts
Rosen’s, Tintinalli, and Hardwood / Nuss.
Adult Emergency Department

Year: PGY-1

Duration: 4 weeks

Location: Roosevelt and St. Luke's

Faculty Liaison: Individual preceptor

Contact: EM chiefs siredchiefs@gmail.com, pager 3100

Goals and Objectives
As an EM-1 you will be taught and will be evaluated on competency in the following:

- Acquire the EM mindset and knowledge base by learning to evaluate patients with acute illness or injury of varying severity.
- Gain an efficient and appropriate complaint focused history, physical exam and work-up on all your patients.
- Generate and present succinct, clear, and appropriate differential diagnosis for your cases.
- Generate and present clear and appropriate work-up and management plans.
- Routinely utilize online and print resources in the ED to look up medical information regarding patients at hand in the ED to broaden your knowledge base.
- Gain procedural proficiency under direct supervision for basic ED procedures.
- Follow up on all lab results, EKGs, imaging tests and respond appropriately.
- Gain basic skills in appropriate, effective, and professional utilization of Consults.
- How will you accomplish these goals and objectives? You will present each case to faculty or a senior resident, who will guide you and give you feedback on your H&P and decision-making. Your faculty or senior resident will also instruct, guide and supervise you to the extent necessary for any indicated procedures.

Procedures/skills
See the procedure list required of EM Residents. (www.new-innov.com go to “RRC Required Procedures)
Be sure to document each ED procedure in EMSTAT and all off service and simulation or procedure lab procedures in New Innovations.

Schedule
A typical EM-1 schedule is 18 twelve-hour shifts / 28-day block. Day shifts begin at 7am, swing shifts begin at 11am; night shifts begin at 7pm. On Tuesday, Thursday, Friday and Saturday mornings at 7am, morning report (see section on morning reports) will take place until 7:30am. A sign-out round takes place with the change of staff. The arriving team will meet all the patients on the assigned team and review their ED course and status. Thoroughness is important. If any confusion exists regarding patient care plan, this is the time to ask and discuss them with the outgoing resident and attending.
These rounds are intended as an organizational tool to acquaint us with our patients and to pass on key medical information to further their care while in our emergency department.

Residents should take a 45-minute break during their shift. The time of each break is at the discretion of the EM3 or attending. This is usually a function of the ED volume and acuity.

You must work exactly the shifts you are assigned. If it becomes necessary to modify your schedule, you must notify the chief residents by e-mail (siredchiefs@gmail.com) of the proposed change and it must be approved in advance.

The chief residents must receive all requests in writing for days off, before they make the schedule for that block.

**Tips**

As an EM-1, don't be concerned about keeping the same pace as the EM-2's or 3's. Your job is to master the basics at a pace that is reasonable and educational for you. It is reasonable for an EM-1 to average one patient encounter per hour. Keeping the ED organized and moving patients through the system is a skill to be learned, but it is not a goal in your initial months. Use all the sources of information at your disposal, including textbooks, medical Internet sites, old charts, and conversations with private physicians. It is counterproductive to begin a complicated work-up during the last hour of a shift, unless the patient is emergent or a notification. Use the last half hour of your shift to tie up loose ends, i.e. checking labs, X-rays, CT's and calling in admission.

Take the time and effort to develop concise, complete sign-outs to the person relieving you, so that they will in turn provide quality patient care. Sign-outs should be succinct and specific. Expect and accept no less from the people you relieve.

One of the many advantages of the life of an EM resident is time. While it is advisable to spend some of this time, enjoying all NYC has to offer, an EM-1 goal should be to read 5 pages of Rosen's text per day.

**Pitfalls to avoid**

- Arrive on time for your shifts. Few things are more frustrating than delaying rounds to wait for a late person.
- Learn the names of all the ED staff including MD's, nurses, ED techs and clerks. Foster a good working relationship with them; teamwork is part of the fun.
- At Roosevelt, the residency office is GE45 near the discharge office. Access code to get in is 3-1-5. Computers, printer and lockers are available for use 24 hrs. At St. Luke's, the residency office is in the Fast Track part of the emergency department. The access code to get in is 5-2-4. These offices are for your use only, so please keep it clean or tidy. Do not expect others to pick up after you.
Pediatric Emergency Department

Year: PGY-1

Duration: 4 weeks

Location: St. Luke’s

Faculty liaison: Angela Tangredi, M.D.

Description
This is a rotation in the Pediatric ED seeing cases of varying acuity. Expect a high volume of patients with a wide array of pathology. You will see patients primarily and present them to an attending, who will guide you in their management.

Goals and Objectives
During your rotation in the pediatric emergency department, you will be taught and evaluated on the following areas:

- Become comfortable in the evaluation and management of acutely injured or sick infants, children and adolescents.
- Gain proficiency in the following skills and procedures in Pediatric patients:
  - Pediatric venous access, phlebotomy
  - Urinary bladder catheterization
  - Lumbar puncture
  - Pediatric sedation and analgesia
  - Laceration repair
  - Reduction of simple dislocations
  - Child Abuse evaluations
  - Endotracheal intubation
  - Demonstrate basic medical knowledge in the evaluation of common pediatric emergency department complaints.
  - Maintain a professional and compassionate relationship with patients and their families at all times.
  - Be familiar with assessment of pediatric vital signs
  - Learn essential concepts of pediatric resuscitation.

Schedule
(18) 12-hour shifts in the Peds ED. Shifts are 8am-8pm, 12pm-10pm, or 8pm-8am. Check with the chief residents the month before you rotate to get the schedule.

Useful texts
- Harriet Lane Manual, Barkin (EM Peds), Ludwig/Fleischer (EM Peds)
- Crain/Gershel, Clinical Manual of Emergency Pediatrics

Tips
- Wash hands often
• Take the time to build good relationship with parents as well as with patients.
• Be sure to complete online pediatrics modules during your month
• Pay attention to vital signs

Anesthesia with ENT/Ophthalmology component

Anesthesia Component

Year: PGY-1
Location: Roosevelt, 5th floor (O.R.)
Faculty Liaison: Jonathan Lesser, M.D., and Willie Cortes (anesthesia coordinator)
Duration: Two Weeks

Goals and Objectives (Anesthesia Component)
During your Anesthesia rotation you will be taught and evaluated on the following areas

Gain mastery in the following airway skills and knowledge
• endotracheal intubation
• bag-valve-mask ventilation
• indications and methods for NIPPV
• rescue airway techniques, such as LMA, elastic bougie and glidescope
• assessing airway and grading the difficulty of laryngoscopy based on anatomy
• medications used for sedation, analgesia, and paralysis during airway management

Schedule and details
• The day begins between 6:30 and 7am in the OR holding area, where you find your assigned room and/or patients for the day.
• Cases begin at 7:30am, Willie Cortes will typically assign you each day to an Anesthesia attending, but this may be flexible. You can consult with Willie as to the day’s schedule, which cases may need intubation, and if you are not assigned to a room- which cases you can join.
• You are responsible for filling out the pre-op checklist to assess pre-op risks and airway strategies, as well as putting in heplock (use 1cc of Lidocaine). Cases continue throughout the day, but often by mid to late afternoon there are no intubations pending.
• The anesthesia experience ends at 12pm each day and residents should then report to ENT on Thursday and Friday afternoons and Ophthalmology on Monday and Tuesday afternoons
• You will do at least one short case from beginning to end each day, except on Wednesdays when you will attend EM conference. You will make pre-op rounds with an Anesthesiologist at least once, to assess pre-op risks and intubation
strategies. Try to accompany the anesthesiology team on-call to all in-patient arrests or intubations.

- To the extent possible, learn regional techniques, such as nerve blocks used for the orthopedic procedures.

Tips
- Generally, we are not to intubate in rooms with first-year anesthesia residents, or in rooms where difficult intubation is anticipated.
- Try to find attendings working by themselves. Anesthesia residents tend to want intubations for themselves, especially at the beginning of the year.
- Having chosen a case, introduce yourself to the attending and resident. Participate in the pre-op evaluation and pre-induction preparation (IV's, monitoring, etc.) of the patient.
- Depending on the day, you may be able to circulate from room to room to maximize the number of intubations.
- It is essential that you use this opportunity to become comfortable with intubating in an elective and non-emergent basis.
- When you are done with your anesthesia rotation, the knowledge and confidence gained will serve you to provide timely and appropriate airway management to all who walk through the ED.

Pitfalls to avoid
- You will play a major role in determining the quality and quantity of your learning experience.
- You must take the initiative to make your availability known to staff. If you simply loiter in the O.R. corridors and surgeons' lounge, the cases will proceed without you.
- It is also frowned upon to zip into the room moments before the intubation, pass the tube, and leave.
- It is your responsibility to inform both the ED chiefs and the anesthesia department prior to any absences. As with all out-of-department rotations, you are expected to maintain the highest standards of professionalism at all times, and always to be where you are expected to be.

Expectations
It is mandatory that you read Ron Walls’ Manual of Emergency Airway Management. Copy of the text is available from Ericka.

ENT Component

Location: ENT Clinic at RH on Thursday and SL on Friday

Goals/Objectives and Procedures/skills
- Gain experience in the approach to ENT complaints
- Learn technique for thorough head and neck exam
- Gain skills in direct and indirect laryngoscopy
- Gain experience in the evaluation and control of epistaxis.
Schedule
The intern on the anesthesia rotation is expected to attend ENT clinic on Thursdays at RH (Winston) from 1:30p-4p and on Fridays at St. Luke’s (Clark 2 Area F) from 1p-4p.

Useful texts
Rosen, an ENT atlas

Ophthalmology Component

Location: Eye Clinic at RH on Monday and SL on Tuesday

Contact: Ericka Salas

Goals and Objectives:
- Become familiar with the architecture and pathology of the eye.
- Gain expertise in the evaluation and management of common eye complaints
- Become comfortable with the evaluation and management of severe eye conditions and injuries
- Practice fundoscopic examinations
- Learn to use the slit lamp
- Gain proficiency in ocular ultrasound.
- Gain proficiency in tonometry

Schedule
After your mornings in anesthesia, interns will report to ophthalmology clinic Monday at RH (Winston) from 1p-4p and Tuesday at SL (Stuyvesant 2 Area J) from 12:30p-5p.

Tips
- Dress well, scrubs are not appropriate. A tie or nice shirt for men and a blouse for women with a white coat will help you fit in and keep up the public image of the ED.
- Remember; you are a representative for the program. While the clinic is a high volume work area, you can both learn and be helpful to the ophthalmology residents. Introduce yourself; don’t be afraid to ask questions.

Useful texts

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Medical Intensive Care Unit

Year: PGY-1
Duration: 4 weeks
Location: St. Luke’s 7th floor
Faculty Liaison: Dr. Wong or Dr. Shapiro
Contacts: Internal Medicine chief residents and ICU fellow

Description
This rotation is an excellent opportunity to follow and manage critically ill patients with multi-system disease far beyond their time in the ED. You will learn that timely ED diagnosis and management often influences a patient’s progress and prognosis over subsequent days in the unit. Furthermore, you will see diseases unmasked and progress during their treatment in the MICU. To enhance education, you are expected to provide follow up to the ED resident and attending who initially evaluated the patient via email or conversation.

Goals and Objectives
During your MICU rotation you will be taught and evaluated on mastery of the following:

- Management of critically ill medical patients.
- Learn our institutional CRISP protocol (Early Goal Directed Therapy for Sepsis)
- Learn the principles of hemodynamic monitoring and vasopressor agents.
- Learn basic skills in the use of NIPPV, ventilator and fluid and electrolyte management
- Become confident in the following Procedures/skills
  - Arterial lines
  - Central lines
  - Paracentesis
  - Thoracentesis
  - Airway management
  - Cardiopulmonary resuscitation

Schedule and details
While on call in the MICU, you will respond to and participate in all medical codes that occur in the hospital. You will have your assigned patients, as well as those you admit while on call. Patients are admitted to MICU from the ED and the inpatient floors. If an intern’s workload becomes disproportionate, the resident in charge will redistribute the patients accordingly. Your daily responsibilities include rounding on your patients, writing progress notes, attending rounds, and scheduling and follow-up of all studies.

- Each morning, interns must review their patients’ course from the night before and develop assessment and plans prior to attending rounds which usually begin...
at 8am (each attending sets the time). In general, if you have 3 patients or less, begin your day at 7am. If you have more, you should probably start around 6am.

- Rounds often last until noon or beyond.
- Afternoons are spent writing progress notes, doing procedures, scheduling and following up studies.
- There are relatively brief work/sign-out rounds in late afternoon to bring the on-call team up to date on all the patients. Depending on the workload a typical day ends between 4 and 6pm.
- The on-call intern covers the unit, together with the resident, until the following morning at 8am, and during this time carries the code beeper and takes new admissions. The resident rotating through the MICU is excused from Wednesday morning EM conference.

Tips
- Write transfer notes/orders as a first priority, followed by progress notes.
- Get the paperwork done as early in the day as possible. Be proactive and volunteer to do as many procedures as possible.
- In general, intubations go to the fellows and central lines are up for grabs.
- Pay close attention to and ask questions about ventilator management. The fellows are fantastic and available for teaching.

Pitfalls to avoid
- The unit can be a psychologically and physically demanding rotation. Do not plan any major personal events during this rotation.

Useful texts, etc.
- "Facts and Formulas" booklet, (text and pocket version),
- Harrison's Marino: The ICU Book,
- Civetta's critical care

Obstetrics

Year: PGY-1

Duration: 3 weeks paired with one week US

Location: Roosevelt, 12th floor, L&D Suite

Contact: Roosevelt's Ob chief residents
(they rotate: see roster in L&D on-call room)

Description:
You will take care of patients at least 20 weeks pregnant and presenting with a variety of OB and medical problems, as well as patients in active labor. (whom you follow through delivery).

Goals and Objectives
• Gain experience doing normal vaginal deliveries (minimum is 10 deliveries; log in on New Innovations website)
• Learn to evaluate, diagnose and manage the pregnant patients’ medical and obstetrical complaints
• Recognize common gynecological infections and diseases
• Gain confidence and expertise in the following procedures/skills
  ■ Pelvic exam in both pregnant and non-pregnant women
  ■ Determination of onset and stage of labor
  ■ Determination of rupture of membranes, basic fetal monitoring
  ■ Normal vaginal delivery, and episiotomy performance and repair
  ■ Become proficient with ultrasound examination of the pregnant and non-pregnant patient

Schedule
• 3 weeks on L&D nights, Sunday through Thursday nights. The shift begins at 6pm and ends at 6am the next day. Show up at 6pm, pay attention to sign-out especially when they discuss triage patients. You are not required to stay for sign-out at 6am the next morning.
• If there are two EM interns on the same month, you each divide weeks of nights and days. You are expected to leave L&D at midnight on Tuesday night and be present for Wednesday conference.

Tips
• When on L&D, you are likely to deliver clinic patients, especially if they are multiparous.
• Pick them up when they initially present in the screening area (triage) and follow them through labor. Neither the patients nor staff appreciates your arriving on the scene at the last moment to do the delivery without having previously met the patient.
• Introduce yourself to private attendings and ask to observe their deliveries; more often than not, they will allow you to assist or actually do the deliveries yourself while they supervise.
• When not involved in deliveries you will be helping in triage, the screening area for pregnant patients greater than 20 weeks. Learn to take a focused history, perform U/S, speculum and vaginal exams.
• Become competent in assessing cervical dilation, effacement, and station because this is where you will get the most practice.

Useful texts
• Williams’ Obstetrics
Cardiac Care Unit

Year: PGY-1

Duration: 4 weeks

Location: St. Luke's (6th fl, Babcock Building)

Faculty Liaison: Dr. Clark, Dr. Herzog-CCU Director

Contacts: Cardiology Fellow

Description
During this rotation, you will learn to manage high risk acute coronary syndrome patients and understand the various medical, interventional, and surgical treatment options involved in optimizing the care of such patients. Emphasis will be placed on interpreting advanced EKGs and familiarizing yourself with the indicated medical therapy for acute coronary syndromes, dysrhythmias, shock, and cardiovascular infections.

Goals and Objectives - You will be taught and evaluated on the following areas

- Gain proficiency in reading ECG’s
- Gain expertise in the management of acute cardiac patients, coronary syndromes, heart failure and arrhythmias
- Learn management of post cardiac catheterization patients
- Become familiar with evaluation and treatment of cardiovascular infections
- Become familiar with cardiac pacing
- Become familiar with antidysrhythmic agents
- Gain proficiency in the following Procedures/skills
  - Advanced EKG and Echo interpretation
  - Central line placement
  - Critical care monitoring
  - Thrombolysis, and assessment of chest xrays

Schedule

- When you are working a day shift you will pre-round on your patients beginning at 7 or 8am depending on the number of patients you are carrying. During pre-rounds, you will review the overnight events, interventions, and changes in management of your patients from the previous day and write the CCU Intern Note.
• Attending rounds (usually beginning at 9am) follow pre-rounding. The remainder of the day is occupied with work rounds based on the desired management changes by the team (i.e.: line changes, phone calls, medical orders, and scheduling/following up on ordered studies). After work rounds, the team will often meet with the fellow to review ECGs, echos, or cath studies.

• If your work is complete after you meet with the fellow, you can sign out to the on-call team and leave (usually around 4pm).

• You will take call with an internal medicine PGY-2. During call you will respond to all the pages, admit any patient accepted by the CCU, and stay until the night team arrives at 9pm. Once you sign out to the night team, you may leave.

• In addition to your day shifts and call, you will partake in a night float system. During a night shift, you will arrive at the CCU at 9pm and take sign out from the call team. You will then take care of any management issue that arises during the night. If the night is quiet, you may use your time to read or nap in the call room until you are paged. You will then pre-round on your patients before attending rounds and leave after you present your patients during rounds (typically 10:30am).

Tips

• When you are on call, be sure to let the Fellow know you are interested in being called to the ED for acute critical patients. The ED consults the fellow when there is a patient who is critically unstable and/or is a candidate for thrombolytic therapy or emergent catheterization.

• When your workload permits, it is useful to evaluate the patient while they are still in the ED. This will give you a more complete and better understanding of the acute presentation and on-going cardiac disease process. Also, it is a good time to review and solidify ACLS algorithms.

• Make an effort to interpret as many ECG’s to the team as possible. The Socratic Method is the best way to become an expert at advanced ECG interpretation.

Useful texts

• Rosen, Marriott's ECG text,
• 12 Lead ECG, The Art of Interpretation. Garcia
• Harrison's (pocket version also)
• House Officer's Seriespocket book by J.W. Heger et. al.: Cardiology, ACLS text. Handbook of Coronary Care by Alpert Francis.
• ECGs for the Emergency Physician by Mattu.

EMS (Integrated within ED rotations)

Year: PGY-1

Location: SLR both sites, Pre-hospital Care Division
Faculty Liaison: Michael Redlener, M.D. Director of PHC, Resident Director of Prehospital Care & Chief Residents regarding schedule

Description
This rotation will provide you with an overview of how the largest emergency medical system in the world functions. All the activities are outside of the hospital and take place on the ALS and BLS ambulances operated by SLRHC. The rotation begins with a didactic session during the July orientation month, including 2 on-line courses in ICS, followed by 7 ride-alongs with the PHC staff at both sites. Additionally the resident will give one lecture to the EMS staff the PGY-2 year. There may be individual opportunities to participate in telemetry on an as available basis.

Goals and Objectives
- Develop a familiarity with and appreciation for EMS as part of the emergency medical healthcare system. Below are some resources we would like you to use to help you gain a better understanding of the role and scope of practice of the pre-hospital professional.
- Develop a basic understanding and appreciation of how this massive system works.
- Recognize the role of the physician within the pre-hospital setting.
- Become more familiar with EMS protocols and procedures.
- Discover whether you are interested enough in EMS to later pursue a fellowship.
- While on the ambulance, the resident is an observer. In Telemetry, you are encouraged to request being allowed on the phone or radio, this will provide online medical control skills.

Additional Information to Augment your EMS education
- The National Incident Management System (NIMS) – was established after 9/11 by Presidential Directive (Homeland Security PD5). These courses are designed to establish a baseline language and understanding among providers involved in providing care during disaster and mass casualty situations
  - Go to the above website and scroll down.
  - Complete course numbers IS-100.HC and IS-200.a (or 200.HCa which is found by clicking on ISP course list in upper right corner). This activity should take no more that 1-2 hours and will give you an understanding of the incident command system (ICS). When you complete these courses, print the FEMA certificate at the end and submit it to Ericka. You will have until August 15th to complete this activity.
- http://www.nycremsco.org/
  - This organization provides oversight through the REMAC to all providers and agencies in NYC. Go to the above website and on the left hand side, click on ALS protocols. These are the treatment protocols that govern what the paramedic can do and how they do it in the field. We would like...
you to browse through the treatment protocols for some of the conditions such as CHF, MI, respiratory distress, etc. to get an understanding of what the medic can and cannot do.

- [http://www.health.state.ny.us/nysdoh/ems/main.htm](http://www.health.state.ny.us/nysdoh/ems/main.htm)
  - This is the site for the State of New York DOH – Bureau of EMS. Please look at the NYS statewide BLS treatment protocols. Also under the education section, the Curricula for each of the levels of EMT certification can be reviewed. These curricula will help you understand the amount and type of training each level (EMT, Paramedic, etc.) is required to have.
  - This website also has links to listing of State certified specialty centers such as trauma centers designation and stroke center designation
  - [www.AAPCC.org](http://www.AAPCC.org)  Information about poison control centers

**Schedule**
EMS shifts will be integrated into your ED months in place of one ED shift for EM1’s.

**EMS Requirements by Year**

PGY-1 Requirements
- Attend Didactic sessions in July orientation
- Complete 8 EMS ride-along shifts (one BLS and 7 ALS)
- Complete the NIMS ICS courses by August 15th

PGY-2 Requirements
- Attend one administrative function with medical director, such as SLREMC disaster meeting, EMLG disaster meeting, NYC REMAC (EMS oversight committee), observation shift at NYC Telemetry Control, or attend a REMAC paramedic oral exam. The individual resident can decide what most interests them, and then schedule with the medical director. It is the resident’s responsibility to schedule this activity prior to completion of the PGY-2 year.
- In addition, you are expected to give a lecture to our EMS providers on a topic to be assigned by Dr. Redlener or the Resident Director of EMS. This lecture will be scheduled by the Resident Director of Pre-hospital Care or the Chief Residents and will precede a mid shift at some point during the year.

PGY-3 Requirements
- Attend one paramedic CME session, which is held every other Tuesday.

**Tips**
Use this time to become comfortable with the EMS protocols. During the ambulance calls do not try to take a leadership position. The crew is well trained and you are there to observe. Talk with the crew. Help carry equipment and you are sure to make a few
friends. This is an opportunity to get to know the paramedics and EMT’s you will be seeing again and again in the ED. In speaking with many of our PHC staff, and residents who have completed the rotation, the EMT’s and Paramedics really enjoy having you on the ambulance with them, and you will find it to be an enjoyable rotation as well.

Be advised that 100% attendance and appropriate attire is required. Any time missed will need to be made up. If you are going to be late, the unit will not wait for you, nor will they search the ED for you prior to returning to service after a call.

Directions
The units turn out of the ambulance bays at both sites.

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Useful texts
- Handout provided by Dr. Redlener
- Tintinalli section 1, chapter on pre-hospital care and disaster management
Orthopedics

Year: EM-1 and EM-2

Duration: 2 weeks EM-1 year and 2 weeks EM-2 year

Location: Roosevelt

Faculty Liaison: Orthopedic chief residents at Roosevelt

Description:
This rotation will ground you in basic principles of bone and soft tissue injuries. Responsibilities include evaluating orthopedic and hand cases in the ED and in clinic. You will also take call with the ortho chief and go to all ortho conferences/didactic sessions. Call averages 9 nights over 28 days, but the pattern is variable. It is expected that you will take call one weekend per rotation. You are not expected to cover floor patients or floor consults. However, you should scrub in to a few (probably two) short, ED applicable cases (like pinning a hip with a Richard's screw or applying external fixators to a Colles' fracture). While on call, you see all ortho or hand consults in the ED. This rotation is exceptional and focuses specifically on what EM residents need to know.

Goals and Objectives
- Become comfortable in the early management of common fractures, dislocations and sprains
- Become proficient in the following procedures/skills:
  - Immobilization techniques (splinting)
  - Reduction methods for various common dislocations and fractures
  - Regional anesthesia techniques, e.g. hematoma and nerve blocks.
  - Sedation and analgesia

Tips
- Make sure you forward beeper 8001 to yourself every morning at 7am so you will be called first for ortho and hand cases. Sign out to the resident on call at 5pm (unless it's you).
- Make sure you are available and ready to answer calls to the ED as soon as you are paged—that means you need to be close by when waiting for pages.
- The ortho office is on the second floor, between the chapel and the general surgery office. It is locked at all times; the key code for the door is 5132. Residents who live near the hospital have found it convenient to take call from home. Residents who do not live nearby have often found it useful to stay at a fellow resident's apartment, especially if the fellow resident is away for vacation or elective.

Residency Manual
July 1, 2013
• Make sure you dress formally for grand rounds (do not wear scrubs). Be aggressive; the ortho residents will let you do most procedures if you ask them. Clinic is a new experience for ED residents. Be sure to read the previous clinic notes for the diagnosis and care plan.

Useful texts

Schedule: Additional Requirements: **Check with your chief, as this schedule varies.
• Monday
  o 6:30-7am  X-ray rounds with chiefs and Dr. Unis (2nd fl ortho conf rm)
• Tuesday
  o 6:30-7am  Anatomy Rounds at CV Hand Center with cadavers
  o 7am-8am  Hand Surgery Conference
• Wednesday
  o 8am-1pm  EM conference
• Thursday
  o 8am-10am  Grand Rounds (alternating weeks at SL and RH)
  o 10am–4pm  Ortho clinic (Winston 2N)
• You also have the opportunity to attend private office hours at the CV Starr Hand Center. Ask the ortho chief resident or hand fellow for times. If you are on call the final weekend of the rotation your call must end at 9 pm to comply with duty hours for a shift on Monday.

Toxicology
Year: EM-1 and EM-2
Duration: 2 weeks EM-1 year, 2 weeks EM-2 year
Location: NYC Poison Center ground floor conference room. Dept. of Health, Bureau of Laboratories. 455 First Ave (Between 26th and 27th Streets)
Pager call with the St. Luke’s-Roosevelt Hospital Toxicology Consult service
Faculty liaison: Tod Bania, M.D. and Jason Chu, M.D.

Contact person: Lewis Nelson, M.D., Assoc. Medical Dir., NYC Poison Control Center

Goals and Objectives:
you will be taught and evaluated on the following
- Develop a working knowledge of the common toxidromes
- Gain familiarity with the most common toxic ingestions and exposures
- Demonstrate skills in the evaluation and management of ingestions and exposures

Schedule
- On Day 1 of the rotation, page the TOXX pager (8099 or 8699) and inform the toxicology attending on call that you are starting your toxicology rotation so they know who to contact. Then report to the Bellevue ED, adult side, at 8:15 am, and ask for morning report. At 9am, after morning report, go across the street to the Poison Control Center and ask for one of the Toxicology fellows. They will have a handout and all the information you will need for the rotation.
- This is high yield rotation. Daily attendance is mandatory except during Wednesday conference.
- General schedule:
  - This rotation will be a combined experience with the NYC Poison Control Center and inpatient toxicology consults with the St. Luke’s-Roosevelt Hospital Toxicology Consult service.
  - Weekdays, 8:15am - 4pm. You will spend the mornings making call-backs for cases that were called in to the Poison Center. There will be plenty of time to read about the cases, and then you present them to the Tox fellow on call. After lunch, there will be attending rounds during which the most interesting cases of the day are discussed.
  - Most Thursday mornings there is Journal Club, except for the first Thursday of every month, when there is a Consultants’ Conference at 2pm in the ground floor lecture hall.
  - Call with the SLR toxicologists:
    - The attending toxicologist will be the first call for the TOXX pager and will screen all the requests for consults. You are expected to be available by pager at all times during the rotation. On weekdays, while you are at the Poison Center between the hours of 8:15am – 4pm, you maybe paged about cases or expected to follow them after you leave the Poison Center.
    - You will be expected to be available to see cases in the ED up to 10pm during the weekdays. After 10pm and on one weekend of the block, you will be called to see cases that the attending toxicologist deems most important and interesting.
The attending toxicologist will make every effort to meet you in the ED or hospital ward to see the patient and review the cases with you. If the toxicologist is unable to make it to the hospital, then review the information, examine the patient and page him/her to discuss the case over the phone.

For active consults still in the hospital, you are expected to round on them daily and discuss care with toxicologist until the service has signed off on the case.

**Toxicology Presentation Requirement:**

- You will be expected to do a morning report based on a toxicology case or topic preferably based on a case you had at PCC or at SLR on the Tox Consultation service. The morning report should be reviewed with one of the toxicologists.

**Sick Call**

The Tox resident covers sick call. You are expected to be reachable by phone or page at all times as you may be called in to cover someone’s shift.

**Online Modules**

- We have been granted access to the John's Hopkins learning modules created by a former SLR resident and toxicologist.
- Go to [www.hopkinsilc.org](http://www.hopkinsilc.org) and register. (It is off to the left.)
- Use the following options:
  - ILC Group: Emergency Medicine Core Curriculum
  - User Group: SLR
- After registering, Andrew Stolbach will email you with your login.
- If there are issues with your login, please email Drs. Chu or Bania.
- The modules start with a short pretest of 5-10 questions then a series of objectives that start with a multiple choice question and a summary explaining the question. This is followed by a post-test. Please do these modules during your toxicology rotation.
  - The modules are:
    - acetaminophen
    - aspirin
    - antidepressants
    - toxic alcohols
    - carbon monoxide and methemoglobinemia
    - toxidromes
    - lithium
    - digoxin
    - antidiabetic medications
    - sympathomimetic poisoning
    - sedative-hypnotic poisoning
Tips

• To get to the Poison Center (455 First Ave, between 26th and 27th), you can take the 1, 2, 3, or 9 train to 42nd st, take the S shuttle to Grand Central, and then take the 6 train to 28th street. Alternatively, you can take the 1 or 9 and to 28th street and 7th Ave and walk cross-town.

• You can take the 1, 2 or 3 train to 34th Street and take the M34 bus to 1st Avenue or the M34A bus to 28th and 2nd Avenue.

• If you prefer a bus, you can take a cross-town bus and transfer to a downtown bus at 2nd Ave. Get off at the 26th St. stop.

• If you plan to drive, you need to pick up a parking pass from Vicki in the ECI (room 345 Bellevue Administration Building). If you drive, plan to get there early (by 7:45am) because the garage fills up very early.

Useful texts, etc.

• Goldfrank's; Ellenhorn/Barceloux; Gosselin.

• Poison Center Toxicology Review Book (Available from one of the Tox Fellows for $25, cash)
Ultrasound

Location: ED at SLRH

Faculty Liaison: Resa Lewiss, Ultrasound Division Director and Turan Saul, Fellowship Director.

Goals and Objectives

● Develop a basic understanding of ultrasound principles and techniques
● Develop proficiency in the performance and interpretation of emergency ultrasound examinations
● Achieve credentialing eligibility in Emergency Ultrasound
● Integrate emergency ultrasound in patient care decision making

Methods

Schedule

● The rotation will begin on Monday with an introduction to the physics and instrumentation of ultrasound. Wednesday, we have our division meeting at 1:00pm in room 1C32 at Roosevelt. We will review your scans; hold our monthly journal club http://www.slredultrasound.com/onlineresources.html.

● On Friday, the credentialing exams will be reviewed. Please start these early as they take some time to complete.

● The majority of your time will be spent doing hands-on scanning with the members of the ultrasound division. Time for independent scanning will be allotted.

● You will be presenting a 5-minute ultrasound case at the Wednesday conference following your rotation. There is a template and an example of a case on the website listed above.

● During your week with Ultrasound, you will serve as an integral member of the ultrasound division. This entails spending time in the ED performing as many ultrasound examinations as possible. You will help to review and interpret the examinations performed and recorded by everyone else in the department. These examinations and interpretations will be first reviewed with you and with the fellows for accuracy, and then subsequently with one of the ultrasound directors. Consequently, you will receive continual feedback on your image acquisition and interpretation skills.

● You are encouraged to participate in recruitment for the IRB approved ultrasound research projects.

Tips

You are expected to attend EM conference and Trauma Conference during this week

Useful Texts

● Heller & Jehle: Ultrasound in Emergency Medicine

Residency Manual
July 1, 2013
• MA & Mateer - Emergency Ultrasound
• Snoey & Simon - Ultrasound in Ambulatory Medicine

EM-2 Rotations

Adult Emergency Department

Location: Both sites

Duration: 4 weeks

Faculty Liaison: individual preceptors

Contact Person: EM chief residents

Description
See general description given above in the “Adult ED” section for EM-1’s.

Goals and Objectives
You will be taught and evaluated on achieving the following:
● Become more knowledgeable and proficient in EM
● Generate and work through complete differential diagnoses
● Become adept in independently initiating patient work-ups and disposition
● Demonstrate greater independence and less reliance on attendings and senior residents (although all cases will be presented to them)
● Develop efficient habits to expedite patient flow through the ED
● Acquire a sense of the big picture in the department
● The EM-2 is expected to learn to manage the emergent and critical patients on the team
● The EM-2 will manage all emergent airway procedures under the supervision of the EM-3 and attending
● Demonstrate mastery over principles of RSI and advanced airway management techniques

Procedures/skills
● The procedure list remains the same. The goal is to improve technique and efficiency, as well as acquire experience with less common procedures. Most importantly, EM-2 manages all emergent airways except in trauma cases. Trauma cases needing emergent intubation are managed by the EM-3 until January.
● From July 1st through December 31st the EM-2 manages all emergent airways except trauma airways which are managed by the EM-3. From January 1-June 31 the EM-2 manages all airways including trauma airways.

Schedule
EM-2 residents work an average of 183 hours per month, comprised of 9 and 12 hour shifts (9 hours on weekdays & 12 hours on weekends). Ideally, the schedule consists of
15 nine-hour shifts and 4 twelve-hour shifts. In extenuating circumstances, you may be required to work 12-hour shifts. Your schedule may be reviewed on www.whentowork.com

All shift trades must be approved in advance by the Chief Residents and must be in compliance with duty hour regulations.

**Tips**
(see ED in EM-1 section)
- Timely patient disposition becomes more important during the second year, particularly because EM-2 residents are expected to see many more patients than EM-1’s.
- When you make your differential and plan, always include patient disposition.
- If you become overwhelmed, remember that most patients can wait, and it is more important to complete workups than to pick up new patients.
- Importantly, re-read Ron Walls’ Manual of Emergency Airway Management prior to starting your ED months as an EM-2.
- You will need to pass the Airway Written and Practical (simulation) Exams prior to starting your EM-2 ED rotations in order to be credentialed to manage emergency airways in the ED.

**Pitfalls to avoid**
(see ED in EM-1 section) As you increase your patient load, be careful not to sacrifice patient care and your education for volume.

**Useful texts:**
Rosen, Roberts and Hedges, Tintinalli, Goldfrank, Walls.

**ED-AC Critical Care Rotation**

**Year:** EM-2 and EM-3

**Duration:** two 2 week rotations in EM-2 year and one 2 week rotation in EM-3 year.

**Location:** St. Luke’s

**Faculty Liaison:** Mark Clark, M.D., Janet Shapiro, M.D.

**Contact Person:** Medicine Chief Residents

**Description**
- Management of critical care patients is an important part of training in emergency medicine. The ED-AC rotation increases EM resident exposure to, and management of critically ill patients under the supervision of the critical care faculty at SLR
- The Med AC determines who will screen which patients. When assigned to a patient to screen, the ED-AC independently performs the screen and presents directly to the critical care fellow or attending. The ED-AC will continue to
manage the patient under the supervision/direction of the fellow or attending and be primarily responsible for the ongoing care of the patient until transition to the ICU team takes place. The ED-AC will keep the AC informed of all status decisions (i.e. screen in or screen out).

- While primary responsibility of the ED-AC will be to perform ICU screens and manage “screened in” patients in the ED and during their transition to the ICU, the ED-AC is encouraged to participate in other critical care activities such as assisting in any invasive procedures, i.e. ABG, central lines, paracentesis etc. In addition, if there are no screens called for, the ED-AC participates in rapid responses and follow-ups of screen outs as needed or requested by the AC. All activity of the ED-AC is done in collaboration with the AC.

- The ED-AC signs out screened patients to the ICU resident. At the end of the shift – 9am or 9pm, the ED-AC signs out any patients remaining in the ED to the incoming med-AC or ED-AC if one is coming on. For screen-outs, the ED-AC gives sign-out to the medicine team.

**Schedule:**

**Week One:**
- Mon 9a-9p
- Tues 9a-9p
- **Wed ED conference*** then 2p-9p
- Thurs 9a-9p
- Fri 9a-9p

**Week Two:**
- Sun 9p-9a
- Mon 9p-9a
- **Wed: ED conference*** then 9p-9a
- Thurs 9p-9a
- Friday 9p-9a

**Goals:**

- Critical Care is an integral part of training in emergency medicine and the ED physician must be an expert in all aspects of the care of the acutely ill and injured patients. The ED-AC Critical Care Rotation provides the opportunity for ED residents to gain expertise while functioning in a decision making capacity in the management of high acuity patients with a variety of acute and life-threatening presentations under the direct supervision and guidance of the critical care fellows and attending faculty. The ED residents will specifically gain valuable experience in the early management of these patients providing a relevant skill set for their future work as emergency physicians with critically ill and boarding ICU patients.
In contrast to ED rotations, the ED-AC critical care rotation allows the resident to remain engaged in the care of the sickest patients in the ED without being pulled away into the care of new ED patients.

Objectives

Patient Care
- Become familiar with the various modes of mechanical ventilation
- Understand the appropriate setting of ventilator modes in patients with respiratory failure
- Demonstrate skill in critical procedures including ongoing airway management, ventilator management and ultrasound guided central line placement
- Initiate appropriate diagnostic work up and management strategies for acutely decompensating patients

Medical Knowledge
- Understand hemodynamic parameters such as preload, afterload and contractility
- Know differential diagnosis of shock states and the diagnostic approach and treatment for each
- Understand the mechanism of action and appropriate use of vasopressors, inotropes and anti-hypertensive medications
- Understand pulmonary physiology including control and work of breathing and the determinants of oxygenation and ventilation
- Understand the differential diagnosis of respiratory failure
- Understand the causes, diagnosis and treatment of ARDS
- Understand the physiological effects of mechanical ventilation
- Understand essential renal physiology
- Know the differential diagnosis and initial evaluation and management of acute renal failure.
- Understand glucose control in the critically ill patient
- Know the differential diagnosis and treatment of severe anemia and thrombocytopenia
- Understand the acute critical care management of disease states typically encountered in the ED including: diabetic ketoacidosis, gastrointestinal bleeding, stroke syndromes, tachyarrhythmia’s, and toxic ingestions
- Understand sepsis and septic shock and be facile in early goal directed therapy

Practice Based Learning and Improvement
- Apply evidence based practices and current literature to support management decisions in the care of critical patients
- Identify areas for improvement and propose strategies to continually improve the quality of the care of critical patients

Interpersonal Communication Skills
- Demonstrate ideal compassionate and skillful communication with patients, their advocates and family members
● Demonstrate true collegiality with counterparts on the medical service and other services with whom interaction is required.
● Clearly communicate with supervising fellows and attending staff

Professionalism
● Develop compassionate and skillful communication with patients and families
● Demonstrate respectful care that elevates the dignity of every patient
● Demonstrate mindfulness of appropriate care interventions and knowledge of and respect for advanced directives.
● Demonstrate sensitivity and responsiveness to age, gender, cultural, sexual orientation and religious beliefs
● Understand and apply ethical principles of informed consent and patient confidentiality
● Understand end of life issues as they pertain to resuscitation status

Systems-Based Practice
● Utilize all consults services appropriately
● Utilize all hospital services as appropriate
● Utilize multidisciplinary services appropriately

Evaluations
● Each resident will receive feedback on a daily basis regarding overall performance and areas for improvement.
● Written evaluations based on successful performance of the above objectives will be provided through New Innovation by the supervising attending and physician.
● Residents with sub-standard performance will be notified early in the rotation and given specific suggestions and direct feedback for improvement

Trauma Surgery

Year:  EM-2
Duration:  4 weeks
Location:  R Adams Cowley Shock Trauma Center (STC),  University of Maryland, Baltimore.

Faculty Liaison:  Mark Clark, M.D. EM Residency Director

Description
SLR EM residents rotate at the R Adams Cowley STC and the state of Maryland’s premier Resuscitation and neuro-trauma Center for 4 weeks. This rotation is designed to complement the exposure to trauma SLR residents receive throughout their training by providing a focused high acuity exposure to multi-trauma patients as integral members of the resuscitation team for the major air and ground receiving hospital for the entire state of Maryland and surrounding environs. This rotation is comprised of
initial management of complex multi-system trauma and neurological injuries and then their continued management in the SICU setting.

Goals and Objectives

- Gather comprehensive and multi-source and accurate information about patients for the initial work-up and evaluations.
- Gain exposure to the emergent evaluation, stabilization and ongoing management of the multi-trauma patient under direct supervision of career traumatologists.
- Become experienced in trauma procedures and protocols including:
  - Tube thoracostomy
  - Central venous access
  - EFAST ultrasound exam for trauma
  - Massive transfusion protocol
  - Open thoracostomy
  - Cricothyrotomy
  - Escharatomy
- Under the guidance of the trauma fellow and attending make informed decisions about diagnostic and therapeutic interventions based on sound evidence based practice and clinical judgment.
- Work closely with other healthcare professionals including those from other disciplines (anesthesia, orthopedics, neurosurgery, nurses to provide patient focused and optimum outcome driven care.
- Ensure that the needs of the patient and team supersede individual preferences.
- Become facile in the primary and secondary trauma surveys.
- Understand and apply proper levels of monitoring
- Provide excellent wound care
- Participate in pre and post operative management of trauma patients
- Understand epidemiology and major trauma mechanisms in children and adults.
- Understand the organization of trauma systems.
- Demonstrate knowledge of types and mechanisms of airway injury signs, symptoms and management of airway compromise and obstruction.
- Appropriately diagnose and manage flail chest, pneumothorax, aspiration.
- Expertly diagnose and manage all forms of shock.
- Understand sequelae of massive transfusion.
- Perform thorough neuro assessment.
- Understand types of brain injury and their management including all forms of ICH and diffuse axonal injury. Understand and prevent secondary brain injury.
- Be knowledgeable in the types of spinal cord injury and their acute management.
- Become familiar with the evaluation and acute management of abdominal, GU and pelvic trauma
- Gain exposure to the acute management of all types of extremity and vascular trauma.

Neonatal Intensive Care Unit
Year: EM-2

Duration: 2 weeks

Location: NICU Roosevelt Hospital 12th Floor

Faculty Liaison: Janice Klein, M.D. Associate Director, Division of Neonatology, Mark Clark, M.D. EM Residency Director

Description:
This is a rotation based in the Neonatal ICU and the Labor and delivery Unit. Emergency Medicine Residents will gain exposure to the assessment and management of neonates by attending high-risk deliveries in L&D and participating in rounds and ongoing care of neonates with the fellows and attending faculty in the NICU.

Expectations, Goals and Objectives:
- Attend morning NICU rounds daily with NICU team
- Attend high risk deliveries and resuscitations with Neonatal Attending or Fellow
- Participate in ongoing care neonates under direction of NICU Attending/Fellow
- Gain experience in delivery room care of neonates
- Become familiar with neonatal transitional physiology and potential complications
- Know the assessment and management of complications of prematurity
- Recognize and provide emergency care of morbidity in the first month of life. (including respiratory distress with and without cyanosis, shock, endocrine disorders and neurological emergencies.)
- Understand the physiology and management of respiratory disorders in the newborn (including hyaline membrane disease, RDS, apnea of prematurity, meconium aspiration, pulmonary hypertension, and BPD (bronchopulmonary dysplasia)).
- When applicable gain exposure to procedures in pediatric patients.

Schedule
- Monday- Friday 8am-6pm -- (exception—on Wednesdays residents will attend Emergency Medicine weekly conference on Wed from 8-1 and report to NICU at 1:45 pm.)
- The EM resident will spend the 1st week on L&D. They will attend deliveries, participate in resuscitation, review maternal history, examine newborn infants, write notes and orders with the supervision and guidance of the Pediatric Hospitalist and/or Neonatologist.
- The EM resident will spend the 2nd week in the NICU. They will review maternal history, examine patients, gather lab data, perform basic procedures, present on rounds, write orders and notes with the supervision and guidance of the Pediatric Hospitalist and/or Neonatologist.
- Perinatal Conference Wed 1pm, Pediatrics Grand Rounds Friday 8 am, Multidisciplinary Rounds Tuesday 2:30 pm.

Pediatric Emergency Department (EM-2)
Year: PGY-2

Duration: 4 weeks

Location: St. Luke's

Contact person: EM Chief Residents

Description
This rotation is in the St. Luke's Pediatric ED. There is usually a high volume of patients with a wide array of pathology. You will see patients and present directly to the attending, who will guide you in management.

Goals and Objectives: you will be taught and evaluated on the following
- Gain mastery in the initial evaluation and management of acutely injured or sick infants, children and adolescents
- Learn and demonstrate skills in the evaluation and management of the pediatric airway
- Demonstrate familiarity in the interpretation of pediatric vital signs
- Become proficient in the evaluation and management of common ED pediatric complaints
- Become proficient in the following procedural skills:
  ■ Pediatric venous access, phlebotomy
  ■ Urinary bladder catheterization
  ■ Lumbar puncture
  ■ Pediatric sedation and analgesia
  ■ Wound management
  ■ Reduction of simple dislocations

Schedule
See Peds E.D. in EM-1 section of manual; 17 twelve-hour shifts per block.

Useful texts, etc.
- Harriet Lane Manual, Barkin (EM Peds), Ludwig/Fleischer (EM Peds)

EM-2 Off-Service Rotations

Orthopedics

Year: PGY-2

Location: Roosevelt

Duration: 2 weeks

Faculty Liaison: Orthopedic chief residents at Roosevelt
Description

EM residents rotate on the orthopedic service for two weeks in the EM-1 year and 2 weeks in the EM-2 year. This is an ED based rotation—designed to focus on the skills you will need most as an emergency physician. You will be first call to all ER orthopedic cases which you will evaluate and manage under the direction of the orthopedic senior residents. This rotation will ground you in basic principles of bone and soft tissue injuries. Responsibilities include evaluating orthopedic and hand cases in the ED and in clinic. You will also take call with the ortho chief and go to all ortho conferences/didactic sessions. Call averages 9 nights over 28 days, but the pattern is variable. It is expected that you will take call one weekend per two week rotation. You are not expected to cover floor patients or floor consults. However, you should scrub in to a few (probably two) short, ED applicable cases (like pinning a hip with a Richard's screw or applying external fixators to a Colles' fracture). While on call, you see all ortho or hand consults in the ED. This rotation is exceptional and focuses specifically on what EM residents need to know.

Goals and Objectives

- Become comfortable in the early management of common fractures, dislocations and sprains
- Become proficient in the following procedures/skills:
  - Immobilization techniques (splinting)
  - Reduction methods for various common dislocations and fractures
  - Regional anesthesia techniques, e.g. hematoma and nerve blocks.
  - Sedation and analgesia

Tips

- Make sure you forward beeper 8001 to yourself every morning at 7am so you will be called first for ortho and hand cases. Sign out to the resident on call at 5pm (unless it's you).
- The ortho office is on the second floor, between the chapel and the general surgery office. It is locked at all times; the key code for the door is 5132. Residents who live near the hospital have found it convenient to take call from home. Residents who do not live nearby have often found it useful to stay at a fellow resident's apartment, especially if the fellow resident is away for vacation or elective.
- Make sure you dress formally for grand rounds (do not wear scrubs). Be aggressive; the ortho residents will let you do most procedures if you ask them. Clinic is a new experience for ED residents. Be sure to read the previous clinic notes for the diagnosis and care plan.

Useful texts

- Wheelelessonline.com (excellent online orthopedic textbook)
- Emergency Orthopedics, The Extremities.

Residency Manual
July 1, 2013
- Raby's Accident and Emergency Radiology.
- Rosen's.
- Hoppenfeld's Physical Examination of the Spine and Extremities.
- Rockwood and Green is the orthopedists' bible.
- The Hand Examination and Diagnosis, American Society for Surgery of the Hand
- The Hand: Primary Care of Common Problems, American Society for Surgery of the Hand

**Schedule: Additional Requirements:** **Check with your chief, as this schedule varies.**

<table>
<thead>
<tr>
<th>Orthopedic Conference and Clinic Schedule</th>
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<tr>
<td><strong>6:30-7:00 am</strong></td>
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<td><strong>Monday</strong></td>
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<td><strong>Tuesday</strong></td>
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<td><strong>Wednesday</strong></td>
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<td><strong>Thursday</strong></td>
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- You also have the opportunity to attend private office hours at the CV Starr Hand Center. Ask the ortho chief resident or hand fellow for times

**Toxicology (4 Weeks – 2 weeks in intern year, 2 weeks in pgy-2 year paired with Sick Call)**
Year: EM-1 2 weeks and EM-2 2 weeks

Location: NYC Poison Center ground floor conference room. Dept. of Health, Bureau of Laboratories. 455 First Ave (Between 26th and 27th Streets)

Pager call with the St. Luke’s-Roosevelt Hospital Toxicology Consult service

Faculty liaison: Tod Bania, M.D. and Jason Chu, M.D.

Contact person: Lewis Nelson, M.D., Assoc. Medical Dir., NYC Poison Control Center

Goals and Objectives: you will be taught and evaluated on the following
- Develop a working knowledge of the common toxidromes
- Gain familiarity with the most common toxic ingestions and exposures
- Demonstrate skills in the evaluation and management of ingestions and exposures

Schedule
- On Day 1 of the rotation, page the TOXX pager (8099 or 8699) and inform the toxicology attending on call that you are starting your toxicology rotation so they know who to contact. Then report to the Bellevue ED, adult side, at 8:15 am, and ask for morning report. At 9am, after morning report, go across the street to the Poison Control Center and ask for one of the Toxicology fellows. They will have a handout and all the information you will need for the rotation.
- This is high yield rotation. Daily attendance is mandatory except during Wednesday conference.

- General schedule:
  - This rotation will be a combined experience with the NYC Poison Control Center and inpatient toxicology consults with the St. Luke’s-Roosevelt Hospital Toxicology Consult service.
  - Weekdays, 8:15am - 4pm. You will spend the mornings making call-backs for cases that were called in to the Poison Center. There will be plenty of time to read about the cases, and then you present them to the Tox fellow on call. After lunch, there will be attending rounds during which the most interesting cases of the day are discussed.
  - Most Thursday mornings there is Journal Club, except for the first Thursday of every month, when there is a Consultants’ Conference at 2pm in the ground floor lecture hall.

- Call with the SLR toxicologists:
  - The attending toxicologist will be the first call for the TOXX pager and will screen all the requests for consults. You are expected to be available by pager at all times during the rotation. On weekdays, while you are at the Poison Center between the hours of 8:15am – 4pm, you maybe paged about cases or expected to follow them after you leave the Poison Center.
You will be expected to be available to see cases in the ED up to 10pm during the weekdays. After 10pm and on one weekend of the block, you will be called to see cases that the attending toxicologist deems most important and interesting.

The attending toxicologist will make every effort to meet you in the ED or hospital ward to see the patient and review the cases with you. If the toxicologist is unable to make it to the hospital, then review the information, examine the patient and page him/her to discuss the case over the phone.

For active consults still in the hospital, you are expected to round on them daily and discuss care with toxicologist until the service has signed off on the case.

**Toxicology Presentation Requirement:**
- You will be expected to do a morning report based on a toxicology case or topic preferably based on a case you had at PCC or at SLR on the Tox Consultation service. The morning report should be reviewed with one of the toxicologists.

**Sick Call**
The Tox resident covers sick call. You are expected to be reachable by phone or page at all times as you may be called in to cover someone’s shift.

**Online Modules**
- We have been granted access to the John’s Hopkins learning modules created by a former SLR resident and toxicologist. It is expected that every resident will complete these modules during their toxicology rotation.
  - Go to [www.hopkinsilc.org](http://www.hopkinsilc.org) and register. (It is off to the left.)
  - Use the following options:
    - ILC Group: Emergency Medicine Core Curriculum
    - User Group: SLR
  - After registering, Andrew Stolbach will email you with your login.
  - If there are issues with your login, please email Drs. Chu or Bania.
  - The modules start with a short pretest of 5-10 questions then a series of objectives that start with a multiple choice question and a summary explaining the question. This is followed by a post-test. Please do these modules during your toxicology rotation.
    - The modules are:
      - acetaminophen
      - aspirin
      - antidepressants
      - toxic alcohols
      - Carbon Monoxide and Methemoglobinemia
      - toxidromes
      - lithium
      - digoxin
• Antidiabetic Medications
• Sympathomimetic Poisoning
• Sedative-Hypnotic Poisoning

Tips
• To get to the Poison Center (455 First Ave, between 26th and 27th), you can take the 1, 2, 3, or 9 train to 42nd st, take the S shuttle to Grand Central, and then take the 6 train to 28th street. Alternatively, you can take the 1 or 9 and to 28th street and 7th Ave and walk cross-town.
• If you prefer a bus, you can take a cross-town bus and transfer to a downtown bus at 2nd Ave. Get off at the 26th St. stop.
• If you plan to drive, you need to pick up a parking pass from Vicki in the ECI (room 345 Bellevue Administration Building). If you drive, plan to get there early (by 7:45am) because the garage fills up very early.

Useful texts, etc.
• Goldfrank's; Ellenhorn/Barceloux; Gosselin.
• Poison Center Toxicology Review Book (Available from one of the Tox Fellows for $25, cash)

Ultrasound

Year: EM-2
Duration: 1 week EM-1, 1 week EM-2
Location: Emergency Department at SLRH
Faculty Liaison: Resa Lewiss, M.D., RDMS and Turan Saul, M.D., RDMS

Goals and Objectives
● Develop a basic understanding of ultrasound principles and techniques
● Develop proficiency in the performance and interpretation of emergency ultrasound examinations
● Achieve credentialing eligibility in Emergency Ultrasound
● Integrate emergency ultrasound in patient care decision making

Methods

Schedule:
● The rotation will begin on Monday with an introduction to the physics and instrumentation of ultrasound. Wednesday, we have our division meeting at 1:00pm in room 1C32 at Roosevelt. We will review your scans; hold our monthly journal club http://www.siredultrasound.com/linereresources.html.
On Friday, the credentialing exams will be reviewed. Please start these early as they take some time to complete.

The majority of your time will be spent doing hands-on scanning with the members of the ultrasound division. Time for independent scanning will be allotted.

You will be presenting a 5-minute ultrasound case at the Wednesday conference following your rotation. There is a template and an example of a case on the website listed above.

During your week with Ultrasound, you will serve as an integral member of the ultrasound division. This entails spending time in the ED performing as many ultrasound examinations as possible. You will help to review and interpret the examinations performed and recorded by everyone else in the department. These examinations and interpretations will be first reviewed with you and with the fellows for accuracy, and then subsequently with one of the ultrasound directors. Consequently, you will receive continual feedback on your image acquisition and interpretation skills.

You are encouraged to participate in recruitment for the IRB approved ultrasound research projects.

Tips
You are expected to attend EM conference and Trauma Conference during this week

Useful Texts
- Heller & Jehle: Ultrasound in Emergency Medicine
- MA & Mateer - Emergency Ultrasound
- Snoey & Simon - Ultrasound in Ambulatory Medicine

EM-3 Rotations

Adult Emergency Department

Year: EM-3

Duration: 4 weeks

Location: Both sites

Faculty Liaison: Individual preceptors

Contact Persons: EM chief residents

Goals and Objectives: You will be taught and evaluated on the following
- The EM-3 resident is responsible for the overall management of the Red Team at both the St. Luke’s and Roosevelt sites.
- The EM-3 is informed for each notification and is expected to direct each and
every resuscitation under the supervision of the attending.

- Primary review of EKG’s—and signing off on EKG’s.
- Provide clinical supervision for junior staff and med students.
- Supervise overall ED patient flow and deal with problems in decision-making.
- Evaluate C-spine clearance of board and collared patients.
- Foster a working relationship with nursing and pre-hospital care personnel.
- Prepare case-based morning reports every Tuesday, Thursday, Friday, and Saturday mornings.

**Schedule**

170hrs per 4-week block divided between 9-hour shifts on the Weekdays, and 12 hours on Weekend.

**Pediatric Emergency Department**

**Year:** PGY-3

**Location:** St. Luke’s

**Faculty Liaison:** EM Chief Residents

**Description**

This rotation is in the St. Luke’s Pediatric ED. There is usually a high volume of patients with a wide array of pathology. You will see patients and present directly to the attending, who will guide you in management.

**Goals and Objectives**

You will be taught and evaluated on your proficiency in the following:

- Gain mastery in the initial evaluation and management of acutely injured or sick infants, children and adolescents.
- Learn and demonstrate skills in the evaluation and management of the pediatric airway.
- Demonstrate familiarity in the interpretation of pediatric vital signs.
- Become proficient in the evaluation and management of common ED pediatric complaints.
- Become proficient in the following procedural skills:
  - Pediatric venous access, phlebotomy
  - Urinary bladder catheterization
  - Lumbar puncture
  - Pediatric sedation and analgesia
  - Wound management
  - Reduction of simple dislocations

**Schedule**

EM-3 residents will work 1 shift per block while they are assigned to their ED months.

**Useful texts**
Research

Year: EM-3

Duration: 2 weeks while also covering sick call

Location: Both hospital sites

Faculty Liaison: Tod Bania, M.D.

Description

- The Department of emergency medicine is committed to scholarly activity and encourages all residents to participate in research. Participation in research or some other meaningful form of scholarly activity is a requirement for graduation from the program. It is best to start this process early with your preceptor or another member of the faculty. Residents who have not completed this requirement by the end of senior year will not be eligible for graduation and will not be cleared to sit for the EM certification exam.

- The scholarly activity may take many forms. You may wish to work with a faculty member on an ongoing project. You may prefer to write up a case report or a chapter for a textbook, or a review of literature on a particular topic. Alternatively, you may wish to conduct an original project of your own, either retrospective or prospective. Any of these are acceptable. Many residents decided to join research projects that are already established within the department. This is fine, but participation must be substantial enough to merit authorship on written work that results from the project. Conducting an original prospective investigation is ambitious, and can be done, but requires careful planning and dedication to the process.

- The department encourages collaboration among residents, faculty, and other services in the performance of research projects. This generally leads to more successful work, a higher rate of completion, and greater likelihood of writing up results for presentation and publication.

- Organizing the research project, including a literature search, should begin in the internship and finish during the first half of the EM-2 year. Do not wait until your allotted research time in this year to begin. Use that time, instead, to complete writing up your proposal, or performing the actual study. The block of research time in the EM-3 year should be used for final data analysis, writing, and preparation for submission or presentation.

- Residents with established projects or a special interest in research may devote their time in the EM-2 year to do this research. If you cannot develop an idea/project by December of the EM-2 year, Drs. Bania/Clark will assign you to participate with a faculty member in one of his/hers projects.
• All resident scholarly activity must have a faculty advisor. The research directors must approve all projects, including resident/attending collaborations, before you begin.
• Ample hardware and software support is available to you. Residents have full access to the department's word processing, spreadsheet, database, statistics, and graphics presentation programs. Statistician assistance is available through Dr. Bania.
• The research time is designed to expose residents to the techniques and skills needed to produce scholarly activity. It aims to teach the basics of hypothesis generation, study design, data collection and analysis, and medical writing. Residents with a specific interest in a research career should consider fellowship training, or an additional degree (e.g., MPH or MSc).
• Residents are strongly encouraged to prepare work for submission to national meetings, such as SAEM and ACEP. Departmental funding is provided to residents to attend a national meeting if a poster/oral presentation is accepted.

Goals and Objectives
During research time, the resident will learn:
• How to read the medical literature critically
• How to conduct a literature review
• Concepts of study design, data collection
• Basic methods of data analysis, including descriptive statistics
• Learn the basics of spreadsheet, database, and statistical software
• Statistical inference techniques in hypothesis testing
• How to prepare a research project for oral and written presentation at national meetings
• How to write a medical paper
• Principles of ethics and law governing medical research

Schedule
EM-3's will be assigned to present a journal club their senior year. The journal club topic may, perhaps should, pertain to the resident's research interest. The EM-3 must contact one of the faculty liaisons the week prior to your assigned research week to establish a plan for a productive and educational week.

Suggested Timeline
Formulate research hypothesis and obtain faculty mentor EM-1: August
Meet with research director EM-1: June
Complete comprehensive literature review EM-2: August
Initial draft of data collection instrument EM-2: August
Prepare IRB proposal (if necessary) EM-2: September
Present project at research conference EM-2: September
Submit IRB proposal EM-2: mid-October
Submit project implementation plan and meet with Faculty mentor and research coordinator to develop data management plan
Implement project after IRB approval
Complete review article (if applicable)
Data analysis and SAEM abstract preparation
Present abstract at regional SAEM (if applicable)
Prepare publishable quality manuscript
Present abstract at national SAEM (if applicable)
Present research at departmental conference

Tips
Prepare in advance. Decide early the type of project you’d like to do (retrospective study, case report, prospective project, collaborate with an attending, etc.)
Know in advance what help you will need, and where to get it. Most attendings can and should mentor research projects.

Pitfalls to avoid
Formulate plans early! Begin in the EM-1 year. Follow the timeline closely if you want to do an independent project. Don’t panic. The department wants you to succeed.

Continuous Quality Improvement (CQI)

Year: EM-3
Duration: 2 Weeks paired with research rotation
Faculty Liaison: Mark Clark, Jeff Rabrich

Description
During the EM-3 year, each resident will takes part in a the review of a QI case. Quality improvement is a critical part of the practice of emergency medicine. The review of adverse outcomes in patient care, and system-wide problems that can affect patient care are critical to the improvement of the clinical practice of emergency medicine. In order to gain exposure to the process of QI in our own department, each EM-3 resident is assigned to be part of this committee for one month during the year.
Participation in the CQI process is a requirement by the RRC and is a strict requirement for graduation from the SLR EM residency program. Residents who have not met this requirement will not be eligible to graduate or to sit for the EM certification boards.

Objectives
- To gain an understanding of the CQI process in the department of emergency medicine.
- To understand the mechanics of running an ED and how the department is responsible for reporting multiple different statistics each month to both the hospital as well as regulatory agencies.
• To gain an in depth experience relating to the core competency “Practice-based learning and improvement.”
  o Specifically, understand the critical appraisal of a case forwarded to the committee involving either morbidity or mortality
  o Understand problems in patient care
  o Evaluate the available evidence regarding the case or systems issue
  o Make recommendations for improvement or education regarding the topics raised in the case
• To have a graded responsibility as a member of the CQI committee that includes interviewing residents and attendings involved in the case under review. This process will give further development of the core competencies related to patient care, medical knowledge and professionalism.

Details of the experience
• Each EM-3 resident is scheduled to be a part of the CQI committee. (see Appendix for schedule for 20013-2014)
• The administrative leadership (site medical directors) will select a case for the resident to review. Working in conjunction with and under the supervision of one of the faculty members on the CQI committee, the resident investigates the case. This involves a comprehensive review of the written medical record and interviews with all providers involved in the care of the patient.
• After completion of the case review, the resident will write-up the case summary used as part of the CQI process in the department.
• The resident attends the monthly CQI meeting (third Friday of the month at 10:15 AM). At this meeting he/she will see all aspects of the department CQI process. Additionally, the resident presents their case to the committee.
• In the weekly resident conference, the resident then present the case in the format of an M&M to the faculty and residents at that meeting and answers any questions related to the case from the audience.
• The resident is expected to follow up on any feedback from either the CQI meeting or the M&M conference and incorporate feedback into departmental recommendation for policy changes to improve care of patients in the future. This is done n coordination with the administrative leadership of the department. Not all cases will lead to policy or other changes but the resident should be focused on looking for positive changes that are possible based on lessons learned from their case. Whether or not changes are implemented, all case write-ups should conclude with recommendations to improve process in the future.

The process--details
• Rotators should expect it to take an average of 5 hours to review and prepare a case for CQI.
• Cases for review are identified in several ways through reports and filters we have created to monitor high risk areas and find cases with potential problems. One of these areas is cases with 24/48 hour returns. The returns are identified by the associate medical director at each site (Dr. Lee / Dr. Quaas) by reviewing the return report which is available by the 5th of the month. The residents assigned to
CQI should contact the associate medical directors if they have not received a case by the first Friday of the month they are assigned so they can be assigned a case for review.

How to review a case

- Read the EMSTAT and EMSTAT MD charts, obtain and review pertinent other documents such as EKG, imaging, consultant notes, ME reports, etc. Review the inpatient chart if relevant to the case. Write up a thorough summary of events / timeline.
- Meet with your mentor for the rotation (Dr. Lee/ Dr. Quaas) to identify what the issues are with the case and questions that need to be answered. You should work in advance and be prepared at the time of the meeting to address the following:
  - What essential information is absent from the chart that needs to be obtained or clarified when interviewing the physicians and nurses?
  - Is this purely a physician issues or are there nursing issues as well? Do we need the nurse manager involved to review the case or to interview nurses?
  - Are there other services involved that need to be queried or notified?
  - What are the systems issues, if any?
  - Identify the standard of care through a literature search if necessary
- Interview the involved physicians regarding the case. This should be done with your mentor if possible. RN interviews, if needed, will be done by the nursing leadership. You should speak with the nurse manager after those interviews are conducted.
- Write up a draft case review using the template you will be provided. This draft should be prepared by the Monday of the week of the CQI meeting, so you can review it with the responsible associate director. The draft will include a narrative summary of the case, then you will list your findings (not a summary of what happened). The findings are concrete issues that are identified (e.g., “the patient did not have a rectal temp obtained as per departmental policy for abdominal pain”). With the help of your mentor you will list the severity code and actions to be taken.

CQI Meeting and Departmental M&M Conference

- The CQI meeting is held on the third Friday of the month at 10:15am in Conference room D, 4th floor Muhlenberg at St. Luke’s. You are required to attend the meeting. At the meeting we first review the metrics for the month which include numerous data points and quality indicators that we evaluate on an ongoing basis. After the data is reviewed, we move on to cases for the month. You will present your case write up to the committee for discussion, modify it as the committee directs and submit a final version to the responsible associate director.
If your case is picked to be presented at departmental M&M, you should be prepared to discuss it at conference, but it is not essential if you are not available for that conference.

Any issues regarding the rotation should be directed to Drs. Clark or Rabrich. If the associate Medical directors do not have a case for you to review, you should contact Dr. Rabrich or Dr. Carey to help identify a case for you.

**EM-2/3 Electives**

You have one, 4-week elective to pursue personal interests here or at another hospital during the PGY-3 year.

**SLR options for elective**

**Ophthalmology**

*Location: St. Luke’s Ophthalmology Clinic. (Ask the guard at the entrance for directions)*

*Faculty Liaison: Mark Clark*

**Goals and Objectives**

- The primary goal of the rotation is to become skilled in slit lamp exams
- Familiarize yourself with the architecture as well as pathology of the eye
- Gain expertise in the evaluation and management of common eye complaints
- Become comfortable with the evaluation and management of severe eye conditions and injuries
- Gain skills in the following procedures
  - Working knowledge and familiarity with the slit lamp
  - Dilated fundoscopic exam
  - Tonometry

**Schedule**

The workweek is Monday through Friday, with weekends and nights off. The day begins at 9am, and usually lasts through the early afternoon. Each resident is expected to join in patient exams, be well read, and stay for the majority of clinic time.

**Tips**

Dress well, scrubs are not appropriate. A tie or nice shirt for men and a blouse for women & white coat will help you fit in and keep up the public image of the ED. Remember; you are a representative for the program. While the clinic is a high volume work area.

Introduce yourself; don't be afraid to ask questions.

**Useful texts**

Location: Roosevelt and St. Luke's ENT clinics

Contact Person: ENT Faculty

Goals/Objectives and Procedures/skills
- Gain experience in the approach to ENT complaints
- Gain skills in direct and indirect laryngoscopy
- Learn technique for thorough head and neck exam
- Gain experience in the evaluation and control of epistaxis

Schedule
ENT clinics meet at the Roosevelt Site on Thursday afternoons, beginning at 1:30pm in the first floor clinic space, and on Tuesday morning 9am-12pm, and Friday at St Luke's (all-day), in the Clark 2 clinic area. These clinics typically end at approximately 5pm. During this elective you are expected to attend every EM conference, Trauma conference, and Journal Club.

Useful texts
Rosen, an ENT atlas

Radiology

Location: St Luke's Clark 3 reading room and SL ED radiology room

Faculty Liaison: Dr. Baer

Goals and Objectives
- Gain skills in the interpretation of radiographs and CT
- Demonstrate working knowledge of radiologic anatomy and pathology in plain films and CT studies
- Improve understanding of indications for particular studies

Schedule
- 7:45am to 12pm Monday through Friday. The morning begins in the SL ED radiology room at approximately 7:45am when the attending of the day arrives to review with you and the overnight radiology resident the films of all ED patients from the previous night. Upon completion of ED film review, the morning continues in the Clark 3 Ballroom, sitting with radiology attendings and residents as they read.
- Because each attending specializes, EM residents have found it useful to divide their time between chest, abdominal, and neuroradiology. Check with one of the Radiology residents or attendings for their conference schedule; many of the topics are relevant to EM. You are expected to attend every EM conference, Trauma conference, and Journal Club. Contact Dr. Baer ahead of time to discuss your schedule.

Tips
Feel free to float around the ballroom on any given morning, sitting with a variety of attendings, which tend to come and go, depending on their clinical duties. Maximize your limited time.

**Useful texts:**
Harris And Harris: The Radiology Of Emergency Medicine

**Dermatology**

**Location**
- St. Luke’s Site: 1090 Amsterdam Ave. Suite 11D
- Roosevelt Derm Clinic in the Brodsky building, 425 W. 59th St., Suite 5C, across the street from the Roosevelt ED.

**Contact:** Dermatology Chief Residents

**Goals and Objectives**
- Gain exposure to the widest possible variety of Dermatologic pathology
- Demonstrate understanding of principles of treatment, and recognize dermatological emergencies

**Schedule**

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<tr>
<td>Monday</td>
<td>8 am-11:30 am</td>
<td>1090 Amsterdam Ave Suite 11D</td>
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<td>Tuesday</td>
<td>1 pm-4 pm</td>
<td>Brodsky Bldg 425 W 58, Suite 5C</td>
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<td>Friday</td>
<td>1 pm-4 pm</td>
<td>Brodsky Bldg Suite 5C</td>
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**Tips**
The Derm clinics are busy, and you are an extra person. How much you see and learn will be determined by effort on your part to make yourself and your goals known to the residents and attendings.

**Useful texts , etc.**
Fitzpatrick; Dermatology Atlas

**Community Emergency Medicine**

**Location:** Southampton Hospital Emergency Department

**Contact Person:** Darin Wiggins; M.D., Chairman Southampton EM (631) 726-8476
Goals and Objectives:
- To become familiar with Emergency Medicine in a community hospital setting

Schedule
- Varied
- You will be assigned to a Board Certified Emergency Physician and will follow his or her schedule; the shifts are usually 12 hours.

Tips
- This is an opportunity to experience how Emergency Medicine is practiced across most of the country. There are few backup specialists in the hospital and you will be involved in the stabilization of sick patients. They do not usually have residents in the hospital, so the staff is eager to teach and happy to have you there.
- Spending a month in the Hamptons with plenty of free time to hit the beach is a nice benefit.
- Depending on availability, you may be given a place to stay near the hospital.

Pediatric Emergency Medicine

Location: At the hospital of your choice (if going away be sure to get your paperwork and permission from the visiting site early)

Faculty Liaison: Tommy Wong, M.D.

Description
In an effort to increase your exposure to acute pediatric care and trauma management, EM-3 residents will rotate through a Pediatric Emergency Medicine Department. While some residents choose to stay at our institution, others have gone to Columbia, Jacobi in the Bronx, St Joseph’s in New Jersey, Philadelphia and Hawaii. You may set up a pediatric elective at a place of your choosing as well but be sure to get this approved by Dr. Clark and Dr. Wong. Make sure you plan months in advance for an away peds elective.

Schedule
As a visiting resident, you will work as any other resident rotating through their ED. You will be assigned 16 shifts during your four-week block if done here at St Luke’s. If at another institution, your schedule will vary.

Useful texts
Harriet Lane Manual, Barkin (EM Peds), Ludwig/Fleischer (EM Peds)
ACADEMICS

The core curriculum of the Emergency Medicine Residency program at St. Luke’s Roosevelt is based on the Model of the Practice of Emergency Medicine and follows an 18-month cycle of topics as outlined below. These topics are reviewed/explored in case conferences and outside lectures and reinforced in review sessions to enhance learning synergy. Our topic schedule cycles completely through the Rosen’s Text twice within a 3-year period.

Our academic conferences take place every Wednesday from 8 am until 1 pm. All Residents are excused from clinical duties during the hours of conference and are expected to be present for conference, except those residents who are rotating through the ICU, the CCU, Shock/Trauma, away elective or vacation. Residents attend conference in compliance with the work hour regulations. Conferences take place in the Muhlenberg 4 Auditorium unless otherwise indicated. The full conference schedule, including presenter information, required reading and previous lectures may be found on the New Innovations website. www.new-innov.com

St. Luke’s Roosevelt Didactic Curriculum Summary

Each Wednesday, organized didactics take place from 8am to 1pm. There are multiple components to our conference day with faculty and resident lectures as well as several hands on interactive sessions and themed conference days. Additionally, there are supplemental repeating elements of our curriculum throughout the year that take place outside of conference.

Didactics in addition to Wednesday Conference

Monthly Joint EM/Surgery Trauma Conference

Joint EM/Trauma conference is held for two hours once a month. This session is led by the Director of Trauma and Surgical Critical Care from the Department of Surgery and the Emergency Medicine Director of Trauma Services and takes place on the third Friday of every month and is teleconferenced between our two clinical sites. Residents are expected to attend a minimum of 4 trauma conferences per year. Residents who have worked in the ED overnight as well as the entire oncoming AM ED team of residents are expected to attend Trauma conference.

Morning Report

- Morning report occurs Tuesday, Thursday, Friday, and Saturday from 7:00-7:30am at both sites (blue team at Roosevelt and in the resident lounge at St. Luke’s). These days correlate with 9-hour overnight shifts for the PGY2’s and 3’s.
- This is a formal, protected educational activity, which consists of a case-based discussion led by the PGY3. The PGY3 should consider letting the AM attending know of the topic at least 24 hours in advance (to allow for any preparation the attending would like to do).
• The AM team will report directly to the areas above for morning report and proceed to the ED for sign out immediately AFTER morning report. Do NOT enter the ED before morning report!

• **Attendance is required by the entire AM team, the overnight pediatrics resident at St. Luke’s, and the overnight PGY2.** The overnight PGY1 signs out to the PGY3 and goes home (because they work 12-hour shifts that end at 7 am).

• The overnight attending and PGY3 cover the ED while the PGY2 is in morning report. Barring any exceptional circumstances (mid-intubation, etc), the PGY2 is required to attend morning report.

• The PGY3 may pick the topic of their choice. The only requirement is that it be a case-based discussion (emphasis on discussion, not lecture! Please ask the other participants questions to make morning report more interesting and educational for all).

• The PGY3’s are encouraged to bring journal articles and other educational materials for the group. The topic need not be eccentric; discussions regarding the management of bread-and-butter EM cases are very useful for the PGY1’s and PGY2’s. PGY3’s are likely to benefit the most from morning report; the preparation and teaching will solidify your knowledge of a broad range of EM topics.

**Evening Board Review:**
• For 8 weeks prior to the annual in-service examination, weekly board review sessions are held on Monday evenings for two hours. During this time, residents practice questions from various sources. This is a faculty run session with a different faculty moderator each week reviewing the answers and questions from the group.

• These review sessions are voluntary, high yield and fun sessions where a family style meal is also provided. The format is informal and discussion based.

**Wednesday Conference**
In total, the residency has conference scheduled on 46 of 52 weeks. We do not hold conference during national meetings, holidays and on the day of graduation. This allows for a total of 230 hours of conference on Wednesdays. Journal Club is also held off site several times a year outside of conference time to change the location to one of our faculty member’s homes. Adding in monthly trauma conference, board review series, and our off site Journal Clubs, we have a total of 266 hours of formal didactic sessions.

Specific elements of our conference include:

**Rosen’s Review**
Following a reading curriculum, the entire two volumes of Rosen’s are covered in an 18-month period. Therefore, each resident will have read Rosen’s twice during the three-year program. This ensures that all elements of the EM curriculum are covered during our conference day in a formal way. This session is led by the Chief Residents and occurs for one hour each week. There are several conferences throughout the
year NYC wide during which we do not have a Rosen's review as well as on our Ultrasound Symposium day. Residents are still expected to complete the reading assignments for that week. (41 hours total annually, does not occur on the Ultrasound Symposium Day or the Mount Sinai Critical Care day).

**PGY2 Follow-up Conference**

Each PGY2 resident is responsible for giving a one-hour lecture on a follow-up case. The resident chooses a case from which he or she learned a great deal during the follow-up. The lecture includes the case history, a review of the pertinent clinical topic, a review of current literature on the topic, and patient follow-up. Each resident reviews his or her talk with the Associate Program Director prior to giving it. (14 hours annually)

**PGY3 Senior Topic Conference**

Each PGY3 is responsible for giving a one-hour topic lecture as his or her senior talk. The goal is for the resident to become an expert on a single topic, focused enough such that the lecture is not a broad review (e.g. not simply a chapter review that the audience could read on their own), but rather subject matter commanded by the resident. Residents perform a literature review and are expected to have mastered the topic both in general and with regards to current literature. Although the resident administers the lecture, each resident will have met with the Associate Program Director to practice the talk and receive feedback for modification prior to conference. (14 hours annually).

**Pediatric Case Based Learning**

These are monthly sessions led by faculty covering a specific topic each month in accordance with the Pediatric EM curriculum. Residents break into small group sessions facilitated by a faculty member and go through clinical cases. The hour is completed with a question and ten-minute wrap-up session by the faculty leader of the day. (12 hours total annually)

**Journal Watch**

These are bi-monthly sessions to review 10 key articles from the recent Emergency Medicine literature. Two faculty members lead the review presented in a one-hour rapid review session of the articles. (6 hours annually)

**Oral Boards and Simulation**

Mock oral boards are held one conference day each quarter beginning at the 9am hour. Residents rotate through multiple stations over a four-hour period of time practicing oral board cases facilitated by members of the faculty. Additionally during this time, one station involves time in the simulation lab practicing cases on the human simulator. (16 hours annually)

**Journal Club**

A key component to our evidence-based curriculum, Journal Club is held monthly. During this two-hour session, our EBM faculty member reviews a key topic of statistics or research based on readings from the JAMA Users’ Guide to the Medical Literatures. Residents are then broken into small groups led by individual faculty members to critically appraise articles from the literature. Some of the Journal Club
conferences are held in the evening in the home of faculty attendings periodically throughout the year. These will be announced in advance. (24 hours annually)

EM/Critical Care Conference
This is a quarterly joint conference between the Departments of Emergency Medicine and Critical Care Medicine. A case is discussed that began in the ED and then followed through the ICU course. Chief Residents from both services with the intimate involvement of faculty in preparation, present the cases. Faculty members from both services then lead a discussion of the case. (4 hours annually)

Follow-up Conference
Scattered throughout the conference calendar are dedicated sessions for Follow-up. Residents come to conference with their follow-up logs. Residents are asked in advance to come prepared to discuss the case, show imaging or other relevant data, and to have two to three teaching points on the case. Faculty facilitate a discussion of cases as they are presented followed by the resident giving follow-up as to what happened after the patient left the ED.

Ethics Curriculum
This is a quarterly series of lectures and small group sessions focusing on issues of medical ethics related to EM.

Departmental M&M
A monthly session led by the Chairman of Emergency Medicine. It follows the format of typical M&M conferences with cases reviewed in the CQI committee presented for discussion. This exposes the residents to the process of CQI and practice improvement as it happens in our department. (12 hours annually)

Grand Rounds:
Throughout the calendar year, a two-hour Grand Rounds Session is held. Speakers from around the country are invited to give this session. Depending on conference availability this occurs with varying frequency throughout the year.

Ultrasound Curriculum:
Each quarter, the ultrasound faculty lead a two hour session in conference involving both didactics and a hands-on component for ultrasound education. (8 hours annually)

St. Luke's Roosevelt Annual Ultrasound Symposium
Each year, for a full conference day, the Division of Ultrasound holds a regional conference on a specific topic related to ultrasound. Speakers from around the country are invited for lectures followed by a research session. Our residents attend this entire day for cutting edge ultrasound education. (5 hours annually)

Mount Sinai Critical Care in EM Conference
An annually NYC symposium, our residents attend this day at Mount Sinai in lieu of a conference day. Lectures focus on aspects of critical care in the Emergency Department and are given by both local and national experts. (5 hours annually)

**Airway Day**
One full day of conference beginning at the 9am hour is dedicated to our airway day. Residents rotate through different stations in small groups involving multiple topics: difficult airway, fiber optic techniques, surgical airway, ventilator management, non-invasive ventilation, RSI. (4 hours annually)

**Disaster Da**
A three hour session in one conference day each year, residents are taken through a simulated table top mass casualty incident to learn and understand the principles of disaster management from the ED perspective. This session is led by our director of Prehospital care and disaster services.

**Advanced Procedure Day:**
A full day devoted to hands on sim lab and trainer model based advanced procedures in EM including trans-thoracic and trans-venous pacing and cardioversion, pericardiocentesis, interosseous access, and chest tube placement (tube thoracostomy).

**Faculty Core EM Lectures:**
Faculty members present sessions on a topic of their choosing. Faculty are given the option of an hour session or breaking their talks into shorter talks consistent with current trends in adult learning. Core faculty and clinical faculty have a specific mandate for numbers of lectures per years to ensure involvement in conference.

**Emergency Simulation**
SLR simulation curriculum is run simultaneous to our Wednesday conference. Residents are scheduled to rotate out of conference for 50 minute sim sessions which accelerate exposure to rare cases and high yield procedures. These sessions are a forum for immediate feedback and resident evaluation of skills, medical knowledge and the other EM Milestones and include both pediatric and adult sim cases. These sessions are run by our simulation faculty and fellows.

Faculty members lead the majority of our conference (in excess of 70%). We believe that it is important for residents to learn from their faculty and not primarily from each other. While it is important for residents to learn how to develop a talk and master a topic, the majority of teaching in our formal didactic curriculum should come from our department’s faculty.

**ANNUAL INSERVICE EXAM**
- On the last Wednesday of February each year, EM residents take part in the National Emergency Medicine Residents In-service Exam. This test consists of questions similar to those on the emergency medicine board exam. Test results
are compared to other residents throughout the country, and reflect individual as well as the residency's performance as a whole (i.e. how well we're doing in preparing our residents for the EM boards).

- Preparation for the exam is best done gradually. The chief residents are available to assist you in learning how to access these programs. The weekly Rosen's review is a continuous opportunity to review the core content. Prior to the examination, 8 evening review sessions take place that are specific to the upcoming in-service examination.
- You will receive a score on the examination that is a national percentile. We use this as a marker of your academic progress. For residents who fall below the 25th percentile nationally, they will be placed into a remediation program with supplemental reading and practice examinations throughout the year.

**Academic Remediation**

On occasion residents will fall below the 25th national percentile on the annual in-training exam or by other indicators are noted to be below the expected level in the medical knowledge competency. This will automatically trigger placement into an academic remediation program. Academic remediation is one step from academic probation and requires a dedicated response on the part of the resident in coordination with the PD, APD and resident preceptor. Elements of academic remediation at SLR include the following:

- Resident will submit a written study action plan to PD.
- Resident will meet with PD and faculty mentor monthly while in remediation to discuss progress.
- Resident will take CORD practice EM Tests online (3 tests/month). These tests will be monitored by PD and used as a format for review of material between faculty preceptor and resident.
- Academic remediation requires a formal letter in the resident's file. This letter will be removed if the resident successfully navigates the remediation process. Failure to comply with or successfully navigate through the remediation process results in academic probation status. Academic probation may result in a failure to advance to the next EM year or ultimate dismissal from the program.

**The Resident Evaluation Process**

Ongoing evaluation of resident progress, clinical performance and competency is a primary function of residency training. Evaluations may be summative—designed to describe the resident's overall level of achievement, or they may be formative—used to instruct— as in the evaluation following a sim session or oral board case where the resident is immediately given feedback and education on the content of a case to augment knowledge and improve performance. During residency training at SLR residents should anticipate both types of evaluation in a rigorous and ongoing manner. Resident clinical performance and competency is evaluated in the following ways in the SLR EM Residency program. All of these data will be reviewed with each resident at the bi-annual summative evaluation session with the program director. In addition this information will be reviewed for each resident on a biannual basis by the clinical
competency committee who will use this multisource data to make a determination for each resident regarding achievement level (1-5) of EM milestones. This determination will weigh heavily into decisions for remediation, advancement and ultimate graduation from the program.

**Shift Evaluations**
These are completed by faculty members in New-Innovations on a daily and monthly basis. These evaluations may be accessed by residents at any time by logging into [www.new-innov.com](http://www.new-innov.com).

**Direct Observation**
Twice annually residents will be observed in clinical encounters by faculty members using a specific evaluation tool that assesses interpersonal skills with patients as well as specifics of the physical exam and history taking components. This evaluation is a more structured format than that used in everyday observation of residents by faculty members in the ED.

**Resident Productivity Reports**
Biannual reports that summarize the average number of patients seen by a resident/hour in the ED are useful indications of resident progress in efficiency and overall productivity. In general it is expected that interns will see .5-1 patient/hour; EM-2’s see 1-2 patients per hour and EM-3 patients see 2-3 patients per hour.

**Peer Evaluations**
Within every 6 month period residents perform a written evaluation of their peers in new innovations. Senior residents evaluate junior residents and vice versa.

**Resident Self-Evaluations**
These are required biannually; are completed in New-Innovations and should represent the residents honest and reflective self-assessment with particular emphasis on self-perceived strengths, weakness and goals for clinical and academic progress in residency.

**Nursing evaluation of residents**
These written evaluations by nurses in the department focus on three assessments: The nurse’s impression of a resident’s communication skill with nursing staff and with patients and their families; and whether or not the nurse would like this resident to care for a family member.

**Patient Satisfaction Surveys**
Patient satisfaction surveys will be used periodically to assess another dimension of resident progress.
Off-Service Rotation Evaluations
At the conclusion of every clinical experience including elective and off-site rotations as well as in-house off-service rotations, residents will be given a formal written evaluation of performance linked to the core competencies and milestones in emergency medicine. This includes every rotation described in the clinical rotation section above. Residents should anticipate this feedback. In some cases and particularly for off site rotations residents are responsible get an evaluation form from the residency office, deliver it to their supervising attending and return the completed evaluation form to the residency office for their file.

Patient Complaint Letters
Adverse information from patients in the form of patient complaint letters will be considered for inclusion in the resident evaluation process. It is understood that sometimes these letters may result from situations not under the resident’s control and in those cases the letters will not be included as a marker of resident performance.

Annual In-Service Scores
The in-service exam takes place every year on the last Wednesday of February. This exam is taken by every resident in the US who is training in EM. Scores are compared to the scores of other EM residents of the same year and each resident is assigned a percentile. While it is understood that these exams are imperfect measures of medical knowledge, they are considered a valid data point and are used to help evaluate resident performance. Residents who score in the 25 percentile or below for their year are automatically placed in to academic remediation. ( see section on remediation for details)

Oral Board Performance
Oral board case scenarios take place 4-5 times every year at Wednesday conference. These are clinical scenarios that the resident navigates verbally and are designed allow the evaluator to see how the resident is thinking through a case. They measure a resident's ability to integrate and act on clinical information, perform critical actions and avoid unsafe practices in the care of patients. They also frequently are used to measure a resident's interpersonal skills. Every resident will be given immediate feedback after performing an oral board exam case. In addition a summary evaluation form for the case including whether or not the resident performance was satisfactory is included in the evaluation data for that resident’s file.

Simulation Lab
Weekly performance on case scenarios in the simulation lab generate immediate feedback as well as written report cards that are also used in the resident evaluation process.

Structured Chart Reviews
Periodically structured chart reviews will be used to assess resident charting and patient care issues. Feedback based on benchmarks of care and documentation will be given to the resident to improve performance.

Monthly Faculty Meeting Resident Discussions
The SLR EM faculty discuss resident performance monthly. Feedback from these sessions is given to residents in a timely manner. When significant feedback arises, the resident is notified. Minor feedback can often wait until the next scheduled summative evaluation.

Residency Follow up Program
The residency in emergency medicine at SLR is committed to the concept of patient follow-up as an integral part of resident education and an essential component of the practice of emergency medicine. Continuous improvement in diagnostic skills is only possible through patient follow up on a regular basis. Patient follow up teaches by indicating whether or not the initial diagnosis was correct, and by demonstrating the patient’s course and response to ED management.

At the end of each clinical shift at the St. Luke’s site, each resident will print out an EMSTAT summary of the patients he or she evaluated during that shift. This summary will provide a framework for follow-up of selected patients. This patient follow up may be accomplished in a variety of ways, including but not limited to discussion of operative findings with surgical colleagues, culture results and official radiographic interpretations available through ED based computer systems and through discharge summaries. In some cases, residents may choose to note the patient’s home telephone number and mark it on the summary sheet in order to later contact the patient for follow-up information. The means of follow-up is less important than the consistent incorporation of some form of follow-up as a routine part of the residents’ practices. The daily patient summaries are to be added to a binder maintained by each resident. Follow up information should be added in the margin of the summary sheets. The residency directors will review these binders during resident evaluations. Last minute completion of these binders defeats the purpose of the exercise and is strongly discouraged.
Career Development and Resident Director Roles

The EM residency at SLR has a strong commitment to the professional development of our residents and we provide significant opportunities for senior resident to demonstrate leadership, build meaningful CV’s and engage in activities that bolster their competitiveness for fellowship training as well as for community EM positions. We have developed Resident Director Roles which provide experience, exposure and mentorship in a resident’s interest area. Residents are selected for these roles at the end of the second year based on level of interest and engagement.

RESIDENT DIRECTOR OF MEDICAL SIMULATION

RESPONSIBILITIES/EXPECTATIONS:
• Facilitate Wednesday simulation sessions
• Work with directors of student clerkship to facilitate medical student simulations sessions from 4-6 pm on 2nd and 4th Tuesday of each month
• Work with simulation division to continue to develop and implement simulation curriculum
• Take part in simulation division research.
• Work with simulation division to coordinate any “sim day” activities
• Participate in national simulation activities such as “Simwars” at ACEP or SAEM.
• Join simulation academy of SAEM.
• Consider using elective time for away simulation experience at advanced sim center such as Brown, or Stanford.
• Be an interface between the Simulation division and the residency.
• Stay alert to national and regional simulation activities.

OPPORTUNITIES:
• Gain valuable experience in the development and execution of simulation curriculum.
• Gain expertise in the use of high-fidelity adult and pediatric simulators, software applications and in programing cases.
• Exposure to national leaders in simulation with the opportunity for scholarship, networking and mentorship.
• Gain expertise in coordinating and directing multidisciplinary simulation educational sessions.
• Significant opportunities for scholarship and research in simulations.
• This experience should be considered a “mini-fellowship” which will provide the resident with substantive exposure.
• Based on performance, contribution and interest, resident directors of simulation will be compensated .5/shift per block reduction in their ED schedule.
• Successful resident directors will exit this experience prepared to run an educational simulation program and to be highly competitive applicants for full simulation fellowships.

RESIDENT DIRECTOR OF EMERGENCY ULTRASOUND EDUCATION

This resident director role is ideal for someone considering an emergency medicine ultrasound fellowship and a career with a focus on emergency ultrasound.

RESPONSIBILITIES/EXPECTATIONS
• Work under the direction of the ultrasound division leadership to continue to develop and implement emergency ultrasound curriculum.
• Gain personal proficiency in all aspects and applications of emergency ultrasound.
• Take part regularly in the ultrasound fellowship weekly meetings.
• Contribute to the planning and execution of the SLR Annual Ultrasound Symposium.
• Regularly teach and facilitate Ultrasound Division educational sessions during the July Intern Month, at Wednesday conference and for additional US sessions under the leadership of the US division.
• Meet monthly with residency leadership.

**OPPORTUNITIES**
• Become an expert in performing and teaching emergency ultrasound.
• Become RDMS qualified.
• For the resident who is so inclined the position will offer opportunities for scholarship, publication and presentation at national meetings.
• Become familiar with emergency ultrasound literature.
• For the resident so inclined the position will offer valuable experience in reading and QI of scans under supervision in the QPATH process.
• For the resident so inclined gain valuable experience with the ultrasound credentialing process.
• Based on performance and level of engagement, opportunity to attend SAEM, ACEP or CORD annual national meeting. (all expenses paid)
• Based on performance and level of engagement, Resident Director will receive .5 shift/block reduction in ED clinical schedule.

**RESIDENT DIRECTOR OF PATIENT SAFETY AND QUALITY IMPROVEMENT**
This resident director role is an important opportunity for residents aspiring to leadership in either the academic or operations/administrative arenas. Patient Safety and Quality Improvement is a vital part of any effective health delivery system which has become central to both the education and operations agendas. The goal is to promote knowledge and skills in these areas which will benefit residents (and their patients) throughout their careers.

**RESPONSIBILITIES/EXPECTATIONS**
• Work with residency leadership and program director to continue to develop and implement professional development curriculum for Quality and Safety Initiatives.
• Work with residency leadership to implement and and oversee the safety/CQI curriculum and residency CQI projects.
• Regularly investigate and report back on CQI/ M&M cases under direct supervision of Departmental Medical Directors and Chairman.
• Regularly take part in departmental CQI and root cause analysis meetings.
• Meet monthly with residency leadership.

**OPPORTUNITIES**
• Gain valuable experience in directing a residency CQI/Patient Safety program.
• Gain valuable experience in the CQI process.
• For the resident who is so inclined the position will offer opportunities for scholarship, publication and presentation at national meetings.
• Become familiar with CQI and patient safety literature.
• For the resident so inclined the position will offer valuable experience in residency and departmental administration.
• Based on performance and level of engagement, opportunity to attend SAEM, ACEP or CORD annual national meeting. (all expenses paid)
• Based on performance and level of engagement, Resident Director will receive .5 shift/block reduction in ED clinical schedule.

**RESIDENT DIRECTOR OF PREHOSPITAL CARE AND DISASTER MANAGEMENT**
The purpose of this leadership role is to provide significant and meaningful experience in the management of a large urban facility pre-hospital care division and post-9/11 disaster management for a resident aspiring to jumpstart a career in prehospital care and disaster management.
RESPONSIBILITIES/EXPECTATIONS
• Work directly with the faculty director of prehospital care, Dr. Redlener, and program leadership to facilitate the pre-hospital care and disaster management curriculum for residents.
• Contribute to planning, organization of SLR EM Residency Disaster Day.
• Serve as liaison to SLR residents and medical students during EMS rotation.
• Regularly attend NYC REMAC meetings with SLR leadership.
• Serve on SLR Emergency Management Committee (Chaired by Dr. Redlener)
• Attend City Wide disaster management meetings
• Plan, execute and supervise delivery of didactic educational program for SLR medics and EMT’s under guidance of faculty director.
• Lead and organize SLR participation in major sporting events and other potential mass casualty events such as the NYC Marathon.

OPPORTUNITIES
• Gain valuable experience in the management of the prehospital care division of a large urban hospital system as well as the city wide EMS.
• Gain valuable experience in planning and teaching disaster management.
• Gain experience in the medical oversight of the largest EMS system in the world, including the development and execution of prehospital care protocols. (REMAM)
• For the resident who is so inclined the position will offer opportunities for scholarship, publication and presentation at national meetings.
• Become familiar with prehospital care and disaster literature.
• Based on performance and level of engagement, opportunity to attend the SAEM and ACEP National meetings. (travel expenses paid)
• Based on performance and level of engagement, Resident Director will receive .5 shift/block reduction in ED clinical schedule.

RESIDENT DIRECTOR OF ETHICS AND PROFESSIONAL DEVELOPMENT
The focus of the Professional Development role and curriculum is an educational agenda which fosters humanism and compassion in medicine, medical ethics, professional responsibility, physician well being and patient centered care in the residency setting. The goal is to promote knowledge and skills in these areas which will benefit residents (and their patients) throughout their careers.

RESPONSIBILITIES/EXPECTATIONS
• Work with residency leadership and program director to continue to develop and implement professional development curriculum.
• Contribute to planning, organization of SLR EM Residency Retreat Program
• Attend and help direct the SLR EM Residency Retreat Program for EM-1, EM-2 and EM-3 classes.
• Take active part in planning and execution of the medical ethics curriculum including didactic case-based educational sessions at conference (4x/year)
• Contribute to development of SLR EM Residency Book Club. The resident director will participate in book selection using themes from educational focus above. Book Club format will be informal dinners at faculty homes with casual discussion.
• Support ideas to promote physician wellness and program unity and to foster warm, collegial and educational residency environment.
• Meet monthly with residency leadership.

OPPORTUNITIES
• Gain valuable experience in directing a professional development program.
• Gain valuable experience in promoting humanistic values in residency training.
• Become more involved and instrumental in mentorship.
• For the resident who is so inclined the position will offer opportunities for scholarship, publication and presentation at national meetings.
• Become familiar with physician wellness literature.
For the resident so inclined, the position will offer valuable experience in residency administration.

Based on performance and level of engagement, opportunity to attend the CORD Scientific Assembly (travel expenses paid) (Denver 2012)

Based on performance and level of engagement, Resident Director will receive .5 shift/block reduction in ED clinical schedule.

Attendance at retreat(s) will be compensated by reduction in ED shift schedule. (2 shifts for EM-2 retreat and 1 shift for EM-1 retreat.

**Resident Director of Medical Student Education**

**RESPONSIBILITIES/EXPECTATIONS**

- Facilitate monthly student orientation first weekday of each month at 10 am. (Confirm with Faculty Director in advance who will be present.) Specific orientation tasks include:
  - Review details of rotation with students (following cheat sheet) outlining tips for success, describing how to get the best educational experience and discussing “rules of the road”---do’s and don’t for students.
  - Divide students into two groups and assign one group to RH nurses and other group to SL nurses for “Procedure Shift.”
  - Give tour of RH and SL ED’s and pair students to their nurses for procedure shift. (Procedure shift expectations—one – two students max assigned to nurse to do IV’s, EKG’s, place pt on monitor, become familiar with oxygen/nebulizer, Foley etc. 3-4 hours.
- Participate in SIM Educational Sessions from 4-6 pm on 2nd and 4th Tues/month.
  - Meet students and give talk or workshop to small groups.
  - Help run sim cases for students (if two directors are present)
- Monthly clerkship education/feedback meeting with faculty directors – 4th Thursday of month for one hour
  - Review quiz with students
  - Lead discussion and provide feedback for student presentations
  - Help select case of the month
- Wednesday Conference: Convey information to students about conference changes in time or location and any other pertinent information regarding Wednesday conference, track medical student conference and sim session attendance and record on spreadsheet. (Attendance to be recorded for every conference/sim session and sheet updated weekly with final update by last day of calendar month.

**OPPORTUNITIES**

- Gain valuable experience in organizing and running a Columbia University 4th year student clerkship/Subinternship.
- Gain expertise in planning and executing educational sessions for the students each month.
- Precept “Directors’ Rounds”
- Serve as mentor and role model for Columbia medical students.
- Participate in quarterly educational/administrative meeting with clerkship directors and residency leadership
- Based on performance, contribution and interest, an opportunity for all expense paid (airfare, hotel and conference) attendance at yearly CORD meeting CDEM track. (This is the annual meeting of EM residency and clerkship directors from across the US. You will gain exposure to the expertise of top educators, opportunities for scholarship and strengthening of your teaching skills.
- Valuable CV building and opportunities for education scholarship.
- Resident Directors will exit this experience prepared to become Faculty Directors and run their own elective.
- Resident Directors who are so inclined will have the opportunity to use this as a building block for other career paths such as residency leadership.
- Based on performance, contribution and interest, resident directors will be given .5/shift per block reduction in their ED schedule.
• Contribute and help incorporate new ideas and innovations for the clerkship as well as ideas for research and scholarship involving medical student education.

Faculty Preceptors for Residents

• Resident-Preceptor Responsibilities:
  • The role and responsibilities of a resident preceptor is both rewarding and demanding. As faculty, we have the opportunity to influence and guide our residents through the most challenging three years of their medical career, and perhaps their lives. It is our collective goal that our residents leave the program, as good emergency physicians and healthy individuals as well. As resident preceptors, we can help and guide them as:
    • Role Models
    • Resident Advocates
    • Career Counselors
    • Mentors in lecture preparation
  • Preceptors meet with residents at least twice a year to discuss concerns, performance, and goals can be most fruitful. Should personal or academic issues arise, it is imperative that they be addressed early so that necessary corrective actions are taken for the benefit of the resident.
  • For residents, work and personal life can be quite compressed, leaving little time for resident-preceptor contact outside the department and conference. It should be emphasized that the preceptor can be a valuable source of support. Just as some residents will seek more guidance than others will, some attendings will be more active than others in their role as preceptors. The ultimate goal of the resident-preceptor relationship is to have available a more personalized source of faculty support.
RESIDENT LIFE MISCELLANEOUS DETAILS

PROFESSIONAL DUES

- The EM Residency Program pays annual dues for residents as members of EMRA (Emergency Medicine Residents Association), ACEP (American College of Emergency Physicians), and SAEM (Society for Academic Emergency Medicine). As members, residents receive the journals of both ACEP - Annals of Emergency Medicine and SAEM - Academic Emergency Medicine.
NYC Marathon

- SLRHC provides staffing for the high acuity P-1 Finish Line Medical Tent of the NYC Marathon. This is an intense experience with a wide array of sports related injuries and illness to be evaluated and treated including heat exhaustion, electrolyte abnormalities and dehydration. The acute care tent contains an ICU with cooling baths and the capacity for bedside point of care electrolyte testing.
- The group consists of ED attendings and residents, as well as Nurses, physical therapists, and paramedics.
- The race is held in early November on a Sunday from approximately 9 or 10am until 3pm. It is an exciting, fun and quintessentially NY experience and is highly recommended.
- In order to participate, residents will be emailed by the residency leadership or Dr. Michael Redlener (director of prehospital medicine). Each resident will need to attend an orientation session and obtain credentials. In addition to the large NYC marathon, several smaller races are held throughout the year which also have opportunity for resident involvement
- The SLR contingent enjoys a family style spaghetti and meatball dinner with red wine at Steve Lynn’s house following the marathon.

Important Websites

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<tr>
<th>SLR EM Residency Site</th>
<th><a href="http://www.slremresidency.org">www.slremresidency.org</a></th>
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<tr>
<td>SLR Emergency Department Site</td>
<td><a href="http://www.sired.org">www.sired.org</a></td>
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<td>Conference, procedure logging and evaluation tools</td>
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<td>SLR Journal Club</td>
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<td>SLR EM Global Health Division</td>
<td><a href="http://www.siredglobalhealth.org">www.siredglobalhealth.org</a></td>
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<td><a href="http://www.slre">www.slre</a> dultrasound.com</td>
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<td>SLR EM Medical Student Rotation</td>
<td><a href="http://sired.org/medical-students">http://sired.org/medical-students</a></td>
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<td>Matt Curley Wilderness Medicine Scholarship</td>
<td><a href="http://www.mrcwildmed.org">www.mrcwildmed.org</a></td>
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<td>ED schedules</td>
<td><a href="http://www.whentowork.com">www.whentowork.com</a></td>
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<tr>
<td>ED logistical information and forms</td>
<td><a href="http://www.shifttrades.org">www.shifttrades.org</a></td>
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<td>Graham Walker’s former slr chief Med Calc Site</td>
<td><a href="http://www.mdcalc.com">www.mdcalc.com</a></td>
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The Matthew Ryan Curley Wilderness Medicine Scholarship Fund

The Matt Curley M.D. Wilderness Medicine Scholarship Fund was established in the fall of 2011 to honor the life and memory of Matt Curley by his family, friends and colleagues. Matt was in his third year of EM residency training at SLR when he was lost at sea during a scuba diving trip in August of 2011. Matt was profoundly enthusiastic about Wilderness Medicine and was planning to pursue a Wilderness Medicine Fellowship. Matt was the quintessential young adventurer. The scholarship is a tribute to honor him by encouraging those, who like Matt, are inspired by the spirit of adventure, wilderness medicine, and the powerful beauty of nature.

The scholarship will be awarded to one US EM resident per year who, like Matt, has a particular interest in wilderness medicine. The fund is administered by the SLR EM residency and the Wilderness Medical Society.

Scholarship recipients will receive $1000 toward travel expenses to attend the national Wilderness Medical Society Annual Conference. The recipient will have the option to deliver a 30 minute “Matt Curley Memorial Lecture” on a wilderness medicine topic of their choosing. This experience will be pivotal for residents hoping to begin a career in wilderness and/or academic EM and will provide access to mentorship by nationally recognized leaders and wilderness medicine faculty.

For more information go to www.mrcwildmed.org
SLR EMERGENCY MEDICINE FELLOWSHIP PROGRAMS

Emergency Medicine Ultrasound Fellowship Program
Fellowship Directors: Turan Saul M.D., RDMS
Ultrasound Division Director: Resa Lewiss MD, RDMS
Number of Fellows: 2 fellows/yr
Duration of Fellowship: 1 year
The Department of Emergency Medicine of the St. Luke’s Roosevelt Hospital Center Columbia University College of Physicians & Surgeons has offered an Emergency Medicine Ultrasound Fellowship since 2002.

Objectives & Goals:
● Fellows will graduate from the program as excellent emergency physician sonographers and educators with RDMS certification. Graduates will obtain extensive experience in image acquisition, optimization, interpretation and application to safe and efficient emergent patient care
● Fellows will develop the administrative skills and experience to credential staff in emergency ultrasound and to conduct a quality assurance program
● Fellows will receive education in performing clinical research by completing a research project upon graduation from the fellowship program
● Fellows will help integrate emergency ultrasound into the fabric of ED practice of residents and faculty at the St. Luke’s Roosevelt Hospital Center

Fellow Responsibilities and Benefits
● 20 clinical hours/week divided between the St. Luke’s and Roosevelt ED sites
● Coordinate the ultrasound education, credentialing and quality assurance for the ED under the supervision of Resa Lewiss, MD and Turan Saul, MD. This includes reviewing all ultrasound examinations performed by emergency medicine residents and faculty to determine accuracy and to provide feedback and remediation
● Coordinate the Emergency Ultrasound rotation and elective and participate in ultrasound courses taught by the division with Drs. Lewiss and Saul
● Complete and publish a research project related to emergency ultrasound
● Obtain the American Registry for Diagnostic Medical Sonography (RDMS)
● Salary and Benefits:$80,000/year. Full benefits including 4 weeks vacation and 1 week CME

Candidates:
www.slredultrasound.com for application instructions.
Emergency Medicine Ultrasound Elective

Emergency Ultrasound Elective for residents and faculty

- Participants will work closely with ultrasound fellowship directors, and emergency ultrasound fellows, as well as emergency medicine residents and faculty already trained in emergency ultrasound.
- Participants will achieve proficiency in performing and interpreting emergency ultrasound examinations.
- Participants will have access to a large ultrasound teaching file of digitized ultrasound images and video.
- Participants will:
  - Receive a review of ultrasound physics and instrumentation and a review of all the relevant emergency ultrasound examinations. This will be followed by a week of hands-on scanning, journal club discussion, image review and completion of credentialing exams.
  - Perform and record all their ultrasound examinations, including their interpretations. Participants will then receive feedback on their interpretations from the ultrasound fellows & the fellowship directors.
  - Review & interpret all ultrasounds performed in the ED. Participants will then receive feedback on their interpretations from the ultrasound fellows & fellowship directors.

SLR EM Global Health Fellowship
Fellowship Director: Deepti Thomas-Paulose, M.D., MPH

DESCRIPTION
- This unique 2-year fellowship focuses mainly on the global impact of infectious diseases - HIV/AIDS, malaria, tuberculosis, as well as other common and emerging infectious diseases - in children and adults in/from developing countries and international travelers seeking pre/post travel medical care. It also recognizes the expanding challenge and burden of non-infectious diseases as a cause of morbidity and mortality.
- A total of two fellows are accepted on an annual basis having met all the necessary prerequisites (successful completion of post graduate training in emergency medicine, internal medicine, or pediatric emergency medicine, and a history of significant international field work). MDs, DOs, PAs and NPs will all be considered.
- The three main components of this fellowship are clinical responsibilities/rotations, didactic work, and international fieldwork.
- Clinical responsibilities are satisfied by working in at St. Luke’s Roosevelt Hospital Center (emergency department, HIV clinic, and travel clinic - adult and
pediatric patients in all sites) and the Bureau of Tuberculosis Control at NYC DOHMH.

- The didactic requirements are met by successfully completing: MPH, Diploma Course in Tropical Medicine, Diploma Course in International Humanitarian Assistance, and a competency exam in HIV/TB/Travel Medicine based on their clinical rotations. They are also required to attend bi-monthly tutorials and conferences.

- The international component is tailored to address the fellow’s specific interest in global health. The fellowship currently has numerous collaborations and partnerships with a number of universities, non-governmental agencies, and several governmental agencies.

- The Mailman’s MPH program give the fellows an arching understanding of the world’s health challenges, and the tools to work collaboratively to effect meaningful change. We recommend a program that emphasizes research and public health programming skills, focusing on training physicians to formulate important service-based research questions and giving them the tools to design, implement, and evaluate programs that deal with respective international issues.

Fellowship Collaborators
St Luke’s/Roosevelt Hospital Center
- Comprehensive Care Clinic for HIV/AIDS
- Division of Infectious Diseases

Doctors of the World
Center for Global Collaboration and Health Initiatives
Fellowship Faculty & Advisory Committee
- Victoria Sharp, M.D., George McKinley, M.D., Bruce Polsky, M.D.,
- Daniel Wiener, M.D., and EM Faculty

Fellowship Appointment
Eligibility Criteria
- EM or PEM residency Graduate
- Medical Licensure in New York State
- Passport/able to obtain Visas
- Able to fulfill travel requirements

Number of Fellows: 1-2
Duration of Fellowship: 2 years

Program Responsibilities
Clinical
Attending in EM Department: 18 h/wk (1/3 in Pediatrics)
CCC Continuity: 12 session/2yrs
TB City Clinic: 8 sessions/2yrs
Travel Clinic: 8 sessions/2yr
ID Consult Rotation: optional

International Work
- 1st yr: site specific needs assessment and sustainable project design
- 2nd yr: project implementation and evaluation
- Collaboration w/ local/international NGO/organization
- Minimum 14 d/field trip, Maximum 16 wks/fellowship
- Compliance w/ required/advised travel vaccines, prophylaxis

Academic/Educational
- Diploma in Tropical Medicine- Ireland
- International Diploma in Humanitarian Assistance – New York City
- Academic Meeting Presentation (ASTMH, ISTM, ACEP, SAEM, HIV, ID, etc) 1-2/yr
- Residency
  - EM Wed conferences: contribute to development/delivery GH Curriculum (attend 25% Wed conferences/yr)
  - Faculty meeting: mandatory attendance unless traveling
- Journal Clubs
  - Center for Comprehensive Care, Multidisciplinary Journal Club
  - Infectious Disease Departmental Journal Club
- GH Fellowship Bimonthly meetings
- Optional:
  - Ultrasound certification/SAFE
  - DOW Human Rights Medical Documentation Training
- Research
  - Understand and contribute to GH literature
  - Complete one research project of publishable quality/scholarly project
  - Present at national/international meeting
Fellow Supervision/Evaluation

- Travel Clinic, ID, CCC, TB rotations will be supervised/evaluated by Consulting providers
- GH Directors/Emergency Medicine Chairman/Advisory Committee

GH Directors/Faculty Responsibilities

- Directors: Program Administration, coordinate all activities, evaluations and continued program/curriculum development
- Fellowship Faculty and Advisory Committee: Promote interest/supervision in specialized areas of study, assist in development research projects and international rotations

SLR Medical Simulation Fellowship

Medical Simulation Fellowship
“See one, Sim one, Do one, Teach one”

Overview
St. Luke’s – Roosevelt Emergency Medicine Simulation Fellowship is designed to provide advanced training in the emerging field of simulation-based medical education. The St. Luke’s and Roosevelt Hospitals Simulation Center is a fully interdisciplinary medical simulation center that provides training for a wide variety of medical and allied health practitioners at all levels of training. The Simulation Center leadership and faculty include physicians from the Department of Medicine Section of Critical Care, Emergency Medicine, Anesthesiology, Surgery, amongst others. Our hospital system is an Academic Affiliate of Columbia University College of Physicians and Surgeons and is divided into two separate facilities with St. Luke’s Hospital located at 113th and Amsterdam and Roosevelt Hospital located at 59th and 10th Avenue in Manhattan. Most medical simulation activities are held at Roosevelt Hospital and include education of all participating programs, students, house-staff, and ancillary staff from each site.

Program Description
The St. Luke’s – Roosevelt Emergency Medicine Simulation Fellowship is a one year mentored fellowship that offers advanced training in simulation teaching, curriculum design, and simulation research. The fellow develops skills in a state-of-the-art simulation center developed at Roosevelt Hospital in 2007. The simulation fellowship is not an ACGME accredited fellowship as there are no ACGME accredited fellowships in Medical Simulation. The program is limited to two fellows per year.

Applicant Qualifications
The applicant must have graduated from an AAMC accredited (or equivalent) medical school and has graduated from an ACGME accredited Emergency Medicine program. A record of achievement in medical education, as provided by letters of reference, publications, teaching evaluations, or prior specialized training or experience in medical education is desired, but not required.

Elements of Simulation Fellowship
• Independent and didactic training in the history and theoretical basis of simulation in medical education.
• Instruction in the operation and programming of a variety of medical simulation technologies, including:
  o High-Fidelity Human Patient Simulators
  o Partial Task Simulators
  o Computerized Simulation Technologies
  o Virtual Reality Simulators
  o Simulation Audio-Visuals
  o Data Management System

Program Objectives
• Spend significant time creating and facilitating comprehensive medical simulation scenarios for the Departments of Emergency, Internal Medicine, Surgery, Anesthesia, as well as for medical students on elective and nursing staff.
• Learn to effectively educate others through the use of high fidelity medical simulation, ultrasound-integrated simulation, procedural simulation, and disaster code simulation.
• Create and implement a simulation curriculum that will enhance medical student and resident education.
• Develop technical programming skills necessary to build real-time case scenario algorithms.
• Utilize medical simulation to help reduce medical errors and improve patient care.
• Become proficient in managing a high fidelity academic simulation center.
• Foster relationships with leading experts in the field of medical simulation by attending at least one regional and one national simulation meeting.

Clinical Activities
Fellows are considered half-time attending faculty and are expected to work an average of 20 clinical hours per week in the emergency department divided amongst the St. Luke’s and Roosevelt sites. Compensation for the Simulation Fellow includes a competitive salary based on half-time attending status. In addition to fellowship-related activities, the clinical duties will allow for enhancement of professional skills.

Research
Simulation Fellows interested in academia will generate independent research questions and develop projects under the guidance of faculty mentors. As interested they can also participate in any one of a number of established simulation-based research efforts at SLR. A minimum of one scholarly project is to be successfully initiated during the 1-year fellowship. Work generated during the duration of the fellowship is expected to be presented or submitted for publication. Fellows will be expected to attend a monthly meeting discussing important topics/articles in the field of medical simulation.

Educational and Academic Activities
This past year, Simulation Fellows have attended the following conferences:
• The Comprehensive Instructor Workshop in Medical Simulation, at the Harvard Center for Medical Simulation
• International meeting for Simulation in Healthcare
• Laerdal Sun Conference
• SAEM Annual Symposia and participation in “SimWars”
• ACEP Annual Symposia and participated in “SimWars”
• “Base Camp”: Medical Simulation Training for Pediatric Emergency Medicine Fellows
Fellowship Directors

Hassan Khouli, MD
Chief, Critical Care Section
Director, Simulation Center
St. Luke's-Roosevelt Hospital Center

Richard Lanoix, MD
Fellowship Co-Director, Simulation Medicine
St. Luke's-Roosevelt Hospital Center

For further information regarding the fellowship and the application process please contact:
Richard Lanoix, MD
Fellowship Co-Director, Simulation Medicine
St. Luke's-Roosevelt Hospital Center
Department of Emergency Medicine, Suite GE-01
1000 Tenth Avenue
New York, New York 10019
Email: RLanoix@chpnet.org
POLICY STATEMENTS

EXPECTATIONS FOR EM RESIDENTS

1. To maintain an overall average attendance record at didactic conferences (including journal club and trauma conference) of 100% of non-excused conferences per year.
2. To maintain a current and accurate procedure log and patient follow-up log.
3. To complete a satisfactory scholarly project by May 1st of senior year that has been approved by the Research Director and/or Residency Director prior to initiating the project. Acceptable scholarly projects must result in a submission to a peer-reviewed journal and must be done under the guidance of a faculty mentor.
4. To complete evaluations of all off-service and EM rotations, the didactic curriculum, and the EM faculty.
5. To obtain evaluations from faculty of all off-service rotations and forward these to the residency coordinator.
6. To provide lectures during the residency of acceptable quality to the residency leadership.
7. To arrive at all clinical and conference assignments on time. Unauthorized absence from clinical assignments (both ED shifts and off-service rotations) and/or failure to maintain an acceptable attendance record during the rotation may result in an unsatisfactory evaluation for the entire rotation, mandatory repetition of all or part of the rotation, and/or disciplinary action up to and including academic probation.
8. Appropriate and timely notification of the Chief Residents and residency leadership of absence due to illness/injury of personal emergency. Notification of absence or lateness must be done directly or by phone—texting and email is not acceptable.
9. Participation in the patient follow-up program for all ED and Pediatric ED rotations.
10. To be available by phone or pager during regular business hours at all times when not on vacation or away elective.
11. To be readily available when on sick call for work in the ED.
12. To check hospital email (chpnet) daily and respond within 24 hours at the latest to residency related emails.
13. To complete all ER charts prior to leaving for the day after a shift.
14. To report to all shifts and conference rested and ready for work.
15. To adhere to duty hour restrictions in all personal shift trades.

Conference Attendance Policy

- Conference attendance is an essential and required part of training in Emergency Medicine. Understanding the didactic underpinnings of patient care is essential to development as a competent physician. Attendance at conference should be viewed with the same sense of responsibility as working a clinical shift.
Resident Duty Hours Policy

New York State has longstanding regulations, which restrict Resident Duty Hours. Effective July 1, 2003, the Accreditation Council for Graduate Medical Education ("ACGME") adopted similar Duty Hour limitations.

In its policy requirements, the ACGME states "providing Residents with a sound academic and clinical education must be carefully planned and balanced with concerns for patient safety and Resident well-being. Each program must ensure that the learning objectives of the program are not compromised by excessive reliance on Residents to fulfill service obligations. Didactic and clinical education must have priority in the allotment of Residents' time and energies. Duty Hour assignments must recognize that faculty and Residents collectively have responsibility for the safety and welfare of patients."

POLICY

New York Codes, Rules and Regulations (NYCRR), Title 10, Section 504.4, and ACGME Final Requirements, "Resident Duty Hours Language," call for Duty Hour restrictions in order that the Resident working conditions and hours promote the provision of quality medical care. The following are limits on Resident Duty Hours:

Duty Hour Limitations

1. Assignment shall be limited to no more than 12 consecutive Duty Hours per on-duty assignment in the Emergency Medicine Department.
2. In the ED, residents may not work more than 60 clinical scheduled hours per week and no more than 72 duty hours per week. Duty hours include conference time as well as clinical time.
3. The scheduled workweek is not to exceed an average of 80 Duty Hours per week, averaged over a 4-week period, inclusive of all In-House Call.
4. Continuous on-site duty, including In-House Call, must not exceed 24 consecutive Duty Hours. Residents are allowed to remain on duty for up to 3 additional hours to participate in didactic activities, transfer care of patients, conduct outpatient clinics, and maintain continuity of medical and surgical care, as defined in Specialty and Subspecialty Program Requirements.
5. Adequate time for rest and personal activities must be provided to Residents. In determining limits on Resident Duty Hours, as set forth in subparagraphs (1) and (2) of this paragraph, the Director of Residency Training ("Director") shall require that scheduled on-duty assignments be separated by not less than 8 non-Duty Hours. At
least one 24-hour period free from all clinical, educational, and administrative activities must be provided per week.

6. There must be an equivalent number of hours off between shifts as the previous shift completed. (If you just worked 12, you need twelve hours off.)

Prohibition

Residents who have worked the maximum number of Duty Hours permitted in subparagraphs (1) through (4) of this paragraph shall be prohibited from working additional hours as physicians providing professional patient care services.

Exceptions

The Graduate Medical Education Committee will neither entertain nor endorse requests for exceptions to this policy.

Supervision of Residents

1. All patient care must be supervised by qualified faculty. The Director must ensure, direct, and document adequate supervision of Residents at all times. Residents must be provided with rapid, reliable systems for communicating with supervising faculty.

2. Faculty schedules must be structured to provide Residents with continuous supervision and consultation.

3. Faculty and Residents must be educated to recognize the signs of fatigue and adopt and apply policies to prevent and counteract the potential negative effects.

On-Call Activities

1. The objective of on-call activities is to provide Residents with continuity of patient care experiences throughout a 24-hour period.

2. In-House Call must occur no more frequently than every third night, averaged over a 4-week period.

3. No new patients, as defined in Specialty and Subspecialty Program Requirements, may be accepted after 24 hours of continuous duty.

4. The frequency of At-Home Call is not subject to the every-third-night limitation. However, At-Home Call must not be so frequent as to preclude rest and reasonable personal time for each Resident. Residents taking At-Home Call must be provided with 1 day in 7 completely free from all educational and clinical responsibilities.

5. When Residents are called into the hospital from home, the hours spent in-house are counted toward the 80-Duty Hour limit, as established under Section III.A.1.b., Policy, of this document.

6. The Director must monitor the demands of At-Home Call in his/her program and make scheduling adjustments as necessary to mitigate excessive service demands and/or fatigue on his/her Residents.

Oversight

1. Each program must have written procedures consistent with this Duty Hours Policy for Residents. This policy and the written department procedures must be distributed to
Residents and faculty. The monitoring of Duty Hours is required with frequency sufficient to ensure compliance and an appropriate balance between education and service.

2. Back-up support systems must be provided when patient care responsibilities are unusually difficult or prolonged, or if unexpected circumstances create Resident fatigue sufficient to jeopardize patient care.

Resident Supervision in the Emergency Department

- The Department of Emergency Medicine provides care to patients twenty-four hours/day, seven days a week. The Department of Emergency Medicine sponsors a fully-accredited Emergency Medicine Residency Training Program, and provides attending coverage twenty-four hours/day, seven days a week. In addition to the educational aspects of their supervisory function, faculty are completely responsible for all aspects of patient care in the emergency department (ED).
- All residents, regardless of level of training, must present all patients they have evaluated in a timely manner to a faculty member. Faculty are responsible for all final patient dispositions. Furthermore, decisions to order diagnostic studies such as Computed Tomography/MRI/V-Q scans, consultations from other services, or urgent/emergency therapeutic maneuvers, must be made in concert with the faculty responsible for the patient. This level of supervision not only ensures the quality of the educational experience for residents in the ED, but also ensures the highest level of patient care. Faculty or residents who do not meet this standard of care in the ED will be subject to disciplinary action.

Procedure Logs

Logging procedures is important and necessary for us to tract your clinical progress, to ensure that you are meeting the minimal standards set by the RRC (see below), and to assure credentialing for your future employment beyond residency. If you are steadfast and consistent, there will be no difficulty obtaining and logging the needed procedures in your three years of training. Start developing good habits early and log, log and log. You will get updates on your procedure tallies in your mailbox 3-4 times a year. The target number of procedures to be logged is as follow:

- First year residents are expected to fulfill and document 50% of all the RRC required number of procedures by the end of their first year. The only exceptions are resuscitations and chest tubes. The requisite numbers will also be posted on New Innovations.
- Second year residents are expected to fulfill and document 50% of the required number of resuscitations, and 100% of the required numbers of all other procedures by the end of their second year.
- Seniors are required to complete 100% of the required number of resuscitations, and in addition, another 25-50% of all other procedures (depending on the procedure and excluding vaginal deliveries).
• Keep in mind that our goal is not to achieve the minimum numbers required by the RRC, but rather, to exceed them. Also RRC required procedures are by no means the only procedures you should log. Other procedures such as ABGs, nasogastric lavage, nerve blocks, and paracentesis, to name a few, are tracked to ensure that you are certified to perform them on your own. There is a comprehensive list of all procedures in the EMSTAT database.
• In addition to EMSTAT, you can also log your procedures into New-Innovation. The web-based site is meant for procedures performed outside SLR ED, such as your ward rotations and away electives. However, you should also enter procedures from animal and simulation labs, as well as procedures you failed to log while working a hectic shift in the ED. The quarterly updates on your procedure tallies will come from both databases.

Emergency Medicine RRC Procedures
• RESUSCITATIONS
• Adult, Medical and non-traumatic surgical (45)
• Adult, Trauma (35)
• Pediatric Medical and non-traumatic surgical (15)
• Pediatric, Trauma (10)
• Cardiac pacing, transvenous or transcutaneous (6)
• Central Venous Access (20)
• Conscious Sedation (15)
• Cricothyrotomy (3)
• Dislocation reduction (15)
• Emergency Bedside Ultrasound
• Lumbar Puncture (20)
• Endotracheal intubation (35)
• Pericardiocentesis (3)
• Thoracostomy (10)
• Vaginal Delivery (10)

SICK CALL COVERAGE
• When a resident calls in sick their shift will be covered by the resident covering sick call or another resident as determined by a Chief Resident. The person who is asked to cover the shift will NOT have the shift paid back on a future schedule. The person covering the shift may receive monetary compensation if the coverage occurs on a night or weekend. It has been our experience thus far, that sick calls are infrequent. Residents need to feel they can take time off when they are ill without compromising their patient care, or departmental function. Conversely, we do not want to burden our colleagues by abusing the system.
• A sick call schedule has been made for the year. Residents are responsible for knowing when they are on sick call. This entails being on page 24 hours a day starting at 7am on the first day listed, and ending at 6:59am on the morning after the last day listed. During this period, you must be able to report to the ED within
one hour of being paged. If there is any question that you are out of beeper range, page yourself to make certain you are reachable. If you will not be carrying your beeper please call the operator and ask that your beeper be forwarded to your cell phone. Be aware that your beeper will not function while you are in the subway. Please be sure your phone is on ring (not vibrate or silent) at all times. If you live with a spouse or significant other consider listing their phone number on when to work under your name in case there is every a problem getting a hold of you.

- **Unfortunately, on several past occasions, on-call residents were not reachable.** Failure to be reachable, be available or to respond to a page while on sick call are considered serious breaches of professional obligation and may impair the functioning of the department. Therefore, not responding while on call will result in the assignment of TWO extra shifts (one to be paid to the person who had to cover for you), and a letter in the resident's file.
- Coverage switches are permitted only after a written agreement emailed in by both parties to the chief email account has been approved and posted on when to work. All swaps must take place more than 24 hours before the coverage is to begin.
- If you think you may need to activate sick call page or call the EM chief resident on call. It is not acceptable to consider text messaging the chief resident as adequate for activating sick call. Direct communication must occur. The pager is 31000 or find their phone number on the home page of when to work. Please contact them as soon as it is apparent you cannot work your shift, preferably several hours before your shift is to begin. The chief will then arrange the necessary coverage and notify all involved departments. If you are not sure if you will need to activate sick call or not it is better to call and give a heads up so everyone can be prepared should you need to active it later.
- There will be three residents on sick call at all times (one from each class). Generally, you cover for your year or a lower year class. If several shifts need to be covered, attempts will be made to distribute the coverage between everyone on sick call that week/month.
- The sick call protocol applies not only to ED shifts, but also to our off-service rotations. If an ED resident on an off-service rotation cannot work due to illness, they too, must inform one of the chief residents.

**Disaster Plan / Phone Tree**

- (Phone tree may be used at other times to disseminate important info.)
- In the event of a disaster the EM chief resident on call will be paged and instructed on the number of casualties anticipated and which site (RH, SL, or both) will receive the bulk of patients. The chief will contact the other chiefs to initiate the phone tree. The tree is based on each resident contacting the next 2 residents on the tree. If a resident is unable to speak live with one of his/her contacts, that resident must take over the next person’s contact duties, moving down the chain to the next 2 residents.
• While we realize that EM residents are not required to carry pagers while off-duty, we know most people have their cell phones with them. Given that we are in the center of NYC and a designated as a priority target by the Department of Homeland Security, it is likely that we will again at some point experience a mass casualty incident, either man-made or natural. The availability of trained residents will be crucial to our response. Residents that are working at the time of a disaster plan activation will be held over after their shift as needed and additional residents will be called in, starting with the sick call residents, followed by off-duty residents with residents who just finished a night shift being called last. Beyond an initial activation, the DOC along with the Residency Director and chief on call will develop a schedule for work/rest shifts for the remainder of the disaster activation.

**Moonlighting Policy**

Moonlighting is strongly discouraged by the EM Residency Administration, and is simply not allowed during the EM-1 and EM-2 years. We believe strongly that these three years of residency training are a crucial time for your learning and development. Consequently, you should dedicate as much time as possible to academic endeavors that will enrich your residency experience, as well as contribute to the residency program. For third year residents who have obtained their New York State license, the Residency Director must approve moonlighting privileges. In order to be granted moonlighting privileges, the third year must demonstrate a high enough level of performance to ensure that moonlighting will not be detrimental to his or her academic development. These moonlighting privileges may be withdrawn at any time if the Residency Director believes that moonlighting is interfering or detracting from the resident's primary obligations to academic pursuits and learning, conference attendance falls below 90%, or if the resident's performance is less than stellar. Moonlighting hours must be arranged in adherence to the 405/Bell Commission Regulations (no more than eighty hours per average week [moonlighting plus SLRHC ED time]); and should never overlap or interfere with the resident's primary responsibilities to the ED schedule, conference and learning at SLRHC. Once moonlighting privileges are granted, the name and contact information of the ED Director must be provided to the Residency Director. In addition, if you are granted moonlighting privileges, in order to comply with the New York State resident work hour regulations (405 Regulations/Bell Commission), you must:

• Provide Ericka Salas, Residency Coordinator, with the ED schedule of your place of moonlighting on a monthly basis, regardless of whether or not you worked there on any given month for review by the PD.
• Highlight your name on the schedule.
• Provide a monthly summary of the shifts that you worked.
• Sign this attestation.
• I have read and agree to comply with the above statement.
DEPARTMENTAL DRESS CODE POLICY

Patients measure us in non-clinical ways. We want our patients to look at us, and to be confident that we will provide them with high quality care. When we dress sloppily and casually, patients might view us in the same manner. They want and deserve professionalism from their physician, so we should act and dress the part. We have outlined the departmental dress code listed below.

- Clean scrub bottoms and tops
- Long white coats are optional
- Blue jeans are not acceptable.
- T-shirts are not acceptable

All staff must wear their hospital ID card at all times.

Promotion Policy

Criteria for Promotion

- Promotion is granted for any summative evaluation of satisfactory or better.
- Residents who receive summative evaluations that are “marginal” can be promoted once but a second consecutive “marginal” rating results in no credit being given for that year of training and subsequently, no promotion.
- Final word for all promotions is reserved for the Program Director.
- The Clinical Competency Committee (CCC) meets semi-annually to review multisource evaluation data for each resident, deliberate, and make a determination as to the level of achievement (1-5) of the EM milestones (which incorporate and are based on clinical competencies). The CCC will make a formal written recommendation to the PD of one of the following for each resident: Remediation required, satisfactory performance, commendation, advancement to the next year, graduation. The CCC may recommend that a resident not be graduated or advanced to the next year. The determinations of the CCC are conveyed to the resident during each biannual summative evaluation session with the PD.

Criteria for Promotion from EM-1 to EM-2:

- Completion of 13 blocks of service delineated on the Resident Master Schedule
- Achievement of Satisfactory Performance or better on monthly and daily attending shift evaluations
- Achievement of Satisfactory Performance or better on monthly resident or peer evaluations
- In the absence of above, successful completion of remedial work as prescribed by the Program Director
- Successful performance on oral board evaluations, simulation sessions and small group review sessions.
- Satisfactory (passing) performance on the annual in-training examination
- Completion and documentation 50% of the procedures delineated by the RRC and indicated on the New Innovations Website.
- Satisfactory (passing) performance on the Airway credentialing written and practical exams in June of Intern year.
- Satisfactory performance on procedure stations at Annual Airway Day (July) and the Advanced Procedure Day (March)
- Timely Attendance at the Wednesday educational conference.
- Satisfactory and timely attendance in all assigned clinic experiences.
- Satisfactory and timely attendance at semi-annual program director’s review
- Recommendation by the CCC for promotion after deliberation and review of multisource evaluation data (see section on resident evaluation process)

Criteria for Promotion from EM-2 to EM-3:
- Completion of 13 blocks of service delineated on the Resident Master Schedule
- Achievement of Satisfactory Performance or better on most monthly and daily attending shift evaluations.
- Achievement of Satisfactory Performance or better on monthly resident or peer evaluations
- In the absence of above - successful completion of remedial work as prescribed by the Program Director
- Completion and documentation of 100% of the procedures delineated by the RRC and indicated on the New Innovations Website (except for resuscitations)
- Successful performance on the ECG Credentialing Exam in June of EM-2 year.
- Timely Attendance at the Wednesday educational conference.
- Satisfactory and timely attendance in all assigned clinic experiences
- Satisfactory and timely attendance at semi-annual program director’s review
- Recommendation for promotion by the CCC after careful review of multisource evaluation data.

Criteria for Graduation from EM-3
- Completion of 13 blocks of service delineated on the Resident Master Schedule
- Achievement of Satisfactory or better Performance on monthly and daily attending evaluations
- Achievement of Satisfactory Performance or better on monthly resident or peer evaluations
- In the absence of above - successful completion of remedial work as prescribed by the Program Director
- Participation in a scholarly work or conducting medical research resulting in submission of to a peer reviewed journal or abstract presentation at a regional or national meeting. Other meaningful scholarly work in place of manuscript or submission or abstract may be approved in advance on a case by case basis by the PD.
- Participation in a Practice Based Learning and Improvement Project or a Quality Improvement/Patient Safety Project. Specifically every senior resident must complete the investigation of a QI case under the direct supervision of a site medical director, attend at least one meeting of the CQI Committee and present case at one Wednesday conference M&M session. In addition, every senior
resident must participate in a patient safety project through the implementation phase. (see above section on CQI requirement)

- Completion and documentation of 150% of the procedures delineated by the RRC and indicated on the New Innovations Website
- Timely Attendance at the Wednesday educational conference.
- Satisfactory and timely attendance in all assigned clinic experiences
- Satisfactory and timely attendance at semi-annual program director's review.
- Satisfactory and timely completion of all administrative responsibilities in a timely and professional manner. This includes timely chart completion and responsiveness to other administrative duties as needed.
- Recommendation for promotion by the CCC after careful review of multisource evaluation data.

Criteria for Dismissal
- Dismissal (release) from the training program occurs under three circumstances:
  - Voluntarily on the part of the trainee in which case adequate notice must be given
  - Voluntarily on the part of the Program Director when a trainee wishes to leave to pursue training elsewhere or in another specialty. This will occur for residents under contract only at the discretion of the Program Director.
  - Following a due process proceeding as outlined in the Collective Bargaining Agreement between the St. Luke's-Roosevelt Hospital Center and the Committee of Interns and Residents CIR/SEIU.GMEC

Due Process
The hospital follows a strict “due process” procedure for disciplinary actions resulting from questions of clinical competency, medical misconduct, academic progress, or board eligibility. This is described in the Collective Bargaining Agreement between the St. Luke's-Roosevelt Hospital Center and the Committee of Interns and Residents CIR/SEIU

The Committee of Interns and Residents (CIR) Due Process Procedure

Grievance Procedure
- A grievance shall be defined as a dispute regarding:
  - the interpretation or application of the instant written Agreement or
  - regular and recurrent assignment of a House Staff Officer to duties not appropriate to a House Staff Officer
- A grievance may be brought by the CIR pursuant to the following three (3) step procedure:
  - Step 1: The CIR shall present the grievance in writing to the Hospital no later than sixty (60) calendar days
after its occurrence. A grievance addressed to the Hospital shall be delivered to the appropriate Chief of Service, with a copy to the Personnel Department. The Chief of Service, or his or her designee, shall take appropriate steps to resolve the dispute but, in any event, must reply in writing to both the House Staff Officer and CIR no later than (10) calendar days after the presentation of the grievance.

- **Step 2:** If the grievance is not satisfactorily resolved at Step I, a written appeal to the Director of Personnel must be made within ten (10) calendar days of the receipt of Step I determination. The Director of Personnel or his or her designee shall take appropriate steps to resolve the dispute, including meeting with CIR within seven (7) calendar days, and shall reply in writing to CIR no later than ten (10) calendar days after the appeal is filed with him or her.

- **Step 3:** If the grievance is not satisfactorily resolved at Step I or Step II, CIR shall either proceed, within twenty-one (21) calendar days after receipt of the Step II determination, to final and binding arbitration before a single arbitrator, pursuant to the Voluntary Labor Arbitration Rules of the American Arbitration Association or, by failing to arbitrate the issue, shall accede to the prior determination and waive all further rights hereunder.

- Any of the foregoing Steps may be waived by mutual written consent of the parties. Should the individual charged with making a determination at Step I or Step II exceed a time limit without such consent then the grievance may be deemed denied and appealed to the next step.

- House Staff Officers shall be entitled to representation by CIR at all Steps of the grievance procedure.

- The Hospital will allow time off to House Staff Officers involved in grievance proceedings so long as such time off shall not interfere with normal Hospital operations.

- Any of the time limits in this Article may be extended by mutual written agreement of the parties.

**Disciplinary Procedure**

- Any discipline of House Staff Officer shall be pursuant to the procedures provided herein.

- The following procedures will apply to all disciplinary actions concerning clinical competence, medical misconduct, academic progress and board eligibility of a House Staff Officer.
A house Staff Officer shall have the right to an internal disciplinary hearing. The Hospital will give the CIR and the House Staff Officer written notice of the proposed charges and contemplated disciplinary actions against the House Staff Officer by certified mail return receipt requested. CIR and/or the House Staff Officer shall have the right to request a hearing on such charges and such request shall be made in writing within seven (7) days of receipt of the written notice of charges. Written notice of the time and place of the internal disciplinary hearing shall be given by certified mail, return receipt requested, no later than fourteen (14) days after receipt of the House Officer's request for a hearing and such hearing shall be held no later than forty five (45) days from receipt of the House Staff Officer's request for hearing.

The hearing shall be held before an Ad-Hoc Committee comprised of five members. Three such members shall be Attending Physicians appointed to the Ad-Hoc Committee by the Hospitals Medical Director. No Medical Staff member who participated in the decision to recommend discipline or non-renewal shall be appointed to the Ad-Hoc Committee. Two members shall be residents appointed by the CIR.

The House Staff Officer shall have the right to have CIR represent him or her in the internal disciplinary hearing.

The House Staff Officer shall have a full-unimpaired hearing, including the right to call and examine witnesses, to introduce written and documentary evidence, to cross-examine witnesses and to rebut any evidence. Each party shall have the right, prior to, during, or at the conclusion of the hearing, to submit written memoranda concerning any issue of fact or procedure, or any written document concerning the merits of the case, to the Ad-Hoc Committee. Such written memoranda or argument shall become part of the hearing record. The Hospital shall have the burden of proving the charges.

Upon the conclusion of the presentation of oral and written evidence, and the receipt of any written closing argument, the hearing shall be closed. The Ad-Hoc Committee shall issue a written decision within fourteen (14) calendar days after the close of the hearing. The Ad-Hoc Committee shall have the authority to accept, reject or modify the charges and/or proposed discipline.

The Ad-Hoc Committee’s final written decision, including the charges and disciplinary action, shall be presented to the CIR and to the affected House Staff Officer.

With respect to disciplinary actions for reasons not described in paragraph 2, above, the following procedures shall apply.

The Hospital will give the CIR and the House Staff Officer written notice of the proposed charges and contemplated disciplinary actions against the House Staff Officer by certified mail, return receipt requested. The affected House Staff Officer and/or CIR shall have the right to a meeting with his/her Department Chair or his/her designee in order to review or reconsider the disciplinary action. The House Staff Officer shall be allowed to present evidence in support of his/her position to the Chief of Service Designee. The House Staff Officer shall request such a meeting within seven (7) days.
of receipt of the written notice of discipline. The Chief of Service or
designee shall hold a meeting within seven (7) days of the date of the
House Staff Officer’s request and shall issue a written decision within three
(3) days of the meeting.
   o If the matter is not satisfactorily resolved after the meeting with the Chief of
   Service or his/her designee, a written appeal to the Hospital’s Medical
   Director must be made within seven (7) days of the date the House Staff
   Officer receives the Chief of Service’s written decision. The medical
   Director shall take appropriate steps to resolve the dispute, including
   meeting with CIR within seven (7) days, and shall reply in writing to the
   House Staff Officer and CIR no later than seven (7) days after such meeting.
   o If the matter is not resolved after meeting with the medical Director, CIR
   shall have twenty-one (21) days after receipt of the Medical Director’s
   written decision to submit a written request to the American Arbitration
   Association that the final charges and disciplinary action be arbitrated
   pursuant to the Voluntary Labor Arbitration Rules of the American
   Arbitration Association. The CIR shall send a copy of the request for
   arbitration to the Vice President of Human Resources at the same time it
   sends the request to the American Arbitration Association. By mutual
   agreement of the parties, the arbitration may be held pursuant to the
      ▪ Arbitration hereunder with respect to discharge, demotion or other
discipline shall determine whether just cause or basis exists for the
action. The arbitrator shall be selected through the Voluntary Labor
Arbitration Rules of the American Arbitration Association and fees
and expenses of the American Arbitration Association and the
arbitrator shall be borne equally by the CIR and the Hospital. The
arbitrator shall be authorized to accept or reject the charges, in
whole or in part, and to accept, reject or modify the disciplinary
action and determine an appropriate remedy. The determination or
award of the arbitrator shall be final and binding, and shall not add to,
subtract from or modify this Agreement in any way.
   o There shall be no termination of a House Staff Officer until the completion
of all due process procedures described in this article. A House Staff
Officer may be temporarily suspended without pay or reassigned from
medical responsibility with pay by the department chair before the
Hospital’s internal procedures take place or are completed. It is understood
that a temporary suspension without pay will be imposed only in cases
where serious medical misconduct is alleged and the employee’s continued
presence in Hospital facilities is deemed to jeopardize patient care or the
safety of the House Staff Officer or others, and reassignment is not viable.
The Hospital shall not report the suspension to any regulatory agencies
until a meeting is held with the Medical Director or his designee to review
the reasons for the discipline.
   o In those serious cases where suspension without pay is imposed, a
meeting of the Medical Director or his designee, and the House Staff Officer,
who shall have the right to have a CIR representative present, shall be held
within fourteen (14) days from the date of suspension to review the reasons for suspension and the viability of alternative assignments. The Medical director will decide whether continued suspension (with or without) pay during the Hospital’s internal procedures is warranted or whether the House Staff Officer shall be returned to full, partial or reassigned duties during the due process proceedings. No unwarranted suspensions or temporary suspensions of less than fourteen (14) days shall be reported to any regulatory agency unless otherwise required by law or accreditation standards. Temporary suspension shall end at any time during due process proceedings when the Medical Director determines that a viable alternative exists.

- The hospital will attempt to arrange the work schedules of House Staff Officers who are involved in disciplinary proceedings so as to permit reasonable time off to attend all meetings and hearings related to the discipline.

- Any of the time limits in this Article may be extended by mutual agreement of the parties

**Hospital Holiday Policy**

- During hospital holidays, you follow the schedule of the service on which you are rotating. On holidays, you are expected to work your assigned shifts in the ED.
Policy For Chest Tube Insertion in the Emergency Department

ST. LUKE'S-ROOSEVELT HOSPITAL CENTER

POLICY & PROCEDURE MANUAL

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Original Date of Issue: May, 2000

Policy:
- To enhance patient care the Emergency Department and Dept. of Surgery are committed to a collaborative relationship in the placement of chest tubes. Whenever possible both services will be involved in the pre-procedure, procedure and post-procedure care of the patient. All residents will receive didactic and simulation training to assure that the same procedure is followed and the same level of clinical care is maintained. The standardized approach to placement of a chest tube is included in this policy.

Procedure:

Non traumatic pneumothorax
- All chest tubes will be placed under the direct supervision of the Emergency Department attending or Surgical attending. Except in cases of extremis, all chest tubes must be placed in collaboration and after consult with the Thoracic Surgical Service.
- Patient in extremis, specifically those patients with a tension pneumothorax will undergo immediate needle thoracostomy, followed by chest tube placement. Surgery should be notified immediately that this procedure is happening so they can come to the ED to collaborate in further management of the patient.
- All nontraumatic chest tubes will be placed by the ED PGY-2 or higher generally supervised directly by a surgical PGY-3 or higher except in cases of patients with:
  - suspected adhesions
  - prior thoracic surgery or procedures
  - concern regarding coagulopathy
  - extreme body habitus
  - loculated pneumothorax requiring directed chest tube placement
  - pediatric patients
- In these cases, the chest tube will be directly placed by the senior surgical resident

Traumatic pneumothorax
- A trauma code or trauma alert will be called as appropriate for all trauma patients.
• Patient in extremis, specifically those patients with a tension pneumothorax, will **undergo immediate needle thoracostomy, followed by chest tube placement.**

• The Emergency Medicine or Surgical PGY-2 will be responsible for placing the chest tube on even and odd on-call days respectively. A junior resident from one service may not be substituted for a junior resident of the other service. **On-call days will correspond to the calendar day i.e. 12 am to 11:59 pm.**

• The senior resident from surgery or an attending will in all instances do the procedure with the junior resident. The senior surgical resident in consultation with the Emergency Department or Surgical attending may choose to do the procedure themselves under the following circumstances:
  - Patient in extremis
  - suspected adhesions
  - prior thoracic surgery or procedures
  - concern regarding coagulopathy
  - extreme body habitus
  - loculated pneumothorax requiring directed chest tube placement
  - pediatric patients

**PROCEDURE FOR CHEST TUBE INSERTION:**
  - Whenever possible a consent should be obtained
  - A “time out” should occur to assure the correct patient, procedure and laterality
  - **Indications:** Abnormal accumulation of fluid or air in the pleural space.
  - **Lab values:** INR <1.5 and Platelets > 50 000 (in elective situations). Coagulopathy is NOT a contraindication in the emergent situation!
  - **Correct side:** Confirm with physical exam, CXR/Chest CT to determine ideal placement of tube.
  - **Select a chest tube:**
    - Air: 24 or 28 Fr straight chest tube to apex
    - Fluid: 28 or 32 Fr chest tube to dependent location (base or posterior). **36 Fr tubes should be considered for traumatic hemothoraces.**
    - DO NOT USE TROCAR CHEST TUBES!! They can puncture the lung, pulmonary vessels, or other intrathoracic or abdominal organs if not controlled. **Additionally, they** have too few drainage holes to be effective.
  - **Prepare the PleurEvac:** Place one “funnel-full” of sterile water in the water seal chamber; this should bring it up to 2 cm. Place enough sterile water into the suction regulation chamber – through the open muffler port – to finish at 20 cm. Close grey rubber stop tightly.
  - **Position:** For most chest tube insertions, the patient should be placed with the affected side elevated ~45-and the arm abducted and extended above the head. Sometimes it is helpful to tape the wrist to the bedrails (do not compromise the circulation to the hand!). **Most chest tubes placed in the setting of acute trauma are placed prior to spine clearance. If the spine has not been cleared, and there is potential for a spinal injury, the chest tube should be placed with the patient supine.**
Placement: For most patients, the anterior or mid axillary line in the 4th to 6th interspace is appropriate, which corresponds to the nipple line in males and just under the breast tissue in females. If possible, try to avoid going thru a large amount of adipose tissue or muscle. Identify the thick latissimus dorsi muscle and stay anterior to it. Avoid the thick posterior chest wall muscles. Do not tunnel the chest tube and enter the chest at the level of skin incision. Keep in mind that a chest tube incision may be used for a subsequent VATS procedure.

In patients with previous thoracotomies, the placement of the chest tube is usually ABOVE the incision. If unsure about where to place tube, obtain CT and speak to attending.

Analgesia: IV narcotics +/- midazolam. In addition, use 1% Lidocaine - may use up to ½ cc per pt’s weight in kg (eg. 30cc (300 mg) for 60kg pt).

Anesthetize:
- Skin
- Subq tract
- Periosteum of the rib above
- Parietal pleura

Skin incision: Make a horizontal incision (about 2cm) (or large enough to insert your index finger) with a knife just above the rib. Dissect bluntly with a tonsil (NOT a Kelly clamp) staying just above the rib. Do NOT create a tunnel. Once you are in the chest, you can use a Kelly clamp to increase the size of the opening. It is helpful to hold the joint of the tonsil clamp with your non-dominant hand, so you avoid an uncontrolled entry into the chest. It is not necessary to insert your finger in the pleural cavity to ensure there are no adhesions.

Suture: Place a s0 silk (NOT 2-0) at the edge of the incision to secure the tube after insertion. Place a 2-0 Prolene U-stitch around the incision. You will use this to close the incision upon tube removal. Leave the ends long and wrap them around the shaft of the chest tube and tape the ends to the chest tube.

Tube position: This is very important. There is a tendency for the chest tube to want to enter the mediastinum. You will have to make an exaggerated attempt to direct the chest tube posteriorly and up to the apex. This sounds easier than it is. A Kelly clamp on the tip of the tube may be helpful. Place the tube and clamp into the pleural space and guide to appropriate position. (It is sometimes helpful to place another clamp on the other end of the tube to prevent fluid from rushing out and soaking the bed or your shoes.) For fluid, you want a dependent drainage position. Secure the chest tubes, cut the end off the tube at the fattest part, and connect to the PleurEvac. This connection should be taped securely.

Dressing: Place a discrete, small dry gauze dressing. Use tape carefully and without tension, as this leads to significant skin burns. Please clean the Betadine off the patient, as this can sometimes lead to burns. NO need for Vaseline or Xeroform around chest tube. Have RN change dressing daily.
- **CXR**: Confirm adequate placement with a CXR
- **Analgesia**: IV Tylenol (1000mgq6h) + narcotic prn
- **Note**: For large pleural effusions, do not allow more than 1.5-2 liter to drain at any one time. If a large amount of fluid is draining, clamp the tube and return in about an hour to complete the drainage.

**EDUCATIONAL FUND ALLOWANCE POLICY**

**Introduction**

Residents pursue a variety of academic activities, which are costly. These include attendance at conferences, purchase of Emergency Medicine textbooks, or seed money for research projects.

**Purpose**

To provide financial support for resident participation in academic activities.

**Method**

Residents must complete a CME request form with appropriate receipts and proof of payment in order to receive reimbursement. Requests will be reviewed by the program director, who will notify the resident of the status of the request. Each resident may receive up to $200 per year in support of academic activities.

Allocations from one academic year can’t be carried over to the next academic year except, with written permission of the program director. These requests will be considered only for support of a research project.

Residents are encouraged to submit requests with ample advance notice.
<table>
<thead>
<tr>
<th>Name</th>
<th>Address</th>
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**EMERGENCY MEDICINE RESIDENCY PROGRAM - RESIDENTS ROSTER**

**Revised** 7/1/2013
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Important Dates 2013-2014

Graduation: June 24 2014

Residency Retreats:
- EM-2 (Garrison Institute): 10/9-10/10/13
- Intern (Mark Clark’s): 01/08/14
- Departing Senior (Jeff Rabrich’s): 05/21/2014
- Rising Senior (Tod Bania’s): 06/04/2014

Interview Season:
- Interview Dates: Nov 4,11,18,25; Dec 2,9,16; Jan 6,13,20,27
- Rank List Due: 2/26/2014
- Match Day: 3/21/2014

National Meetings:
- ACEP (Seattle): Oct 14-17 2013
- SAEM (Dallas): May 14-17 2014
- CORD (New Orleans): March 30-April 3 2014

NYC Marathon: Nov 3 2013 followed by Family Style Dinner Steve Lynn’s

Special Conference Days:
- Airway Day: 7/17, 2013
- Advance Procedure Day
- Residency Meetings: 8//7/13, 11/6/13
- In-Service Exam: 2/26/2014
- Senior Breakfast/ ECG and Airway Exams: 6/18/2014
- SLR EM Ultrasound Symposium: 4/9/2014
- Critical Care Conference Mt. Sinai: 1/8/2014
- All NYC Conferences: 8/21/2013, 3/12/14

Social Events
- Intern Sail: 7/3/2013
- Intern Welcome Party (Tommy Wong’s): 7/13/13
- Post In-Service Party (Tommy Wong’s): 2/26/2014
Resident Lectures 2013-2014

PGY2
- Laura Borman 5/7
- Jessica Cook: 10/30
- Aaran Drake 12/11
- TR Eckler 2/5
- Beau Gemignani 3/5
- Antoinette Golden 4/23
- Nick Governori 8/14
- Neil Kathuria 10/2
- Jessica Leifer 3/19
- Danielle Matilsky 11/20
- Matt Morrison 6/11
- Max Morrison 5/28
- Dan Solis 1/22
- James Young 8/28

PGY3 (PGY2 Talks not given last year)
- Anh 10/9
- Jess 7/10
- Ben 7/3
- Meyer 11/20

PGY3
- Meghan Ahearn 12/18
- Aziz Ahmed 5/28
- Smita Badhey 8/7
- Luke Buhrmester 1/22
- Dave Diller 7/3
- Tim Koo 10/23
- Elyse Lavine 7/10
- Carolyn Meyer 3/19
- Anh Nguyen 4/30
- Jess Noonan 11/13
- Gehres Paschal 8/28
- Rishi Vohra 2/19
- Ben Zabar 4/16
Pre-hospital Care Lecture Series Schedule 2013 2014
SLR Prehospital Care Lecture Series 2013- 2014

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<td>9/19</td>
<td>1 pm</td>
<td>New Topics in Pre-hospital Trauma: Quick Clot, Artificial Blood</td>
<td>TR Eckler</td>
<td>SL</td>
</tr>
<tr>
<td>10/3</td>
<td>1 pm</td>
<td>GU Emergencies</td>
<td>Matt Morrison (working RH mid)</td>
<td>SL</td>
</tr>
<tr>
<td>10/17</td>
<td>1 pm</td>
<td>Prehospital Tox: Alcohol and Drugs of Abuse</td>
<td>Beau Gemignani</td>
<td>RH</td>
</tr>
<tr>
<td>11/7</td>
<td>1 pm</td>
<td>Dental Emergencies</td>
<td>Nick Governatori</td>
<td>SL</td>
</tr>
<tr>
<td>11/21</td>
<td>12 pm</td>
<td>Cold Emergencies: Hypothermia, Frostbite</td>
<td>Laura Borman</td>
<td>SL</td>
</tr>
<tr>
<td>12/5</td>
<td>1 pm</td>
<td>COPD/Asthma</td>
<td>James Young</td>
<td>RH</td>
</tr>
<tr>
<td>12/19</td>
<td>1 pm</td>
<td>OB/GYN Emergencies; Emergency Childbirth</td>
<td>Neil Kathuria (working RH mid)</td>
<td>SL</td>
</tr>
</tbody>
</table>

Appendix C: Jitney Schedule

JITNEY SCHEDULE

The Roosevelt site jitney stop is on Tenth Avenue at the curb directly in front of the main entrance of the new building. The St. Luke's jitney stop is on Amsterdam Avenue between 113 and 114th streets.

Traveling Northbound, the jitney takes Amsterdam Avenue. Schedule permitting and upon request, the driver will stop at West 77th, 84th, 96th and 108th Streets. Traveling Southbound, the jitney takes Columbus Avenue. Schedule permitting and upon request the driver will make the same stops as above as well as the 58th Street entrance of 555 West 57th Street.
Should traffic on the usual routes cause schedule delays, the jitney driver will use alternative routes that are less congested, i.e., Columbus Avenue, Broadway, Riverside Drive, West End Avenue or a combination of the above.

<table>
<thead>
<tr>
<th>ROOSEVELT</th>
<th>ST. LUKE'S</th>
</tr>
</thead>
<tbody>
<tr>
<td>6:00AM</td>
<td>6:15AM</td>
</tr>
<tr>
<td>6:45AM</td>
<td>7:15AM</td>
</tr>
<tr>
<td>7:45AM</td>
<td>8:15AM</td>
</tr>
<tr>
<td>8:45AM</td>
<td>9:15AM</td>
</tr>
<tr>
<td>10:00AM</td>
<td>10:30AM</td>
</tr>
<tr>
<td>11:00AM</td>
<td>11:30AM</td>
</tr>
<tr>
<td>NOON</td>
<td>12:30PM</td>
</tr>
<tr>
<td>1:00PM</td>
<td>1:30PM</td>
</tr>
<tr>
<td>2:00PM</td>
<td>2:30PM</td>
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<tr>
<td>3:00PM</td>
<td>3:30PM</td>
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<tr>
<td>10:00PM</td>
<td>10:30PM</td>
</tr>
<tr>
<td>11:00PM</td>
<td>11:30PM</td>
</tr>
<tr>
<td>MIDNIGHT</td>
<td>12:30AM**</td>
</tr>
</tbody>
</table>

**The last jitney departs from the St. Luke's site at 12:30AM and arrives at the Roosevelt site at about 12:45AM. The jitney will no longer return to St. Luke's site after dropping off the riders at the Roosevelt site.**