EMERGENCY MEDICINE

Overview

Most of the Emergency Medicine Experience occurs predominantly during PGY-1 or PGY-2 Emergency Blocks. In addition, all inpatient rotations provide residents varying degrees of Emergency Medicine Experience, whether as consultants or admitting physicians to patients in the Emergency Department (ED).

All Internal Medicine residents will complete at least four weeks of direct experience in the ED in blocks not less than 2 weeks, and not to exceed 3 months in 3 years of training. Categorical PGY-2 and PGY-1 osteopathic residents each complete a one-month Emergency Medicine rotation. During this rotation there are fifteen 9-hour shifts, including weekend and night shifts. The residents perform initial evaluations of adult and adolescent patients presenting to the ED with undifferentiated medical and minor surgical problems. Residents participate in the diagnosis, management and admission decisions across a broad spectrum of medical, surgical, and psychiatric illnesses such that residents will learn how to determine which patients require hospitalization. All patients are presented to the Emergency Medicine (EM) attending. The residents and EM staff, together develop a diagnostic and therapeutic plan.

Goals

To teach residents to become competent and effective in the assessment, stabilization, and resuscitation of patients with emergent medical and surgical problems.

To teach residents the fundamentals of patient triage and prioritization of medical care.

To teach residents to comprehend the initial presentation and early management of emergent and urgent care medical problems, as well as the disposition of these patients.

To teach residents to understand how health care and social issues effect emergency departments and the working relationship between emergency medicine and internal medicine departments.

To teach residents how to access, manage and provide proper follow-up of their patients within the Saint John and OU-Tulsa systems.

Objectives

Patient Care

- To effectively interview patients in the ED setting;
- To effectively examine patients in the ED setting;
- To effectively perform initial evaluation and management of patients with medical emergencies and minor surgical emergencies;
- To effectively assess patients need for hospitalization and appropriate level of inpatient care;
• To learn airway management including bag-valve-mask and intubation techniques;
• To understand pulse oximetry and carbon dioxide monitoring; and
• To become familiar with methods of intravenous access including central line access.

Medical Knowledge

• To expand the knowledge base of the basic and clinical sciences underlying the care of the patients with medical and minor surgical emergencies (specifically in the content areas noted below); and
• To access and critically evaluate current medical information and scientific evidence relevant to medical and surgical emergent care.

Practice Based Learning and Improvement

• To identify deficiencies in one's knowledge, skills and attitudes in the care of the ED patient;
• To develop strategies for correcting deficiencies in one's knowledge, skills and attitudes in the care of the ED patients;
• To learn judicious use of laboratory, radiographic and other ancillary tests;
• To evaluate reasons for patients' return visits to the ED after discharge;
• To evaluate patient's satisfaction with the ED visit and the physician care; and
• To retrospectively evaluate unexpected patient outcomes.

Interpersonal Skills and Communication

• To communicate in a sensitive and effective manner, with patients and families from diverse ethnic and socioeconomic backgrounds;
• To address the patient's chief complaint;
• To ensure that all the patient's questions have been satisfactorily answered;
• To communicate effectively with physician colleagues in the ED and members of other health care professions to assure timely, comprehensive patient care;
• To document the ED visit completely and legibly; and
• To clearly and concisely provide the necessary information to the clinician assuming care of the patient from the ED.

Professionalism

• To be professional in all interactions with patients, families, colleagues and all members of the health care team;
• To ensure patient understanding of their medical illnesses and consent to treatment plans; and,
• To demonstrate respect for alternative, but appropriate treatment plans recommended by one's resident and faculty colleagues.

Systems Based Practice
• To recognize the community’s use and abuse of the ED and the ED’s role in trying to meet its patients’ primary health care needs;
• To understand and coordinate the provision of multidisciplinary resources for the optimal care of ED patients;
• To educate members of the multidisciplinary team in an effort to assure appropriate and quality care of ED patients;
• To use evidence-based, cost conscious strategies in the care of ED patients;
• To recognize that different insurances have different coverage benefits for ED services;
• To be familiar with community resources and assist patients access these resources;
• To assist the patient deal with the complexities in their care; and
• To be a patient advocates.

Knowledge to be assessed

To be an effective IM clinician involved in the acute care and management of patients, the resident should have knowledge and understanding of the following medical illnesses/condition/topics, (though not exclusively) by the completion of their Emergency Medicine Experiences:

| Advanced Cardiac Life Support Protocols: | Chest pain: |
| Cardiac Dysrhythmias | Differential diagnosis including cardiac, pulmonary, vascular, and GI causes. |
| Pharmacotherapeutic and electrical treatment of Dysrhythmias. | Unstable angina |
| Advanced Trauma Life Support Protocols: | Acute MI |
| Cervical spine immobilization and radiography interpretation | Pulmonary embolus |
| Primary survey | Aortic aneurysms. |
| Secondary survey | Asthma |
| Tetanus immunization protocols | Hypertensive urgencies and emergencies |
| Wound management including wound cleansing and suturing | Sepsis |
| Orthopedic evaluations including basic splinting techniques | Diabetic ketoacidosis |
| Introduction to Managing Toxic Ingestions: | Seizure disorders including first time seizures, convulsive and nonconvulsive |
| Recognition of toxidromes | Status epilepticus |
| Impart an understanding of skin, ocular, and GI decontamination: | Acute abdominal pain, |
| Alkalization | Acute GI bleeds |
| Whole bowel irrigation | Abdominal pain in pregnancy |
| Introduction to specific antidotes | Basic OB/GYN complaints |
| Management of specific ingestions with an emphasis on the alcohols, cocaine, tricyclics, salicylates, and acetaminophen | Basic dental complaints |
| Appropriate use of Poison Center, Toxicology Consultation | Basic ophthalmologic complaints |

Procedural skills
• Arterial puncture
• ACLS
• Central line
• Thoracentesis
• Lumbar puncture
• Nasogastric tube insertion
• Arthrocentesis and joint injections
• Endotracheal intubation
• Suture of lacerations
• Incision and drainage of skin lesions

**Interpretive skills**
• CXR
• ECG
• UA
• KOH and wet prep exams of vaginal discharge
• Gram stains of sputum
• CT head, chest, abdomen and pelvis

**Methods of achieving objectives**
• Direct patient care under the supervision of the EM Attending
• EMS “ride along” experience
• Patient Care recommendations from the consultant services
• Review of patient outcomes after admission
• Core conference series
• OU-Tulsa electronic databases and computerized resources
• Critical review of relevant journal and text publications
• Assigned readings from “Just the Facts in Emergency Medicine” (provided)
• Self directed study

**Assessment tools**
• Attending will evaluate Resident’s history and physical examination of patients
• EM Attending will monitor Resident’s interaction with patients and other health care team members
• EM Attending will critique Resident’s assessment and plan regarding patient’s acute complaints/illnesses
• 100 question multiple choice test based on assigned readings
• EM Attending will monitor Resident’s self-directed learning efforts
• Ancillary Staff will periodically assess the Resident’s professionalism
• EM-IM Rotation Coordinator will determine whether Resident has met the objectives detailed above

**Evaluation process**
• Goals and Objectives will be reviewed with the resident at the beginning of each rotation.
• Resident signs attestation acknowledging receipt of goals and objectives
• Verbal feedback throughout from various EM Attending and at the completion of the rotation from the EM-IM Faculty Rotation Coordinator
• Completion of the evaluation document by the EM- Faculty Rotation Coordinator at the conclusion of the rotation.

Policies and procedures

EM-IM Rotation Coordinator: Tom Hutto, M.D.
EM-IM Rotation Coordinator secretary: Terri White

Emergency Medicine Rotation

Two to three weeks prior to the start of the rotation the resident will contact the EM-IM Rotation Coordinator to establish their upcoming schedule. Shifts must be selected to encompass day, night and weekend experiences. Shifts will be coordinated such that there will be no overlap among the residents of varied services rotating through any given ED area. A resident assigned to do a shift in a designated area of the ED will not be permitted to move to a different ED area during that shift. In addition, the residents will schedule shifts such that they do not overlap with their Continuity Clinic. Residents rotating through the ED will maintain their same obligations to their Continuity Practice. Once the schedule is completed and approved by the EM-IM Rotation Coordinator, a copy will be forwarded to the IM Program Director.

Prior to the beginning of the rotation, the EM-IM Rotation coordinator will review the goals and objectives of the rotation with the resident.

During their shifts, the resident will perform the initial evaluation of patients. Management and disposition decisions will be reviewed and critiqued by EM Attending.

The following are additional guidelines:

The resident is expected to attend IM conferences.
If the resident believes a patient needs immediate intervention, the EM Attending should be consulted; if the EM Attending is not immediately available the resident should contact the EM Chief on duty.
The resident must abide by all IM policy and procedures when rotating outside the IM Department.

This document was reviewed by the faculty of the Department of Medicine OUCMT 9/06 who approve and support the contents.