

University of Maryland
Emergency Medicine
Residency Manual
2013 - 2014

Department of Emergency Medicine
University of Maryland Medical Center
Baltimore, Maryland

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I RESIDENCY BACKGROUND

A. HISTORICAL PERSPECTIVE

The current era of emergency medicine at the University of Maryland started in 1985, when Robert A. Barish, MD, who was completing his residency in emergency medicine at Georgetown/George Washington, accepted the position as chief of emergency medicine here. The offer was extended by physicians at Maryland at the suggestion of Michael A. Rolnick, MD, who was chief of emergency medicine at Georgetown at the time.

Dr. Barish persuaded two other emergency physicians, Brian J. Browne, MD, and Elizabeth Tso, MD, to join him in the task of building the program. On the foundation laid by these three physicians, who recruited additional physicians from across the country, the department has grown into what it is today, with more than 74 full-time faculty members. The Department of Emergency Medicine currently staffs 5 hospitals in the downtown area (Baltimore VA, Bon Secours, Maryland General, Mercy Medical Center, and the University of Maryland Medical Center) in addition to managing the emergency departments at 9 other locations (Upper Chesapeake, Harford Memorial Hospital, The Memorial Hospital at Easton, Dorchester General Hospital, Queen Anne's Emergency Department [free standing ED], Chester River Hospital, Laurel Regional Hospital, Prince George's Hospital Center, and Bowie Health Center [free standing ED]).

From 1986 to 1990, the program was a clinical site for the Georgetown/George Washington Emergency Medicine residency. During this time, all the components of a successful Emergency Medicine residency program coalesced here at Maryland. DePriest Whye, MD, JD, led the development and submission of the residency application. When the residency started in 1991, Jonathan Olshaker, MD, was named its director and served in that capacity for 6 years. Brian Euerle, MD, directed the residency through an important expansion period from 1997 to 2002. Amal Mattu, MD, was appointed program director after Brian Euerle and led the residency program to national and international prominence. In March 2011, Amal Mattu, MD, was promoted to Vice Chairman of the Department of Emergency Medicine, and Michael Bond, MD, was appointed to the role of program director.

The first class of residents in our 3-year categorical Emergency Medicine program started in July 1991 and graduated in 1994. In July 1994, the first class of residents started in the 5-year combined Emergency Medicine /Pediatrics program. This was followed by the start of the 5-year combined Emergency Medicine /Internal Medicine program in July 1996 and the Emergency Medicine /Internal Medicine/Critical Care Medicine program in 2006. When all of these programs are full, we have a total of 65 Emergency Medicine residents, which makes us one of the largest Emergency Medicine programs in the country and one of the largest residency programs at the University of Maryland. Our graduates have accepted a wide variety of positions in academic and private practice settings as well as fellowships in specialty training.

Emergency Medicine at the University Maryland was a division of the Department of Surgery for 20 years. In May 2006, our application for full, independent department status, compiled under the leadership of Dr. Brian Browne, was granted by the Office of the Dean. Dr. Browne was named interim chair of the department in 2006 and was appointed chairman of the Department of Emergency Medicine in the spring of 2009.

B. Key Departmental People

- Departmental Leadership
 - Brian Browne, MD, Chairman of the Department of Emergency Medicine
 - Amal Mattu, MD, Vice Chairman of the Department of Emergency Medicine
 - Laura Pimental, MD, Vice President and Chief Medical Officer, Emergency Medicine Network
- Residency Leadership
 - Michael C. Bond, MD, Residency Program Director
 - Ken Butler, DO, Associate Residency Program Director
 - Mimi Lu, MD, Assistant Residency Program Director
 - Michael Abraham, MD, Assistant Residency Program Director
 - Michael E. Winters, MD, Director Emergency Medicine/Internal Medicine Residency Program and Co-Director Emergency Medicine/Internal Medicine/Critical Care Residency Program
 - Rose Chasm, MD, Co-Director Emergency Medicine/Pediatrics Residency Program
 - Nannette Catterton, Residency Program Coordinator
 - Angela Taylor, Residency Program Coordinator
- Medical Student Leadership
 - George Willis, MD, Director of Undergraduate Medical Education
 - Joseph Martinez, MD, Assistant Dean for Student Affairs
 - Siamak Moayedi, MD, Director of Medical Student Education, Mercy Medical Center
- Fellowship Directors
 - Michael Witting, MD, Research Fellowship Director
 - Veronica Pei, MD, International Medicine Fellowship Director
 - Debra Lee, MD, EMS Fellowship Director
 - Brian Euerle, MD, Emergency Ultrasound Fellowship Director
 - Amal Mattu, MD, Cardiovascular and Faculty Development Fellowship Director
 - Robert Rogers, MD, Teaching Fellowship Director
- Medical Directors
 - Michael E. Winters, MD, University of Maryland Medical Center
 - Stephen Schenkel, MD, MPH, Mercy Medical Center
 - Douglas Mayo, MD, Prince George's Hospital Center
 - Marcia Cort, MD, Bon Secours Hospital
 - Adam Geroff, MD, Maryland General Hospital
 - David Jerrard, MD, Veteran's Affairs Medical Center
 - Fermin Bauretto, MD, Upper Chesapeake Medical Center

- Administrative Staff
 - Casey Antonakos, Administrative Manager and Administrative Assistant to Brian Browne, MD
 - Kristin Cioffi, Operations Support Manager and Administrative Assistant to Amal Mattu, MD
 - Ginger Young, CPA, Director of Finance
 - Jim McMillian, Director of Recruitment
 - Linda Kesserling, MS/ELS, Technical Editor/Writer

II EMERGENCY MEDICINE CONFERENCES

Conferences are held every Wednesday, from 7:30 a.m. until 12:30 p.m. The first four hours are held in the Shock Trauma Auditorium, and the last hour is held in the ED conference room.

A. ATTENDANCE

1. **Attendance at 70% of the program’s planned educational events (“conference”), averaged over the course of the academic year, is required by the Residency Review Committee (RRC) for promotion and graduation.** Conference hours missed while the resident is on vacation are not included in this calculation.
2. Residents are required to track their educational conference attendance throughout the year to ensure they are meeting the 70% attendance requirement. The tracking is done through our department’s website, www.umem.org. Each resident must meet this requirement for each year of the residency.
3. Attendance is monitored by sign-in sheets available before the start of conference. Residents shall sign in only for the hours of conference they attend. The program director will intermittently verify that hours signed for are actually attended.
4. *It is considered a serious breach of professionalism to sign in fellow residents who are not in the conference.*
5. The sheets must be signed on the day of conference. Office personnel are not permitted to add names after the conference.
6. During certain conference hours, faculty members will monitor attendance.
7. If conference is missed due to a family or personal emergency, the resident should contact the program director by phone or e-mail on the day of conference regarding the absence.
8. When any resident has a pattern of unexcused absences, the following steps will be taken:

- a. A letter will be written by the program director and placed in the resident's file.
 - b. The resident will be asked to appear at a meeting of the Residency Education Judiciary Committee, made up of senior faculty members. Any additional actions will be planned at this time.
8. Given the structure of our curriculum, the RRC's 70% attendance requirement should be easily achieved. However, an individual resident's clinical schedule may at times place him or her close to or below this requirement. In this situation, supplemental conference activity (e.g., eMedHome write-ups, attendance at and write-ups from an approved conference, radiology conference) will be assigned to the resident. This supplemental activity must be completed in order for the resident to be eligible for promotion and/or graduation. This policy is implemented at the program director's discretion. The program director is available every Wednesday afternoon to discuss these asynchronous learning activities should you have any questions.
9. Conference Reading Policy

Residents who arrive at conference or journal club on time and demonstrate evidence of having done the reading have fulfilled the conference reading requirements. Residents who do not meet the requirements of arriving on time and having read the assigned material must submit, in writing, a one-page summary for every assigned article in the reading curriculum. This includes all *Fifth Hour Conference (FHC)* reading assignments and all journal club readings.

The summaries must be written in the following outline format:

- a. Hypothesis
- b. Research design
- c. Summary of the outcome
- d. List of potential biases and confounders
- e. Take-home points

Any write-up consisting of less than these five points will not count.

The summaries must be submitted, in writing, to the program director in paper form or as a Microsoft Word document attached to an e-mail message. Write-ups submitted in programs other than Word or as part of the body of an e-mail message will not be accepted. Write-ups are due to the program director the Friday following the absence from conference.

The following residents will receive a waiver from this policy (their status will be reevaluated on a weekly basis):

- a. Residents who are out of the country and prior to the conference date, inform the program director that they will not have e-mail access during their travels.
- b. Combined residents on the Pediatric or Internal Medicine service.

Submission of these write-ups does not count as conference credit. Nevertheless, it will henceforth be considered a residency requirement. Non-compliance will result in preferential scheduling of nights, weekends, and shift during residency functions (parties) and/or removal of any elective time.

10. Residents who fail to meet the 70% conference attendance requirement will be required to do remediation by attending extra conferences until the hours are made up. Residents who fall below the 70% figure will not be allowed to advance to the next level or graduate at the end of the year. Residents who have a pattern of poor conference attendance may be subject to extra weeks of sick call, extra shifts, or staffing the ED during residency social functions. These residents are ineligible for moonlighting privileges and will be ineligible for off-campus electives. These decisions will be made at the discretion of the program director, the associate residency director, and the Judiciary Committee, as necessary.

11. The RRC's duty hour requirements dictate that conference should not interfere with "rest time" between clinical shifts. Therefore, if conference occurs during a resident's 12 hours off between two shifts, the resident is excused from conference.

12. Conference time is not considered duty hours or rest hours.

13. Conference is mandatory during all rotations, with the following exceptions:

- a. Trauma – you are to attend conference unless you are post-call or scheduled for a day off. Other days you should give your patient signouts to a fellow resident and attend conference.
- b. Trauma ICU – you should be attending the CCM lecture series.
- c. A resident who is on a medicine rotation (ICU, CCU) and is post-call should make rounds with the medicine team on Wednesday morning before going home. A resident who is on the ICU/CCU rotation but is not post-call should sign out patients to the resident either the morning or evening before conference so as to be able to attend. **Residents are not responsible for pre-rounds or rounds on conference days unless they are post-call, as these rounds will interfere with conference attendance.** This issue has been discussed with and agreed upon by Dr. Wolfsthal, the Internal Medicine Program Director.
- d. If conference interferes with "rest time" between adult ED shifts, the resident should not attend conference. See Item 11, above.

B. Resident Conferences and Guidelines

1. RESPONSIBILITY FOR PRESENTATION

- a. The majority of conferences are given or organized by the faculty. However, certain conferences have been designated to be given or run by the residents. It is hoped this will enhance residents' educational and academic experience.
 - b. The conference assignments are made in the beginning of the year, well in advance. Thus, residents will have plenty of time to prepare a professional, stimulating conference. Ideally, conference presentations should include a *handout*, a list of references, and audiovisual materials as needed (depending on the topic).
 - c. Dr. Mimi Lu takes a special role in mentoring residents in regard to their conference presentations and slide preparations. The resident who will give the lecture is responsible for preparing its audio-visual presentation. Residents should speak to Dr. Lu or a designated faculty member no less than 6 weeks prior to the conference in order to get advice and suggestions on how to improve the lecture.
 - d. All lectures should be presented in a professional manner (including presenting a professional appearance [no scrubs, shorts, etc.]) and should follow principles discussed in the following handouts on medical lecturing, which can be obtained from Dr. Mattu:
 - "There is No Gene for Good Teaching: A Handbook on Medical Lecturing"
 - "Preparing a Presentation and Developing Speaking Skills"
 - e. All Senior presentations should be accompanied by a handout.
2. Combined Case Conference
 - a. When a member of the combined Pediatric/Emergency Medicine or Internal Medicine/Emergency Medicine program is scheduled to give a conference, it will be titled as a Combined Case Conference. The format can be identical to that described above for a case conference, but it is suggested that combined residents take advantage of their additional training and concentrate on these areas.
 - b. Combined residents are encouraged to involve other residents or faculty from their other area of training when appropriate.
 - c. The combined residents may wish to modify the case presentation format in order to fully concentrate on a particular topic from their other area of specialty training.
 3. Fifth Hour Conference (FHC)
 - a. This conference will be given by a faculty member each week. Dr. Mattu is the coordinator of this conference.

- b. Reading assignments from a variety of sources are made at the beginning of each month. **Residents are expected to have read the assigned material prior to conference.**
 - c. Upper-level residents may be given additional reading materials or may be invited (completely voluntary) to precept the sessions, under direct supervision of faculty, in order to learn about and get feedback on small-group presentation skills.
4. Junior Lectures (PGY2 Categorical, PGY2, PGY3, and PGY4 Combined)
- a. This is a resident-run, resident-directed conference. The intended audience is interns and junior residents. The conference will be run by a single resident, at one higher level of training than the intended audience. Each categorical resident at the PGY 2 level or equivalent will be assigned to run a conference once or twice a year.
 - b. The conference can be initiated by presenting an interesting case. This may be a tough case, a bread-and-butter case, or a controversial case.
 - c. A review of the literature should follow, emphasizing take-away points.
 - d. The presentation does not need to cover every last detail of the topic. The biggest mistake people make is to present too much information!
 - e. Juniors can choose to do a formal Grand Rounds type of lecture instead of a case conference; if they choose to do this, they should follow the same format noted below as for the Senior Lectures.
 - f. These case conferences should be **25 minutes in duration** with a little additional time for questions and discussion.
5. Senior Lectures (PGY3 Categorical, PGY5 Combined)
- a. These will no longer be simply “case conferences,” though they may incorporate one or more interesting cases.
 - b. These lectures should be presented as formal Grand Rounds type lectures, approximately **45 minutes in duration** with a little additional time for questions and discussion.
 - c. The topics should be cutting-edge, controversial topics. Debate should be invited. The resident may want to present a controversy, then take a stand on the topic, and support the topic with evidence.
 - d. The title or topic of the lecture must be submitted for approval to Dr. Bond by June 1st of the junior year. This is to ensure that the same topic is not covered by more than one person. A request to update your topic can be made provided that the request is made more than 6 weeks from the assigned lecture date.
 - e. The lectures should *absolutely not* be simply summaries of review articles or textbook chapters. Ideally, the information presented should not be available in any single standard reference.
 - f. **A handout is required.** The handout should be well organized and professional. The handout can be either comprehensive or written in a shorter outline format. If the shorter format is used, it must contain a list

of key takeaway points, pearls and pitfalls, etc. The handout should be worth saving for future reference by audience members.

- g. The topic should not be the same as the resident's scholarly project.

III. POLICIES

A. PROCEDURE AND RESUSCITATION LOG (PxDx)

1. **It is mandatory for each resident to keep an accurate and up-to-date log of the procedures and resuscitations that he/she performs.** This is a requirement of the RRC. Any individual who does not comply places the entire program's accreditation at risk.
2. The PxDx log in E*Value is used to document all procedures and resuscitations.
3. The RRC requires the following data to be tracked:

Resuscitations

- a. Adult medical and non-traumatic surgical
- b. Adult trauma
- c. Pediatric medical
- d. Pediatric trauma

Resuscitation is defined by the ACGME as "patient care for which prolonged physician attention is needed and interventions such as defibrillation, cardiac pacing, treatment of shock, intravenous use of drugs (e.g., thrombolytics, vasopressors, neuromuscular blocking agents), or invasive procedures are necessary for stabilization and treatment."

Resuscitation of patients with severe hypotension/shock (even if simply with vigorous fluid hydration), respiratory distress (even if with bronchodilators and steroids), or other very "ill" conditions should be recorded. In other words, many patients other than "codes" can be considered resuscitations.

The minimum requirements mandated by the RRC are listed below; additional types of procedures can be recorded. **Any procedures and "resuscitations" (e.g., code scenarios) done in the cadaver lab and any simulation teaching should be entered into E*Value's PxDx log according to the setting in which they were done.** For example, cricothyroidotomies done in the cadaver lab, pediatric arrest scenarios in simulation workshops, and "Code Blue" conferences should be documented in the PxDx log in E*Value according to the setting field (**e.g., Emergency Medicine, Inpatient, Lab, or Outpatient**) to keep laboratory procedures documented separately. **Make a special effort to record the FAST ultrasounds done while on the trauma rotation** as well as other ultrasounds done during ED rotations.

Procedures*

| | |
|---------------------------------|----|
| Adult medical resuscitation | 45 |
| Adult trauma resuscitation | 35 |
| ED bedside ultrasound | ** |
| Cardiac pacing | 06 |
| Central venous access | 20 |
| Chest tubes | 10 |
| Procedural sedation | 15 |
| Cricothyrotomy | 03 |
| Dislocation reduction | 10 |
| Intubations | 35 |
| Lumbar puncture | 15 |
| Pediatric medical resuscitation | 15 |
| Pediatric trauma resuscitation | 10 |
| Pericardiocentesis | 03 |
| Vaginal delivery | 10 |

*Numbers include both patient care and laboratory simulations.

**The primary responsibility for determination of procedural competency rests with the program director and the faculty.

4. Information entered into E*Value will be monitored on a regular basis. It will be discussed at the semi-annual evaluation and may be distributed periodically at conferences.

B. ACGME OUTCOMES PROJECT

In addition, the ACGME Outcomes Project requires that each resident complete specific competencies, including chief complaint, procedure, and off-service competencies. To ensure compliance with the ACGME and RRC requirements for Emergency Medicine, every resident needs to complete the following:

1. Chief Complaint Competencies: During each year of the residency, each resident must complete seven (7) competencies for each the following chief complaints: abdominal pain, chest pain, and dyspnea. To document a competency in the emergency department, the resident notifies an attending that (s)he has a patient with the particular complaint. The attending observes the resident complete the history and physical. After the patient encounter is over, the attending documents that the competency has been completed. The resident then delivers the completed form to the Residency Office for inclusion in the resident's permanent folder.
2. Procedure Competencies: During each year of the residency, each resident must complete seven (7) competencies for the following procedures: conscious sedation, central line, intubation, and wound repair. To document a competency in the emergency department, the resident notifies an attending that (s)he has a patient who requires the procedure. The attending observes the resident perform the procedure. After the patient encounter is over, the attending documents that the competency has been completed. The resident then delivers

the completed form to the Residency Office for inclusion in the resident's permanent folder.

3. Off-Service Competencies: Residents must complete an online multiple-choice examination after they have completed the following rotations:
 - a. Obstetrics/Gynecology
 - b. PCU/CCS Cardiology
 - c. Anesthesia
 - d. Pediatric – Children's DC or UMMS Pediatric Emergency Medicine
 - e. Toxicology
4. If an individual shows repeated noncompliance with procedure documentation, the steps outlined under unexcused conference absence will apply, including extra sick-call assignments, ED staffing during residency social functions, and ineligibility for moonlighting and off-campus electives.
5. This topic is of such importance that the section from the ACGME program requirements is reproduced here for reference.

Resuscitations and Procedures

Each resident must have sufficient opportunities to perform invasive procedures, monitor unstable patients, and direct major resuscitations of all types on all age groups. A major resuscitation is patient care for which prolonged physician attention is needed and interventions such as defibrillation, cardiac pacing, treatment of shock, intravenous use of drugs (e.g., thrombolytics, vasopressors, neuromuscular blocking agents), or invasive procedures (e.g., cutdowns, central line insertion, tube thoracostomy, endotracheal intubation) are necessary for stabilization and treatment. The resident must have the opportunity to make admission recommendations and direct resuscitations.

1. *Programs must maintain a record of all major resuscitations and procedures performed by each resident. The record must document their role, i.e., participant or director; the type of procedure(s); the location (ED, ICU, Lab, etc.); age of patient; and admission diagnosis. Only one resident may be credited with the direction of each resuscitation and the performance of each procedure.*
2. *These records should be verified by the residency director and should be the basis for documenting the total number of resuscitations and procedures in the program. They should be available for review by the site visitor and the Residency Review Committee.*

C. PATIENT FOLLOW-UP LOG

1. All residents **must** follow-up on a minimum of 15 patients during each month of any adult or pediatric emergency department rotation and document this process electronically in a log. The exact number is a guideline and will vary based on the month, census, and acuity of the shifts. Follow-ups should be done on a mixture of admitted and discharged patients. Follow-up can be

obtained in a variety of ways, such as calling patients or physicians, patient visits, and chart reviews. ***Try to select patients who are diagnostic dilemmas, in whom follow-up will provide the greatest educational benefit.***

2. Information entered electronically into your log will be monitored on a regular basis. Your progress toward program requirements will be discussed at your semi-annual evaluation.
3. If an individual shows repeated noncompliance, the steps outlined under unexcused conference absence will apply, including extra sick-call assignments, ED staffing during residency social functions, and ineligibility for moonlighting and off-campus electives.

D. ELECTIVES

1. ***All electives need to be arranged 4 months ahead of time.*** Away electives in the categorical program occur during the PGY-2 and PGY-3 year. The on-campus electives are often used as sick-call rotations. Refer to Section E.
2. All electives must be approved by the program director, the Graduate Medical Education office, and Maryland Medicine Comprehensive Insurance Program (MMCIP). All faculty and rotation evaluations must be up-to-date, and all curriculum readings must be tracked in E*Value prior to rotations. Elective forms and resident off-site location forms are found on our website, www.umem.org, under “Forms.” They must be completed in detail, signed, and given to the residency coordinator prior to the 4-month time-slot. Off-site location forms are submitted to our MMCIP/Risk Management Office for approval of malpractice coverage during your elective. Resident electives that are designed “from scratch” (electives that are not pre-existent) require additional paperwork.
3. **A resident may be assigned to a specific elective at the discretion of the Program Director**, if needed to help correct any deficiencies in the resident's training or deficiencies in specific skill sets (e.g., ECG interpretation, airway skills, pediatric emergency medicine knowledge).

E. VACATION

1. All residents will have 3 weeks of vacation per year.
 2. All vacation requests must be submitted in writing to the chief residents and approved by them.
 3. **During an emergency department rotation, vacation cannot be taken on major holidays or during the last 2 weeks of December.**
 4. **Vacation cannot be taken by any resident, regardless of rotation, at the following events/times:**
 - The ACEP Scientific Assembly (held in September or October every year)
 - The in-training examination (held on the last Wednesday of February)
 - The last 10 days of December and first 2 days of January
- a. EM/IM PGY1 Vacation Policy

- (1) The EM/IM PGY1 intern who ends the Year 1 on EM (and therefore begins Year 2 on IM) will receive the "extra" fourth week of vacation at the end of PGY1. This week will coincide with the extra week off that categorical IM interns receive during the last week of June. This time will come from IM.
 - (2) The EM/IM PGY1 intern who begins his/her training in EM (and therefore ends Year 1 on IM) will take the fourth week of vacation during an EM rotation. This will likely occur at the end of PGY5 or during an elective. This intern will therefore end on IM in June and start Block 1 on EM during the last week of June.
 - (3) Dr. Winters, Director of the EM/IM Program, will track vacations by the EM/IM residents to ensure they are evenly distributed between the Medicine and Emergency Medicine rotations over the course of the 5-year program.
- b. EM/Pediatrics Vacation Policy
- (1) Dr. Rose Chasm, Interim Director of the EM/Peds Program, will track vacations by the EM/Peds residents to ensure they are evenly distributed between the Pediatrics and Emergency Medicine rotations over the course of the 5-year program.

F. SICK CALL

1. All residents share the responsibility of providing sick call, as assigned by the chief resident(s).
2. The chief resident(s) will keep a record of all uses of this coverage system.
3. For short-term illness (≤ 4 shifts), the sick-call resident will provide coverage with the following guidelines:
 - a. The sick-call resident may work no more than four shifts between Sunday night shift and Saturday day shift.
 - b. The sick-call resident must have 12 hours off between shifts.
 - c. **ALL sick-call shifts will be repaid at a mutually convenient time.** If the involved residents are unable to agree on repayment, the chief resident will assign the payback coverage.
 - d. **The sick-call resident must be ready and able to report to work within 1 hour of being called and be available at all times by beeper or phone.** This resident is responsible for ensuring that their contact information is kept up-to-date on the website. If you are needed and not reachable by phone within 1 hour, an extra shift will be added to your ED schedule.
4. Long-term Illness (>4 shifts)
 - a. Initial coverage as in Item 3, above.
 - b. Subsequent coverage will be arranged by the chief resident(s) and the program director and may include the following:
 - (1) Change of rotation
 - (2) Change of published schedule
 - (3) Added coverage by other residents

G. MOONLIGHTING

Moonlighting in the emergency department setting is permitted for PGY3–6 residents under the following conditions:

1. Requests for moonlighting at local area EDs must be submitted in writing to the program director.
2. The program director, in conjunction with faculty members of the Education Committee, shall approve moonlighting privileges. Faculty members at one of the formal Education Committee meetings will vote on approval for a given resident. Approval will be granted only if 75% of the faculty vote in favor of granting privileges. Written feedback will be provided to the resident regarding the voting, and this shall include any concerns expressed regarding moonlighting by the individual resident by the faculty members at the meeting.
3. Approval of moonlighting privileges will be applicable only to a given hospital. If the resident desires to moonlight at another hospital ED, (s)he must submit a request for moonlighting privileges at other hospitals. In other words, *approval of moonlighting privileges at one hospital is not transferable to other hospitals.*
4. To be considered for moonlighting, the resident must be in excellent academic standing, which includes all of the following:
 - a. Conference attendance >70%
 - b. In-service examination score from the previous year >75
 - c. Up-to-date with all logs (follow-up logs, procedure logs, etc.) and evaluations
 - d. Evaluations from faculty that reflect excellent competence and professionalism
 - e. Up-to-date with all scholarly project deadlines
5. Moonlighting can be performed only in a setting in which other ED attendings are immediately available for support, i.e., *moonlighting in single-coverage settings is prohibited.*
6. Moonlighting is strictly prohibited on Tuesday evenings and any time on Wednesdays, as it would interfere with Wednesday conference attendance and pose potential duty-hour violations. Moonlighting cannot interfere with conference attendance and duty hours; if there is a violation here, moonlighting privileges will be revoked.
7. *Moonlighting hours are considered “duty hours”* in terms of ACGME and residency requirements. Moonlighting is prohibited if it interferes in any way with the ACGME and residency duty-hour limitations. Appropriate time off between shifts cannot be precluded by moonlighting shifts.
8. The program director reserves the right to immediately revoke the moonlighting privileges of any resident who becomes non-compliant with the policies stated above or if new concerns are expressed by members of the faculty that moonlighting is interfering with the resident’s clinical work or professionalism (e.g., due to fatigue). If either of these events occurs, faculty members of the Education Committee will vote regarding revocation of moonlighting privileges until the resident is once again fully compliant.

9. Prior to scheduling any shifts, the resident should make the chairman or clinical director of the emergency department where the resident intends to moonlight aware of all of these requirements. The chairman or clinical director should also be made aware that compliance with residency requirements takes precedence over moonlighting and that non-compliance by the resident will result in immediate revocation of moonlighting privileges, as noted above.

H. PREGNANCY AND MEDICAL LEAVE

The Department of Emergency Medicine is committed to promoting an environment that is supportive of the welfare of our residents. We recognize that issues relating to pregnancy may arise during the course of a resident's employment. Those individuals so involved have the right to work in an environment that is free from perceived reprisal, hostility, or inappropriate commentary. It is our goal to provide such an environment.

The residency program supports residents in every way possible in regard to family planning. To this end, any comments or actions related to the pregnancy of a resident or the spouse of a pregnant resident that may be deemed to be hostile or inappropriate will not be tolerated. Individuals who have experienced negative behavior related to pregnancy are encouraged to report the incident(s) to the residency director or department chairman. After appropriate investigation of the reported incident, disciplinary action as deemed appropriate may be instituted.

The residency follows the policy of the University of Maryland Medical Center regarding maternity and paternity leave. The Family and Medical Leave Policy (HRM411) can be found on UMMC's intranet at http://intra.umm.edu/umm/human_resources/policies_hr.htm.

The 36-month residency training may be interrupted for family planning, personal or family emergencies, or illness. The residency and faculty will support in every way a return to the residency of any resident who must take a leave of absence for any of the reasons listed above; however, **the 36 months of training (and corresponding number for combined residents) must still be completed before the program director can verify to ABEM that the resident has completed the full residency training program.** With these issues in mind, any resident who takes a leave of absence will be required to complete any rotations that (s)he missed during the leave before completion of the residency can be declared. We will work with the UMMC Department of Human Relations and the Graduate Medical Education Committee Office to determine what needs to be done in order to extend the residency in this event.

I. SHIFT SCHEDULING AND DUTY-HOUR RESTRICTIONS

1. Shifts in the adult ED are scheduled by the chief residents. Generally, residents will do approximately 17 or 18 shifts per month block. The chief residents will elicit requests for days off well in advance, and they will do their best to accommodate these requests; however, they cannot guarantee that all requests will be honored. Requests for days off will be honored, with priority given to residents who have maintained compliance with residency requirements, residents who have major personal or family obligations (e.g., weddings); and residents who have performed extra work for the program and for their colleagues (e.g., those who have participated significantly in the interview process and those who have done extra sick call).
2. Off-service rotation schedules are set up by the off-service rotation education directors. Those directors are also committed to maintaining compliance with ACGME duty-hour requirements.
3. If a resident is assigned a schedule that violates duty-hour restrictions, or if the resident is required by a service (either the ED or an off-service rotation) to work in such a way that duty-hour restrictions are violated, (s)he should report this immediately to the program director or submit a formal grievance to the Grievance Committee.
4. *Residents should arrive to the ED no later than 10 minutes prior to their shift in order to ensure that they are prepared and ready to take sign out at the start of the shift.* Arriving late is considered unprofessional.
5. Duty Hours Policy
 - a. Purpose

To establish a policy for the Department of Emergency Medicine to monitor and schedule appropriate work/duty hours of the house officers. This policy supports the physical and emotional well-being of residents' educational environment and facilitates quality patient care and safety.
 - b. Scope

This policy applies to the Department of Emergency Medicine at the University of Maryland Medical Center (UMMC). All information contained in this policy shall be absolute criteria for house officer duty hours. Other general information can be found in the UMMC Institutional Policy on Duty Hours (Procedure GMS-P, available at the Graduate Medical Education website, www.umm.edu/gme/gme_policies.htm).
 - c. Definitions

House Staff or House Officer – refers to all interns, residents, and fellows enrolled in an UMMC/SOM post-graduate training program.
Post-Graduate Training Program – refers to a residency or fellowship educational program, accredited by the ACGME, for purposes of clinical education.
Duty hours – refers to all clinical and academic activities related to the residency program, i.e., patient care (both inpatient and outpatient), administrative duties relative to patient care, the provision for transfer of patient care, time spent in-house during call activities, and scheduled

activities such as conferences. Duty hours do *not* include reading and preparation time spent away from the duty site.

d. Responsibilities/Requirements

- (1) The program director is responsible for the duty schedules of the emergency department. The program director is responsible for making the ultimate decisions regarding scheduling of all duty hours for all residents within his or her scope of supervision.
- (2) On-call rooms are provided for residents with night-time duty hours.
- (3) The on-call schedule is developed with the administrative assistance of the chief residents. The individuals developing the on-call schedule are charged with adhering to the following guidelines:
 - (a) In general, when working in the emergency department, residents shall not be scheduled to work in excess of 60 hours in any 7-day period and no more than 72 hours including conferences, call, and clinical duty.
 - (b) While on duty in the emergency department, residents may not work longer than 12 continuous scheduled hours. There must be at least an equivalent period of continuous time off between scheduled work periods.
 - (c) Residents must be given one day out of every seven free of duty. This day free of duty may require the house officer to carry a pager.
- (4) Residents will never be scheduled for call more frequently than every third(3rd) night.
- (5) Moonlighting, when permitted by the program director, must not interfere with residents' ability to achieve the goals and objectives of the educational program and will require written approval, consistent with the institutional policy on extracurricular employment/moonlighting (Procedure GMS-I, available at www.umm.edu/gme/gme_policies.htm).
- (6) All program residents and teaching faculty are required to complete the sleep education training program developed and adapted from the Sleep, Alertness, and Fatigue Education in Residency (SAFER) program of the American Academy of Sleep Medicine.
- (7) On a periodic basis, the program director will review the compliance of this policy with the Graduate Medical Education Committee.

J. RESIDENCY COMMUNICATION

1. **Residents are expected to promptly return ALL pages they receive**, whether those pages are from the ED administrative offices, the chief residents, or the program director. **Failure to respond to pages regularly will be considered an act of unprofessional behavior** and may be formally addressed by the Education/Judiciary Committee.
2. **Residents are required to check their emails on a daily basis.** The importance of this cannot be understated. Many important communications

from the administrative office, the residency coordinators, and the program director are sent via email. In fact, **if a resident does not get emails from the residency coordinators and program director at least weekly, he/she should assume there is a problem with the email system** and inform the program director immediately.

3. All readings for FHC, Journal Club, and Leadership/Administration Conference are posted on the department website (www.umem.org). Residents are expected to complete the assigned readings and come to conference prepared to discuss them. **If the resident is unable to download the readings from the website, (s)he should notify the residency coordinators with enough lead time so that the problem can be solved and the readings can be obtained in time to prepare for conference.** Notifying the residency coordinator or program director on the day before or the day of conference is unprofessional and unacceptable.

K. DRESS CODE

1. Background: In contemporary North American society, there has been a gradual trend toward casual attire in the workplace. This trend has carried over into the practice of medicine. Numerous studies have shown that the physical appearance of a physician is important to our patients. In fact, in recent studies, the majority of patients prefer professional attire to casual dress. Furthermore, casual attire has been cited to negatively influence patients' perceptions of physician competence.
2. Purpose: The purpose of this policy is to outline appropriate professional attire for the faculty and residents of the Department of Emergency Medicine. It is important to note that the purpose of this dress code is not to inhibit personal freedoms, but rather to acknowledge the unique role that physicians have in patient care.
3. Application: This policy applies to clinical and educational activities of the Department of Emergency Medicine. This includes (but is not limited to) clinical shifts, educational conferences, department committee meetings, UMMC committee meetings, and non-EM resident rotations. This policy also applies to non-EM resident physicians and students working in the emergency department.
4. General Principles: It is expected that the faculty and residents of the Department of Emergency Medicine maintain a standard of dress that projects an image of professional integrity. As such, the following shall apply to all activities listed above:
 - a. Clothing should be clean and in good condition.
 - b. Lab coats should be clean and in good condition.
 - c. Hair
 - (1) Hair should be clean and neatly groomed.
 - (2) Hair may not be dyed unnatural colors.
 - (3) Facial hair shall be clean and neatly trimmed.
 - d. Shoes
 - (1) Shoes must be clean and in good condition.

- (2) Heels shall be no higher than 3 inches.
- e. The following items are considered unprofessional attire and shall not be worn at any time:
 - (1) Athletic wear (spandex, sweat suits, muscle shirts, T-shirts, etc.)
 - (2) Shorts
 - (3) Baseball caps/hats
 - (4) Denim pants of any color (matching denim scrubs are considered an exception)
 - (5) Revealing clothing (scrubs through which undergarments are visible, shirts that expose the abdomen, halter tops, etc.)
 - (6) Logo T-shirts (t-shirts with script writing across the chest, e.g., Abercrombe, Princess)
 - (7) Flip flops, sandals, and slippers
- 5. Emergency Department

While working in the emergency department, the following additional items shall apply:

 - a. Identification badges should be visible at all times.
 - b. Acceptable attire for men
 - (1) Pants and collared shirt
 - (2) Scrub wear
 - (3) Tie is optional.
 - c. Acceptable attire for women
 - (1) Pants and blouse
 - (2) Skirt and blouse
 - (3) Dress
 - (4) Scrub wear
 - d. Scrub wear should be clean and matching.
 - e. Lab coats should be clean and free of bodily fluids.
 - f. If lab coats are not worn while wearing scrubs, it is expected that scrub tops will be tucked in and neat in appearance.
 - g. Shoulder length or longer hair shall be pulled back or covered.
 - h. Although collared polo short sleeve shirts are acceptable for educational activities, only those displaying the University of Maryland logo are appropriate while working in the ED.
 - i. Socks shall be worn at all times.
 - j. Shoes
 - (1) Close-toed footwear is required (OSHA regulation pertaining to personal protective equipment).
 - (2) Open-toed footwear is prohibited.
- 6. Violations: Student violations of the dress code policy may be addressed by residents. Resident violations of the dress code policy should be addressed by senior residents, the chief residents, or the faculty member observing the violation.

Repeated violations by students should be addressed with Dr. Willis (Director of Undergraduate Medical Education) and may affect the student's grade.

Repeated violations by residents will result in a notation in the resident's file under "professional competency" and may also result in a formal meeting with members of the Education Committee to discuss the issue. Faculty violations will be referred to the applicable clinical director or department chair.

IV. IN-TRAINING EXAMINATION

- A. The emergency medicine in-training examination is given to residents across the country on the **last Wednesday in February every year.**
- B. **Every resident in the program is required to take this examination each year. As noted earlier, vacation is prohibited during the in-training examination.**
- C. The review conferences held each Wednesday are designed to help you prepare for the in-training examination; however, you must supplement this instruction with your own studying, reading, and review.
- D. Department leaders and faculty members take the results of this test very seriously, and so should you. If you need guidance or help with preparation, please contact the program director, the associate program director, or any other faculty member. We are all willing to help.
- E. Categorical PGY1 and PGY2 as well as combined PGY2–4 residents who score significantly below the class or national averages will be placed into the **in-service (i.e., in-training examination) mentoring program.** In this program, review questions are distributed to each resident electronically on a weekly basis. Residents are required to meet with their in-service mentor every 2 weeks. At that time, the resident should turn in his or her answers along with a textbook reference. All questions and answers will be discussed. This program is designed to help the resident prepare for the following year's in-training examination. Continuation in the program will be based on compliance with this required mentoring program and may also be based on the next in-training examination score.
- F. Completion of all requirements of this mentoring program is necessary for advancement and/or graduation

V. EVALUATIONS

- A. Each resident will meet with the program director or associate program director at least twice yearly for a formal evaluation and feedback session. **All residency requirements (e.g.: follow up logs, procedure logs, competencies) shall be up to date prior to this meeting.**
- B. Each resident receives an E*Value evaluation after each rotation from each faculty member with whom they worked. It is recommended that you review these evaluations on a regular basis.
- C. Through E*Value, residents are required to evaluate faculty members twice a year and rotations upon their completion.
- D. Prior to each rotation, each resident is required, by the RRC, to read the curriculum for that rotation. Residents will be reminded of this requirement via email. Compliance is tracked through E*Value.

VI. RESIDENT ADVISORS

- A. During the course of the residency training period, a faculty member may be assigned to a resident based on areas of interest that the resident develops during his/her training. For example, a resident who develops a strong interest in pediatrics will likely be assigned an advisor with a strong academic interest in pediatric emergency medicine, and a resident who develops a strong interest in leadership will likely be assigned an advisor from among the faculty leadership.
- B. The purpose of the advisor/mentoring program is to provide the resident with additional resources and contacts to learn more about developing his/her “niche” in emergency medicine.
 - 1. The advisor/mentor relationship can change as the resident’s interest changes.
 - 2. Residents who are interested in the advisor/mentor program can discuss their interests with the program director at any time. The program director will take an active role in helping residents find advisors/mentors to help them achieve their full potential in the residency and beyond.

VII. RESIDENCY SCHOLARLY PROJECT REQUIREMENT

- A. All residents will be required to complete a formal scholarly project before graduation. This project should include the following elements:
 - 1. A problem identification and/or hypothesis formation.
 - 2. Some form of information gathering or data collection.
 - 3. An analysis of data or some evidence of analytic thinking.
 - 4. A statement of conclusion or interpretation of results.
- B. Examples of scholarly projects include, but are not limited to, original research (prospective or retrospective), systematic reviews, case reports, quality assurance projects, and community projects.

You will find a wide variety of resources to help you meet this requirement, both at the university level and within our own department. Your mentor and our research director are the suggested starting contacts.

To ensure that your planned project is suitable, we require each resident to submit a written proposal. This proposal is due by March 1 of the PGY2 (or PGY4 for combined residents) and should be submitted to the residency coordinator. Final projects are due by March 1 of PGY3 (PGY5 year for combined residents). Draft proposal forms for various types of scholarly projects are available in the residency office.

- C. Dr. Michael Witting, the program’s Research Director, serves as the Chair of the Scholarly Project Subcommittee within the Education Committee. He and other senior faculty decide which projects have satisfied the criteria for completion of the scholarly project requirement.

VIII. RESIDENT SELECTION

Medical students must apply through ERAS and register for the National Resident Matching Program (NRMP). Required materials include an ERAS application, MSPE (Medical Student Performance Evaluation) from the Dean, medical school transcript, three letters of recommendation, USMLE Step 1 score, CV, and a personal statement. Special consideration is given to candidates with significant research experience, a history of volunteer work, or other advanced degrees. Interviews are granted based on the quality of the application. Faculty interviews and various components of the application are used by the residency program director to complete the final ranking of all candidates. The final rank list is submitted to the NRMP in February.

IX. CRITERIA FOR ADVANCEMENT IN PROGRAM

- A. Criteria for advancement include all of the methods of resident evaluation, with the most important being the judgment of the faculty, chairman, and program director.
- B. Residents will be evaluated by the Clinical Competency Committee semi-annually using the 23 milestones established by the RRC-EM.
- B. Possible actions after evaluation of each resident include the following:
 - 1. Continuation in the program and advancement
 - 2. Remediation
 - 3. Probation
 - 4. Additional training
 - 5. Suspension
 - 6. Dismissal

A formal grievance process is available when actions are taken that could result in dismissal of a resident (see Section XII, Resident Grievance Committee/Board).

X. RESIDENT DISMISSAL

- A. Residents with academic or professional difficulties are identified early. Discussions are documented in the resident's folder and an appropriate educational prescription is determined based on the resident's needs, e.g., personal tutoring, adjusted clinical supervision, schedule changes, psychological evaluation, drug testing. The entire portfolio is taken into account such that weakness in a single area will be addressed by appropriate remediation in that area. Discussions and updates on the resident's progress are held on a regular basis with the program director, associate program director, chief residents, chairman, and Residency Education Committee. The intent of the Committee and the Program Director is to be proactive in developing a plan of remediation. Minutes from the Committee are documented. The results of this intervention are three-fold:
 - 1. If remediation is successful, the resident will be promoted to the next year of training.
 - 2. If progress is made but remediation is incomplete, the resident may be promoted to the next year of training or be required to complete a specified number of months at the current training level.

3. If remediation is unsuccessful or if progress is inadequate, the resident will be dismissed from the program. The institution's Due Process Hearing Procedure (Procedure GMS-C, available at www.umm.edu/gme/gme_policies.htm) allows the resident to file a formal grievance about an adverse action.
- B. Residents demonstrating unethical or unprofessional behavior will be dismissed from the program.

XI. RESIDENT GRIEVANCE COMMITTEE/BOARD

A. MEMBERSHIP

Chair: Dr. Adam Geroff

Faculty Members

- One from UMMS
- One from the VA
- One from Mercy Medical Center
- An associate or assistant residency director
- An at-large senior faculty member

Residents

- One chief resident
- Another resident who is not a chief resident

B. INTRODUCTION

This committee/board shall serve under the Residency Education Committee. It shall serve as the official forum to hear all residents' grievances. Any categorical or combined EM resident with a legitimate complaint or grievance shall submit in writing (electronic or hard copy) a detailed description of said grievance to the chair or any board member or members or all members. The board will meet as needed to discuss each grievance submitted. Meeting dates will be staggered and not set but should not exceed one meeting per month. The board should endeavor to meet within 2 weeks after receiving a grievance. Board meetings are not required if there is no grievance to be heard.

C. PURPOSES

1. Hear grievances
2. Serve as a forum to ensure residents are heard by designated persons
3. Document all grievances
4. Recommend certain action to the Residency Education Committee
5. Substantiate or refute any statements made to the ACGME or RRC by any of our residents or faculty
6. Discourage "curbside" complaints
7. Prevent airing of complaints during valuable conference time
8. Prevent the "snowball effect" of the public airing of complaints
9. Centralize complaints

The board's purpose is NOT to act independently of the Residency Education Committee. Nor is it the board's purpose to communicate on that committee's

behalf unless that committee or the residency director has granted in writing permission to act on its behalf.

The board, though not empowered to act, shall strongly influence the Residency Education Committee.

D. PROCESS

The complainant(s) must file a signed written grievance with a member or members of the Board via electronic mail or letter. This member must notify all other Board members that a grievance has been filed. The Board members shall agree on a date to hold a hearing, which ideally should be within 2 weeks after the initial notification but shall not be more than 1 month from the initial notification. The Chair will review the grievance on a preliminary basis and, if necessary, will assign a Board member to investigate the grievance with site visits, phone calls, or chart reviews. The Board member designated for this investigative purpose shall be selected logically; for instance, if the grievance applies to a Mercy block, the Mercy representative shall be selected.

To ensure that the Board does not convene to hear frivolous grievances, a preliminary vote shall be taken by the six members of the board after each has reviewed the filed grievance. The Chair of the Board shall conduct this vote by communicating individually with each Board member. If all six members unanimously agree that the grievance is frivolous, the grievance shall not be heard and the complainant(s) will be notified of the Board's decision to dismiss the grievance without a hearing.

When a hearing is deemed appropriate, those present at the hearing shall be the complainant(s) and at least four of the six Board members. The complainant(s) may invite a party or a witness to speak on his or her behalf. The complainant(s) must provide the Board with written notification of the name(s) of any additional person(s) designated to speak at the hearing. The hearing shall be closed to other faculty and residents, unless one of them has a legitimate purpose as a witness. The hearing shall be called to order by the Chair of the Board. The format will be in the form of an open forum and discussion. After the complainant(s) and Board members are finished with any discussion and questions, the complainant(s) shall leave the hearing and an open discussion among Board members shall ensue. At any point during this discussion, any Board member may call for a vote, if necessary, to decide what the Board's action or recommendation will be. A two-thirds majority shall decide any vote. It may be necessary to suspend discussion pending further investigation.

If further investigation is necessary, the Board shall agree which member(s) will conduct the investigation. The Board will notify the complainant(s) of this circumstance. The Board member(s) should complete any investigation within 2 weeks, unless particular circumstances surrounding an investigation preclude such timely completion. As soon as any investigation is complete, the Board

member(s) shall notify the rest of the Board of its completion so that another meeting can be scheduled urgently to complete the discussion and render a decision.

Once the Board has decided what to recommend to the Residency Education Committee, the Board shall notify the residency director and the complainant(s) in writing.

The Chair or any Board member shall report on any Board activities or recommendations to the Residency Education Committee.

E. APPEAL

The complainant(s), if dissatisfied with the Board's recommendation or the Residency Education Committee's action, may file a notice of appeal. The appeal must be filed in writing via email or letter with the Chair of the Board. The appeal will be heard by an Appellate Board consisting of the most senior of the faculty: the Department Chair at University, the Clinical Director at University, the Department Chair at Mercy, the Director at Bon Secours, and the Chief of Service at the VA. An additional Chief Resident shall be appointed to this Appellate Board. This Chief Resident shall be a different resident than the Chief Resident serving on the Grievance Board.

The appeal should be heard within 1 month of the filing of notice of appeal and those present at the appeal shall consist of the complainant, at least four members of the Appellate Board, a member of the Grievance Board, and the Residency Director or Associate Director(s). This meeting shall take the format of open discussion. The Grievance Board member will first brief the Appellate Board on the history of the complaint, any investigation, and the Grievance Board's recommendation. The Residency Director or Associate Director will brief the Appellate Board on the action taken by the Residency Education Committee. The appellant will brief the Appellate Board on his or her reasons for appeal.

In order to decide the appeal, a vote among the above appellate judges shall be taken after the Appellate Board discusses the matter. Discussion and voting shall be closed to all persons except those Appellate Board members. The Appellate Board decides whether to uphold the Grievance Board's recommendation in its entirety, to overturn it in its entirety, or to uphold the recommendation with revision(s). A simple majority shall decide any vote. The Board member present at the appeal will notify the other Board members, the complainant(s), and the Residency Education Committee of the Appellate Board's decision. The Grievance Board shall abide by the Appellate Board's decision. The Appellate Board's decision and/or recommendation shall serve as the Grievance Board's recommendation to the Residency Education Committee.

F. RECORD KEEPING

Minutes of all hearings shall be taken by a Grievance Board member or an appellate judge. Minutes shall be kept on file by the residency coordinator. Copies of any and all written communications between the Board and the complainant(s) or any other parties shall be kept on file with the residency coordinator. These records shall be considered private and subject to the same confidentiality standards to which all other residency-related documents are held.

G. CONTINGENCY

If a grievance involves a Board member or an Appellate board member, that member shall be notified that his or her membership will be suspended for the purposes of the preliminary vote and for any hearings.

H. DUTY HOURS

Board activities at which residents are present shall not be included in resident duty hours and shall be considered time off duty.

XII PROFESSIONALISM

- A. It is expectation of the department and the medical center that you will act professionally at all times especially in regards to social media.
- B. Professionalism is evaluated in multiple areas, including but not limited to: clinical duties, timely response to emails and pages, use of sick call, attendance and participation in conference, attire, completion of reading assignments, adherence to deadlines, and participation in social media. Residents must maintain the highest level in order to be eligible for moonlighting.
- C. The University of Maryland Medical Center has a Social media policy located at www.umm.edu/socialmedia/social-networking-policy.pdf . Please ensure that you are familiar with this policy and abide by it.
- D. Professionalism is evaluated in multiple areas, including but not limited to: clinical duties, timely response to emails and pages, use of sick call, attendance and participation in conference, attire, completion of reading assignments, adherence to deadlines, and participation in social media. Residents must maintain the highest level in order to be eligible for moonlighting.
- E. Please be careful of taking photos in the ED and hospital that might have identifiable information, e.g., tracking boards or patient charts visible in the background. If in doubt do not post it.
- F. Common sense rule: If you would not be comfortable having the photo or post displayed on a billboard in the middle of town do not post it. Remember that patients and family members do not understand medical humor.

XIII KEY POINTS

- A. Conference attendance must be 70% or greater in order to be promoted to the next PGY level or to graduate.
- B. FHC conference readings are required even if you are not able to attend conference. If you can not attend you must submit a summary in outline format as instructed in II-9.
- C. All procedures should be logged into E-Value
- D. You must complete seven (7) competencies for each chief complaint and procedure as outlined in section III-B.
- E. Off Service competencies should be completed at the end of the rotations as outlined in section III-B-3.
- F. Vacation is not permitted during:
 - a. The last 10 days of December and the first 2 days of January.
 - b. ACEP Scientific Assembly
 - c. The In-training examination (held on the last Wednesday of February)
- G. The sick call resident must be ready and able to report to work within 1 hour of being called and be available at all times by beeper or phone.
- H. Moonlighting is only permitted for PGY3-6 residents that have been approved by the program director and have meet all the requirements as outlines in section III-G.
- I. Residents are expected to promptly return ALL pages.
- J. Residents are expected to check their emails daily.

- K. Residents are expected to follow the dress code whenever they are in the hospital for any work related reason. Dress code is highlighted in section III-K.
- L. Residents should speak to the program director or Dr. Mimi Lu no less than 6 weeks prior to their assigned lecture to review their topic, and again at two weeks to review their slide presentation.
- M. Residents need to insure that they arrive for shifts on time prepared to work. This means that they should arrive at least 10 minutes prior to their shift to ensure that they are ready to receive sign-out.