# Queen’s University Emergency Medicine Resident Handbook

## Guidelines and General Information

(Updated June 2019)

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# Queen’s University Emergency Medicine Resident Handbook

**Guidelines and General Information**

Revised June 2019

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Introduction

This handbook is intended to formally outline all aspects of the Emergency Medicine Residency Program for our residents. It is intended to give incoming residents an overview of the teaching program and should be useful for residents at all stages of the program to help understand the direction of the educational mandate we have.

This manual includes:

- A preamble to the clinical and academic curriculum of the Emergency Medicine residency training program
- Important policies
- A concise table with the clinical rotations taken in the five years of the program
- A description of each year from PGY1 to PGY5 and the rotation specific goals and objectives
- A description of the overall program goals and objectives. Residents are expected to demonstrate achievement of this standard by the end of their training.
- A description of Emergency Medicine training expectations and level of responsibility for each year of the training program
- A description of electives and elective policies
- A schedule and description of academic rounds
- A content list for the core curriculum, scholar competency curriculum and administrative series

The curriculum for the residency program consists of clinical rotations and required training experiences. Please pay particular attention to the descriptions of each year and the section of Emergency Department rotations.

Jaelyn Caudle
Program Director
Queen’s University Emergency Medicine Residency Program
Mission Statement

The Queen’s University Emergency Medicine Residency Program is committed to providing a program of educational and clinical excellence. Our program is rigorous, enjoyable and compassionate. We embrace diversity and teamwork and value the community we form with our patients, their families and our medical and allied health colleagues. We aim to create a culture of support and mentorship in which our residents enjoy working and learning.

Our program is dedicated to training:
- specialist Emergency Medicine physicians who are outstanding clinicians and compassionate patient advocates
- specialist Emergency Medicine physicians who are leaders in research, administration and educational scholarship dedicated to the advancement of knowledge in the specialty of Emergency Medicine
- specialist Emergency Medicine physicians who are self-reflective, resilient and willing to embrace emerging technologies such as simulation as a means to optimize personal performance and the safe delivery of patient care
- specialist Emergency Medicine physicians who demonstrate a commitment to personal wellness, career sustainability and professional development and are able to successfully integrate work and life within the challenges of working in the ED environment
Section 1: A Little Bit About Queen’s EM

History of Emergency Medicine in Canada and Queen’s University

Emergency Medicine has had a growing profile at Queen’s University starting in 1971 with the staffing of both of Kingston’s Emergency Departments by Emergency Physicians and culminating in the granting of University Departmental status in 1996.

Important dates and events in our specialty and in our residency program are:

<table>
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<th>Year</th>
<th>Event</th>
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<tr>
<td>1972</td>
<td>Council (RCPSC) requests proposals for education programs in Emergency Medicine</td>
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<td>1972</td>
<td>Council (RCPSC) accepts the concept of specialty in Emergency Medicine</td>
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<td>1972</td>
<td>McGill begins residency program</td>
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<td>1974</td>
<td>Guidelines for training programs in Emergency Medicine</td>
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<td>1975</td>
<td>Emergency Medicine receives Divisional status in the Department of Surgery at Queen’s University</td>
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<tr>
<td>1976</td>
<td>University of Western Ontario begins residency program</td>
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<tr>
<td>1977</td>
<td>Queen’s University begins residency program</td>
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<tr>
<td>1978</td>
<td>CAEP formed</td>
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<tr>
<td>1979</td>
<td>Approval of Emergency medicine as modified Conjoint Board in the United States</td>
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<tr>
<td>1980</td>
<td>Approval by RCPSC as new Canadian specialty</td>
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<td>1996</td>
<td>Emergency Medicine receives departmental status at Queen’s University</td>
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<tr>
<td>2017</td>
<td>Queen’s Emergency Medicine residency program transitions to a Competence by Design framework</td>
</tr>
<tr>
<td>2018</td>
<td>RCPSC transitions to a Competence by Design framework for all Emergency Medicine training programs</td>
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To date over 100 residents have graduated from the Emergency Medicine residency program at Queen’s University. Our residents have and continue to have leadership roles in academic Emergency Medicine across the country. A list of our graduates is included.

The CCFP(EM) program at Queen’s is run through the Department of Family Medicine and we are proud to have played a part in the clinical and academic training of the residents in this program.

Our program is fully accredited by the RCPSC and last accreditation was in 2018. We accept four residents per year into the five-year program. Our success rate for the RCPSC exams has been excellent. We anticipate our tradition of success to continue due to the high quality of residents we attract each year and the excellent academic and clinical support we receive from our Emergency Medicine Faculty.

Revised June 2019
## Department of Emergency Medicine Residents 2019-2020

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<tr>
<td>Dr. Savannah Forrester</td>
<td>PGY 5</td>
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<tr>
<td>Dr. Eve Purdy</td>
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<tr>
<td>Dr. Kristen Weersink</td>
<td>PGY 5</td>
<td>University of Ottawa</td>
</tr>
<tr>
<td>Dr. Ali Yakhshi Tafti</td>
<td>PGY 5</td>
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<tr>
<td>Dr. Amy Burton</td>
<td>PGY 4</td>
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<td>Dr. Andrew Helt</td>
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<tr>
<td>Dr. Kirsten Litke</td>
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<td>Dr. Chris Meyer</td>
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<td>Dr. James Ahlin</td>
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<tr>
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<th>University Rank</th>
<th>Specialty Qualifications</th>
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<td>FRCPC</td>
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<td>Jaelyn Caudle</td>
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<tr>
<td>Louise Rang</td>
<td>Assistant Professor</td>
<td>FRCPC, RDMS</td>
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<td>Clinical/Teaching/Ultrasound</td>
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<tr>
<td>Andrew Reed</td>
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<td>FRCPC, MSc</td>
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<td>Clinical/Teaching/EMS</td>
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<tr>
<td>Nicole Rocca</td>
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<td>Clinical/Teaching/Critical Care</td>
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<tr>
<td>Stephanie Sibley</td>
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<tr>
<td>Craig Simpson</td>
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<tr>
<td>Marco Sivilotti</td>
<td>Professor</td>
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<tr>
<td>Matt Stacey</td>
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<tr>
<td>Adam Szulewski</td>
<td>Assistant Professor</td>
<td>FRCPC, MHPE, PhD Candidate</td>
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<td>Clinical/Teaching/Research, Resuscitation and Reanimation Fellowship Program Director</td>
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<tr>
<td>Melanie Walker</td>
<td>Assistant Professor</td>
<td>PhD</td>
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<td>Teaching/Research</td>
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<tr>
<td>Heather White</td>
<td>Assistant Professor</td>
<td>FRCPC</td>
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# Department of Emergency Medicine Past Graduates (2009 – Present)

<table>
<thead>
<tr>
<th>Resident</th>
<th>Graduating Year</th>
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<th>Graduating Year</th>
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<tbody>
<tr>
<td>Dr. Emily House</td>
<td>2019</td>
<td>Dr. Andrew Hall</td>
<td>2014</td>
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<tr>
<td>Dr. Mackenzie Howatt</td>
<td>2019</td>
<td>Dr. Conor McKaigney</td>
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<tr>
<td>Dr. Graeme Ross</td>
<td>2019</td>
<td>Dr. Stephanie Sibley</td>
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<tr>
<td>Dr. Zackary Warren</td>
<td>2019</td>
<td>Dr. April Tozer</td>
<td>2014</td>
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<tr>
<td>Dr. Mikayla Brenneis</td>
<td>2018</td>
<td>Dr. Chris Evans</td>
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<tr>
<td>Dr. Stuart Douglas</td>
<td>2018</td>
<td>Dr. Rachel Poley</td>
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<tr>
<td>Dr. Aaron Ruberto</td>
<td>2018</td>
<td>Dr. Andrew Robinson</td>
<td>2013</td>
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<tr>
<td>Dr. Heather White</td>
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<td>Dr. Mark Froats</td>
<td>2012</td>
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<tr>
<td>Dr. Matthew White</td>
<td>2018</td>
<td>Dr. Andre Lui</td>
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<tr>
<td>Dr. Caley Flynn</td>
<td>2017</td>
<td>Dr. Jennifer Tang</td>
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<td>Dr. Carly Hagel</td>
<td>2017</td>
<td>Dr. Jason Bornstein</td>
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<tr>
<td>Dr. Sharleen Hoffe</td>
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<td>Dr. Donna Lee</td>
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<td>Dr. Eric Mutter</td>
<td>2017</td>
<td>Dr. Geoff Sanz</td>
<td>2011</td>
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<tr>
<td>Dr. Colin Bell</td>
<td>2016</td>
<td>Dr. Mike Geddes</td>
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<tr>
<td>Dr. Colin Mercer</td>
<td>2016</td>
<td>Dr. Tom Kaul</td>
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<tr>
<td>Dr. Nicole Rocca</td>
<td>2016</td>
<td>Dr. Eric Bruder</td>
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<tr>
<td>Dr. Katherine Stuart</td>
<td>2016</td>
<td>Dr. Alison Kabaroff</td>
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<tr>
<td>Dr. Erin Brennan</td>
<td>2015</td>
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<tr>
<td>Dr. Andrew Hurst</td>
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<tr>
<td>Dr. Jody Stasko</td>
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<tr>
<td>Dr. Adam Szulewski</td>
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<tr>
<td>Dr. Tim Chaplin</td>
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Section 2: Important Policies

Registration

New residents and returning residents both can register on-line with our Postgraduate Office.

Instructions and log on information are available on the Postgraduate Website at:
https://meds.queensu.ca/academics/postgraduate/current/registration

Registration must be completed before 4pm on June 27, 2019 for the upcoming year.

Department of Emergency Medicine Residency Program Safety Guidelines (Reviewed June 2019)

The purpose of these guidelines is to enhance the health and well-being of our residents by offering guidelines for personal safety during clinical shifts in the emergency department. These guidelines are made available in the on-line residency manual and are reviewed annually. Key items will be covered in the core curriculum.

Preamble: The environment in the emergency department poses many threats to the personal safety of Emergency Medicine residents and staff emergency physicians. The risks are due to:

- Threat of communicable disease
- Threat of physical violence, intimidation and harassment
- Risk of harm related to shift work
- Risk of legal action by patients and families
- Risk of legal action caused by use of social media

Guidelines are as follows:

1. Residents should wear appropriate protective gear during high-risk patient interactions (trauma patients, airway management procedures, bleeding patients, and patients presenting with febrile illnesses) when necessary.

2. Residents must receive and maintain appropriate fit testing for personal protective equipment (i.e. N95 mask) prior to clinical shifts in the emergency department.

3. Residents should adhere to hospital infectious disease prevention and reporting policies.

4. Residents must possess adequate knowledge of technical skills and practice appropriate technique to protect themselves and others from needlestick injuries. Residents must recognize the importance of reporting adverse events and be aware of the indications for post exposure prophylaxis.

5. Residents should recognize patients who pose a threat of physical violence and understand measures that can be taken to prevent and protect themselves from physical harm (nonviolent crisis intervention, panic buttons, safe interview rooms, police or security presence, physical and chemical restraints).

6. Residents must understand the threats related to shift work including signs of physician burnout or substance misuse, impact of shift schedules (i.e. short shifting) and the
impact of shift work on interpersonal relationships. Residents are advised to seek assistance from available resources (Program Director, Occupational Health, Employee and Family Assistance Program) if they are experiencing negative effects of shift work.

7. Residents should be aware of the importance of safe transportation to and from work. The use of security escorts to transportation home especially after evening shifts is encouraged.

8. Residents must understand the physiology and importance of good sleep hygiene.

9. Residents are advised to have a chaperone for pelvic, breast and rectal exams on women and male patients.

10. Residents are advised to ask for a witness during anticipated or developing difficult patient encounters and the importance of careful documentation of these encounters.

11. Residents are advised of the importance of careful documentation in patient encounters that are likely to proceed through the judicial system (i.e. sexual assault, motor vehicle accidents, physical assault/domestic violence).

12. Residents should be aware of the Queen’s University policy on intimidation and harassment. Residents are encouraged to report events according to the policy.

Residents are encouraged to review the following guidelines established by the Postgraduate Medical Education office:

Blood Borne Diseases and the Health Care Worker
https://www.cpso.on.ca/Physicians/Policies-Guidance/Policies/Blood-Borne-Viruses

Communicable Diseases Protocol

Immunization
http://cou.on.ca/papers/immunization-policy/

KGH Workplace Health and Safety Review
http://meds.queensu.ca/education/postgraduate/policies/workplace_health

Maintaining Appropriate Boundaries and Preventing Sexual Abuse
http://www.cpso.on.ca/policies-publications/policy/maintaining-appropriate-boundaries-and-preventing

Pre-placement Communicable Disease Screening
https://cou.ca/reports/immunization-policy/

Physicians and Health Emergencies

Resident Health and Safety Policy
http://meds.queensu.ca/education/postgraduate/policies/safety
Resident Intimidation and Harassment Policy

Social Media

**Resident Intimidation and Harassment Policy** (Reviewed June 2019)

The Queen’s Emergency Medicine residency program strives to promote a culture of inclusiveness and collegiality. Our program adheres to the PGME policy on intimidate and harassment.

Residents are encouraged to review the policy available at:

**Guidelines for Prescription of Controlled Drugs** (Reviewed June 2019)

Physicians in the Department of Emergency Medicine at Queen’s University agree to the following guidelines for the prescription of opioid analgesics and other controlled drugs upon discharge of patients from the Emergency Department at KGH and the Urgent Care Centre at HDH. The document “Ontario Consensus Guidelines on Opioid-Prescribing in Emergency Departments” is attached for reference. These guidelines are intended to promote standardization and best practices for outpatient prescribing of opioids and other controlled drugs in the ED/UCC setting. We acknowledge that deviation from the guidelines may at times be necessary and acceptable in the professional judgment of the treating physician, but that the reasons for such deviation should be communicated to the patient and documented in the medical record.

1. The attending physician will carefully supervise the prescribing of controlled drugs for patients being discharged from the ED or UCC. Prescriptions written by residents will be reviewed by the attending physician with regards to the agent, dose, interval, instructions and quantity of the controlled substance being prescribed in light of the patient’s condition.

2. Non-opioid and non-pharmacologic options will also be considered for all patients with pain.

3. Patients with chronic pain will be discouraged from obtaining prescription renewals at either the ED or UCC. As a department, we have had a policy in effect since 2009 and signage at triage that we will not renew expired, lost, stolen or destroyed prescriptions for controlled substances. Any deviation from this policy should be considered an exceptional event, and the singular nature of this exception should be explained to the patient. The medical record should detail the dose and amount of controlled substances reportedly received by the patient in the recent past, efforts and results of efforts to corroborate this medication history from independent sources, and the presence or absence of stigmata of withdrawal. Moreover, the discussion regarding how future requests of this nature will be handled must be documented in the medical record to assist in their management.

4. Physicians are encouraged to advise patients presenting in opioid withdrawal that: 1) tolerance is already being lost; 2) there is a substantial risk of accidental fatal overdose should they resume dosing at their prior dose, or seek illicit sources of opioids or “alternatives;” and 3) supervised detoxification options exist in the community. These notions also apply to some extent to withdrawal from sedative/hypnotic agents.

Revised June 2019
5. Prescriptions for opioids in the emergency department should be administered in limited quantities at appropriate doses for short intervals for acute and recent injury or illness. These prescriptions should be accompanied with information regarding the use of alternatives to opioids including over-the-counter analgesics and non-pharmaceutical adjuncts.

6. Physicians should avoid initiating sustained-release formulations of opioids and be mindful of drug-drug interactions with sedatives, ethanol, other prescription opioids and illicit drugs.

7. Patients with chronic pain should be encouraged to seek primary care from a family physician, and be considered for referral to multidisciplinary pain clinics, practitioners and services for management of chronic pain when appropriate.

8. Patients with addiction may be referred to the Street Health Centre who will attempt to see all referrals from the ER within the week for assessment for counseling, opioid agonist treatments, naloxone training and kit provision, referral for residential treatment etc. Contact information and referral forms can be found on the Links section of EDIS.

**Restricted Registration Policy** (Updated June 2019)

Queen’s Emergency Medicine allows senior residents to participate in the College of Physicians and Surgeons of Ontario Restricted Registration Program within the following guidelines:

1. Residents must complete the mandatory rotations in Critical Care, Anaesthesia and Cardiology before consideration will be given to an application for restricted registration.

2. In general, residents will be permitted to moonlight in the disciplines of Emergency Medicine or Critical Care Medicine.

3. Residents who wish to apply for the Restricted Registration Program must apply in writing to the Program Director. Applications must identify the clinical area, number of requested shifts and rationale for the application.

4. To be considered for restricted registration, residents must fully meet the criteria of the CPSO Restricted Registration Program plus:
   - Consistently demonstrate clinical excellence on all rotation evaluations
   - Consistently fulfill all the requirements of the training program
   - Consistently demonstrate good citizenship and professionalism within the residency training program

5. Each application for restricted registration will be presented at the quarterly Competence Committee for discussion. The decision is binding and will not be considered for appeal.

6. Residents who are granted permission to participate in the Restricted Registration Program will provide the dates of all moonlighting shifts to the Program Director for each block prior to the start of the block.
7. The maximum number of shifts permitted in each block is two (2) shifts unless approved, in advance, by the Program Director. Restricted Registration (moonlighting) shifts cannot interfere with participation in any activities of the residency training program.

8. Residents who are denied permission to participate in the Restricted Registration Program will receive feedback on the reasons underlying the decision. Residents may submit another application to the Program Director in advance of the next scheduled Promotions and Appeals Committee meeting provided significant improvement in any previously identified deficiencies has been made.

9. All residents in the Restricted Registration Program will be reviewed quarterly to determine if they continue to meet the inclusion criteria. Residents who no longer fulfill the inclusion criteria, will be notified and the Program Director will rescind permission with the CPSO.
Section 3: Resident Work Life Balance

Annual Social Functions

A key component of physician wellness is work-life balance. To that end, the Department of Emergency Medicine hosts several social events:

- Orientation BBQ – to welcome our new PGY1, CCFP(EM) and Resuscitation and Reanimation and Global Health fellow residents – July
- Staff vs Residents baseball game - join your (usually winning) team and take on the staff in a game of baseball - July
- Annual Summer Party – another welcome to residents and staff - July or August
- Pub Crawl – usually a team based pub-golf pub crawl to introduce our new members to several of Kingston’s finest watering holes - August
- The Big Mac Challenge – a leisurely group ride to Gananoque followed by a big mac meal and a full out sprint back to Kingston. The race starts once everyone has their big mac, large fries, apple pie and large drink. Several prizes are up for grabs - July or August
- Department of EM Christmas Party – usually an afternoon of curling with a dinner following - December
- Department of EM Ugly Christmas Sweater pub night - a pub night organized by our nursing colleagues to celebrate the holidays. Wear your ugliest Christmas sweater!
- TMTL – an afternoon of informal talks by faculty and residents on any non-medical topic of importance to them to remind us all that There’s More to Life...
- Resident Retreats – the winter retreat brunch is held at a local restaurant. The summer retreat is an overnight sleepover at a staff cottage - June & December
- CaRMS Social – traditionally held at the Grizzly Grill, faculty on the selection committee and all residents play host to the CaRMS candidates to showcase our awesome program – January
- Resident Appreciation Day – coinciding with the release of the CaRMS Match results, a pizza lunch is offered to celebrate the wonderful residents and celebrate our newest additions to the team – March
- Departmental Golf Tournament and Graduating Resident Farewell – a friendly golf tournament including our nursing and paramedic colleagues to celebrate and say goodbye to the graduating PGY5 and CCFP(EM) residents – June
**Resident Health and Wellness Resources**

Physician wellness is essential to a happy, sustainable career in Emergency Medicine. Our program has an open-door policy and residents may approach any of the faculty if feeling distressed. The Program Director is always available to counsel residents in crisis. During quarterly review meetings with Program Director, residents will be asked whether they are experiencing any issues and are reminded about resources on the Postgraduate website.

The Postgraduate office at Queen’s University offers urgent psychiatric and personal support for residents in crisis in a timely and effective fashion with a core of excellent professionals available at any time. This service can be accessed at the request of the Program Director or the resident. Kingston General Hospital also offers an employee assistance service.

A full list of wellness resources can be accessed on the PGME Resident Health and Wellness website available at: [https://meds.queensu.ca/education/postgraduate/wellness](https://meds.queensu.ca/education/postgraduate/wellness)

A lending library of books related to resilience and wellness is available in our Department Library.

There is a dedicated bulletin board in the resident lounge where wellness resources are posted to facilitate anonymous access to resources. There is also a link to the PGME Resident Health and Wellness page on our departmental website.

To promote a culture of wellness in our department, we hold a TMTL (There’s More to Life) half day where faculty and residents are encouraged to provide a brief (10 minutes) presentation on any non-medical topic of importance to them. This session is highly valued and well attended by faculty and residents.

**Wellness, Resilience and Performance in EM (WRaP EM)**

This year we are offering a curriculum dedicated to wellness, resilience and performance in Emergency Medicine. Half-day seminars are offered roughly every second month and the curriculum will operate on a two-year cycle allowing residents to receive the content twice during residency. Topics cover a breath of areas essential to personal wellness and career sustainability such as crisis resource management, gender and diversity in the workplace, communication skill training, financial wellbeing and personal purpose.

This curriculum is a work in progress so we are eager to hear feedback on what’s working and what can be improved.
Section 4: Teaching and Clinical Facilities

Kingston General Hospital (KGH)

All in-hospital core rotations with the exception of Obstetrics and Orthopedics take place at KGH. KGH is a 480-bed tertiary care hospital and is the referral center for a population of 500,000. KGH is the regional trauma center receiving an average of 380 multiple trauma patients (defined by an Injury Severity Score of greater than 15) per year. The Emergency Department is staffed 24 hours per day with triple coverage by attending physicians from 1100 – 0100 daily. A nurse practitioner is present to assess and manage lower acuity patients from 1100-1900 daily. The Emergency Department patient volume is 60000 unscheduled visits yearly and the admission rate is approximately 19%. The Emergency Department consists of six patient areas and has 44 active treatment beds, 15 overflow patient care beds and 12 chairs for ambulatory patients. There are 21 monitored beds and the acute resuscitation area has nine beds. Triage nurses assess all patients on arrival. Residents, staff physicians and the charge nurse are linked with cordless telephones to facilitate communication. Paramedics have direct phone link communication with the attending staff and senior residents. All medical records, including patient charting, laboratory and radiology investigation and physician order entry is performed on the Emergency Department Information System (EDIS).

Hotel Dieu Hospital (HDH)

All outpatient clinics and a large outpatient imaging service are located at the HDH. The Urgent Care Center (UCC) is open from 0800 – 2000 daily and is equipped to handle ambulatory emergencies. There is triple coverage from 1500-1600 and double coverage from attending physicians from 1100-1500 and 1600-1900 daily. The patient volume is 50000 patients per year. The HDH is an excellent facility for learning the management of less serious outpatient medical problems, minor procedural skills and ED administrative principles.

Children’s Hospital of Eastern Ontario

Pediatric Emergency rotations take place at CHEO. Residents do one block of Pediatric Emergency Medicine at CHEO in first year as a junior resident and two blocks in PGY3 at the senior resident level. CHEO is a University of Ottawa teaching hospital and is the tertiary pediatric referral center for Eastern Ontario.

Other Teaching facilities

The toxicology rotation is based at the Ontario Poison Control Center located at the Hospital for Sick Children in Toronto.

The Obstetrics and Gynecology rotation is arranged through the Department of Family Medicine and takes place in Oshawa.

Residents may pursue mandatory rotations outside of the usual locations listed above upon approval of the Program Director. If rotations are completed outside of the usual location, residents are required to fund associated accommodation and transportation costs.
Section 5: Resident Funding and Resources (Reviewed June 2019)

The Department of Emergency Medicine Academic Fund provides generous financial support for the academic activities/educational resources. Residents may apply to the Department of Emergency Medicine Academic Committee for financial support for other worthwhile academic pursuits not included in the list below.

Conference Support

1. Residents will receive a travel stipend of up to Cdn$750 to attend the ACEP Scientific Assembly once during their residency training (usually during the PGY2 or PGY3 year).

2. Residents will receive a travel stipend of up to Cdn$750 to attend the SAEM Annual Meeting once during their residency training (usually during the PGY3 or PGY4 year).

3. Residents will receive a travel stipend of up to Cdn$500 to attend the CAEP Annual Meeting once during their training.

4. Residents will receive up to Cdn$500 or CAEP registration fee (whichever is less) for up to three (3) resident team members annually to represent Queen’s Emergency Medicine in the Simulation Olympiad and/or Sonogames at CAEP. Individual residents may only receive this funding twice during their training.

5. Residents presenting an oral or poster abstract at a national meeting will usually have travel, hotel and early registration costs reimbursed, provided the following:
   - The conference is a national emergency medicine meeting (i.e. CAEP Annual Meeting, SAEM Annual Meeting or ACEP Scientific Assembly), or the national meeting of the subspecialty related to the abstract being presented (e.g. North American Congress of Clinical Toxicology, National EMS Meeting)
   - The conference is on the North American continent.
   - All travel and accommodation arrangements are made by the resident using the most economical means possible.
   - Funding under category 4 can only be used for a single conference for the materially same research/abstract. This does not preclude the use of conference funding under categories 1, 2 or 3 to support travel to the additional conferences. In each case, the Academic Committee Chair will be the final judge of duplicate presentation.
   - Application for funding under category 4 can be made more than once during residency subject to the restrictions above regarding duplicate presentation.

For all conference support, application must be made, in writing, to the Chair of the Academic Committee at least one month in advance of the early registration deadline of the conference. The current Academic Director is Dr. Bob McGraw.

When applying under category 4, the application must be made seven days prior to the abstract submission deadline, and must be accompanied by the abstract, as well as any related abstracts previously submitted from the same project.

Funds will only be released with the written authorization of the Academic Committee, typically in the form of the minutes of the Academic Committee meeting at which the application is approved.
Funding Support for Mandatory Academic Activities

1. Membership fees will be provided annually as follows:
   - Emergency Medicine Residents Association (EMRA) of ACEP – residents are automatically registered by office
   - Canadian Association of Emergency Physicians (CAEP) - residents must register and are reimbursed

2. Enhanced Training and Certification Courses – tuition fees will be reimbursed once for each of the following courses during the residency program:
   - ACLS Instructor
   - ATLS
   - ATLS Recertification
   - ATLS Instructor
   - PALS
   - National Review Course (PGY5 year; max $900.00)

3. Examination preparation - Examination fees will be paid annually directly by the department for:
   - FRCP Canadian In-Training Exam (CITE)

4. Miscellaneous Benefits - reimbursement will be provided once for:
   - Purchase of a textbook in Emergency Medicine (max $350.00)
   - Purchase of work boots for EMS ride-outs (max $100.00)
   - Up to Date - a hospital subscription is available for use

5. To improve teaching skills, residents are encouraged to register for the sessions Teaching in the Classroom and Teaching at the Bedside workshops offered through Office of Continuing Professional Development in the Faculty of Health Sciences. Resident who attend both sessions will receive a certificate. Tuition for these sessions is covered by the PGME office directly.

Funding Support for Accommodation and Transportation for Mandatory Out of Town Rotations

Accommodations for mandatory out of town rotations are provided through the Regional Education Office at Queen’s University. Residents will receive an automated notification through the MedTech system sent to their “@queensu.ca” account asking them to confirm the accommodations. The email link contains detailed information regarding the accommodation.

If accommodation requests for mandatory rotations surpass Regional Education Office’s capacity residents will receive an accommodation allowance of $800 per month and the residents will be required make their own arrangements.

If a resident chooses not to stay in the arranged accommodations when there is availability, the resident will be responsible for arranging their own accommodations at their expense and an allowance will not be provided.
Mandatory out of town rotations for Queen’s Emergency Medicine are:

CHEO (1 block in PGY1 and 2 blocks in PGY3)
- Accommodation in Ottawa: Arranged by EM Program Administrator and provided through the Regional Education Office at Queen’s University as described above.
- Travel: Costs to be reimbursed by the Regional Education Office at a rate of $105 per 2 weeks or $210 per month.

Toxicology (1 block in PGY4 or PGY5)
- Accommodation in Toronto: Arranged by EM Program Administrator and provided through the Regional Education Office at Queen’s University as described above.
- Travel: Costs to be reimbursed by the Regional Education Office at a rate of $120 per 2 weeks or $240 per month.

Obstetrics & Gynecology (1 block Obstetrics in PGY2)
- Accommodation in Oshawa: Arranged by EM Program Administrator and provided through the Regional Education Office at Queen’s University as described above.
- Travel: Costs to be reimbursed by the Regional Education Office at a rate of $110 per 2 weeks or $220 per month.

Additional Resources Available to Support Academic Activities

To support the educational and academic mandate of our residency training program additional resources are available for residents including:

- Research nurses at Kingston General Hospital and Hotel Dieu Hospital – available to facilitate clinical resident research
- Departmental Epidemiologist – available to provide assistance with selection of research methodology and statistical analysis
- Emergency Department library with up to date texts and journal selections
- Three computer work stations in the library
- Departmental lap top computer
- Computer Data Projector

By application to the Program Director, the costs for the following will be supported if prior approval is obtained:

- Slides for presentations at regional/national meetings
- Defray travel costs for presentations at regional/national meetings
- Paper costs for research projects
- Poster presentations

Department Library

The Departmental Library is maintained by the Department of Emergency Medicine Academic Fund.

There are collections of relevant texts in both emergency departments for immediate access. These texts are for the use of members of all departments in the emergency department.
The library is located in the resident room on Victory 3 at KGH and is intended for use by departmental staff and residents only. It is a secure area. The library is stocked with textbooks in Emergency Medicine and other relevant disciplines. This is your library and you are asked to follow some simple rules to keep the library functional.

- Re-shelve all books after use
- Keep the library tidy
- Books are not to be removed from the library

The library also has three-computer workstations with internet access (lots of Emergency Medicine links), Ovid access, the hospital PCS, and EDIS.
Section 6: Resident Committee Responsibilities

Emergency Medicine residents are expected to take part in various departmental committees. Resident involvement is very important in maintaining the educational standards and working environment of our residency program. The Department values input provided by resident members on these committees.

Residents participate in the following committees:

- **Residency Program Committee** (see attached Terms of Reference)
  This Committee oversees the academic mandate and evaluation of the residency training program. There is one resident member elected by the resident cohort who is the delegated liaison for the resident group with the Program Director and faculty. Residents are automatically committee members during the Chief Resident year (PGY4). Representatives from the other training years are elected annually by their peers.

- **Residency Selection Committee** (see attached Terms of Reference)
  This Committee is tasked with the selection of residents into our program, usually through the CaRMS process but may be asked to evaluate applications for transfers into our program. All PGY3 residents are involved in the screening, interviewing and ranking of applicants as official Selection Committee members. During the CaRMS process, the other residents are involved in designated tasks.

- **Department of Emergency Medicine Clinical Care Committee**
  This Committee is tasked with the oversight of the clinical care, quality improvement and health care policy development for the Department of Emergency Medicine. The acting Chief Resident is automatically a committee member.

Residents may participate in other committees of interest within the hospital, School of Medicine, Queen’s University or an external organization such as PARO with approval of the Program Director.
Department of Emergency Medicine

Residency Program Committee Terms of Reference (Updated June 2019)

In keeping with the mandate of the RCPSC and the CFPC, the Residency Program Committee (RPC) is present to assist the Program Directors in the planning, organization and supervision of the Emergency Medicine Training Programs at Queen’s University. As of June 2005, the FRCPC and CFPC (EM) Residency Program Committees meet conjointly. Meetings are co-chaired by the FRCP and CFPC (EM) Program Directors.

Committee Membership:
- FRCP Program Director (Co-Chair)
- FRCP Assistant Program Director
- FRCP Program Administrator
- CFPC (EM) Program Director (Co-Chair)
- CFPC (EM) Assistant Program Director
- CFPC (EM) Program Administrator
- FRCP Chief Resident (PGY4)
- CFPC (EM) Chief Resident
- CFPC (EM) Resident
- One FRCP resident from each year PGY1, 2, 3 and 5 elected by their peers
- CBME Lead (Chair of FRCP Competence Committee)
- Ultrasound Director
- Resident Research Director
- Simulation Director
- Trauma Services Director
- Wellness and Career Sustainability Lead
- Faculty Member at large x 2
- CFPC Enhanced Skills Program Director (corresponding member)
- Surgical Foundations Program Director (Site Liaison for surgical rotations-corresponding member)
- CHEO Site Liaison (corresponding member)
- Lakeridge Health Obstetrics and Gynecology Site Liaison (corresponding member)

Membership Term:
Resident members will be elected annually.
Faculty members with a portfolio title will serve on the Residency Program Committee for the duration of the position.
Faculty member(s) at large will be elected for a two-year term, renewable once.

Voting:
Decision making will be done by consensus when possible. Each member, with the exception of corresponding members, is entitled to one vote.

Meetings:
Meetings will be held on a quarterly basis. Minutes will be recorded for each meeting and distributed to all committee members, residents in both programs and the Department Head. Minutes will also be posted in the resident lounge.

Revised June 2019
Responsibilities:
The Residency Program Committee will monitor the educational mandate of the residency program and facilitate communication between the residents and the faculty members in the Department of Emergency Medicine.

The Residency Program Committee will ensure, through the Selection Committees, a fair selection of candidates for our residency programs.

The Residency Program Committee, with the help of the Program Directors, will aid in the process of residency evaluation, promotion and remediation or appeal should the need arise.

The Chair of the Competence Committee will submit a report to the Residency Program Committee quarterly regarding individual FRCP resident progress and recommendation for promotion or remediation as appropriate.

The Residency Program Committee and the Program Directors will ensure that mechanisms are in place to provide career planning and wellness resources for residents in the program.

The Residency Program Committee will aid the Program Directors in the process of program evaluation.

Subcommittees:
FRCP Selection Committee
CFPC (EM) Selection Committee
Promotions and Appeals Committee
FRCP Competence Committee
Residency Program Committee

FRCP Selection Committee Terms of Reference (Updated June 2019)

The Selection Committee is responsible for the fair selection of residents into our program maintaining a high standard for admission. Most resident selection will occur through the CaRMS match process.

Committee Membership

- FRCP Program Director (Chair)
- FRCP Past Program Director (if appropriate, one year term, renewable)
- FRCP Assistant Program Director
- Four Faculty Emergency Physicians
- FRCP Residents in their PGY3 year

Meetings

The Selection Committee will meet a minimum of three times during the CaRMS process. The Selection Committee may be convened on an ad hoc basis to evaluate the merit of non-CaRMS applications (typically transfers) if appropriate funding and training space is available.

Responsibilities

CaRMS Selection Process

- Selection Committee will abide by the Queen’s University Postgraduate Medical Education policies regarding resident admission and selection
- Committee members will complete CaRMS file review individually using a standardized review form
- The Committee will meet once in November/December to rank all of the CaRMS applications and determine which students will be selected for interviews
- The PGY2 residents will contact all candidates invited for an interview by telephone or email and will forward a program information package via mail
- The Committee will meet in January to interview the candidates. Interviews will be done by two teams; each team will consist of two staff physicians and one or two PGY3 residents depending on the number of resident members available. A standardized interview rating form will be used. All candidates will participate in an exit interview with the Program Director and Assistant Program Director. The exit interview will not be rated.
- On interview day, PGY1 Residents will offer tours of Kingston hospitals, the simulation facility and important city landmarks. The PGY2 and PGY4 residents will present an orientation information session. Additional faculty may participate in the orientation information session if appropriate.
- The Committee will reconvene immediately following the interviews to determine the final rank order of candidates for submission to CaRMS. An initial rank order will be generated from the composite scores of both interview sessions for each candidate. The Program Director will facilitate discussion during the rank order process; however, the final rank order list will be decided by consensus decision of the Selection Committee members only.
Non-CaRMS (Transfer) Process

- Candidates will be subject to the same selection committee process used for the CaRMS process (i.e., suitability for our program based will be assessed based on the merit of the candidate).
- The candidate must ensure funding is available prior to initiating the application process.
- The Residency Program Committee will determine if there is appropriate training space and resources available to proceed with the application.
- If funding and training space are available, the applicant will be asked to provide an application to the Program Director that includes: a letter of intent to transfer, three letters of reference, medical school transcripts, and all resident evaluations received to date. Details of documentation required is listed on the CaRMS website under the Queen’s University Emergency Medicine program description.
- The Selection Committee will review the applicant’s file to decide whether to offer an interview using the same criteria and standardized forms as per the usual CaRMS process.
- Should the application be offered an interview, the Selection Committee will conduct one interview using the same standardized form as per the usual CaRMS process.
- The Selection Committee will decide by consensus decision whether or not to formally accept the candidate into the residency program immediately following the interview. This decision will be communicated to the Postgraduate Medical Education office.
Section 7: Electives

Electives can be taken during the residency program but must be discussed with and approved by the Program Director and meet the standards of the Royal College Emergency Medicine Specialty Committee.

All requests for electives should be submitted in writing to the Program Director and must include a list of learning objectives and measurable outcomes.

Mandatory off-service rotations can be taken at other hospitals after approval by the Program Director. It is the responsibility of the resident to ensure that the rotation is approved by the hospital, college and licensing board of the facility involved. Travel and accommodation costs are the responsibility of the resident.

Electives in other areas are usually taken during the PGY3-5 years. Electives can be in core type rotations (General Surgery, etc.) or in the Emergency Medicine subspecialty areas that may include (not inclusive):

- Emergency Medical Services
- Disaster Medicine
- Trauma
- Toxicology
- Critical Care Medicine
- Research
- Public Health
- Global Health
- Wilderness Medicine
- Medical Education

The resident is responsible for obtaining the electives, initiating the paperwork and covering any associated costs. Time spent in these electives can be considered part of fellowship training in some subspecialties.

Residents may also do Emergency Medicine electives in other centers (academic or community based).

Residents will be asked to provide a brief written summary of the elective experience to be included in a resource binder for future residents. This binder is accessible in the Department Library (resident lounge).
Section 8: Resident Evaluation and Progression

Resident Evaluation Methods

The evaluation process consists of many steps to help you become a competent consultant in Emergency Medicine and to help you pass the RCPSC Specialty Exams held in spring of the PGY5 year. For residents entering through the CBME Curriculum, specialty examinations will be completed in the spring of the PGY 4 year.

Daily Evaluations
Each resident is evaluated on a daily basis using a workplace based assessment of Stage Specific Entrustable Professional Acts (EPAs). The evaluation will be performed electronically on the MedTech platform and will include an assessment of milestone achievement and a global entrustment score. The evaluation should occur immediately following the period of direct observation, however, may occur at some later time due to clinical demands. Residents are required to obtain at least one evaluation per clinical shift in the Emergency Department.

Residents can review their evaluations and track overall progress on their personal electronic dashboard on MedTech.

OSCE
Formative OSCE examinations will be completed in the Simulation Lab twice yearly. These assessments will be videotaped to allow each resident to self-reflect on his/her performance and learning issued identified by the OSCE preceptor.

Multi-disciplinary Evaluation
Residents are required to obtain evaluation from nursing and allied health professionals annually using a 360 Evaluation Tool twice per year. These forms can be triggered using MedTech.

Periodic Performance Assessment
Residents may receive a periodic performance assessment to provide a global evaluation of performance on some rotations where the use of EPAs workplace based assessment may not be feasible or consistent. In this regard, Periodic Performance Assessments are expected to be completed weekly.

Personal Learning Plans and Self-Reflection
Residents are required to complete a personal learning plan prior to each quarterly review to encourage a lifelong commitment to principles of professional development, highlight milestone achievements and facilitate a discussion on learning needs or issues. Each month you will receive, by email, a file of return visits of your patients. Patients who return to the KGH or UCC within 7 days of discharge are included in this list. Review of this list in a thoughtful manner provides you with an opportunity to reflect on your practice patterns and resource stewardship and identify any missed or incorrect diagnoses with the intent to improve patient safety and quality care.

Oral Examinations
Practice oral exams are scheduled once per block during the academic year. All PGY levels are involved on a rotational basis with increasing frequency as resident progress through their training. On average, PGY1 residents may expect to participate in one oral examination/year whereas PGY5 residents may expect to participate in oral examinations monthly. Participation in oral examinations is mandatory.

Revised June 2019
Written Examinations
Two written examinations are offered annually. Written examinations are considered mandatory training experiences and residents must receive permission from the Program Director to be absent or to write the examination outside of Queen’s University

- Canadian In-Training Exam (CITE): a full day exam consisting of two short answer exams (each three-hour duration) produced nationally. Performance on this exam will be benchmarked against the Canadian resident cohort for each PGY year of training (October/November and February/March)
- National Review Course for all PGY5 residents – includes practice oral examinations by an examiner outside of Queen’s University
- A monthly short answer quiz will be distributed by email. An answer key will not be provided and residents are encouraged to look up the answers to any questions they have difficulty with. These quizzes are intended to help guide personal learning and neither participation nor performance are monitored.

Process for Resident Promotion and Remediation

Quarterly Review
The Program Director will meet individually with each resident on a quarterly basis to go over evaluations, future rotations, career planning, and the goals and objectives for upcoming rotations. Any problems the resident is having can be discussed at these meetings although all residents are encouraged to contact the Program Director at any time for help with personal or professional problems.

Academic Advisor Review
Each resident will meet with his/her assigned Academic Advisor usually quarterly but at minimum once per stage of training. Prior to the meeting, the resident will be tasked to complete a detailed self-assessment of their progress toward completion of the required training experiences for his/her stage of training. Based on this review, the resident will prepare a personal learning plan that includes at minimum two learning goals, each of which reference at least two CanMEDS roles. The personal learning plan should also identify the action plan, time frame and outcome objectives of these learning goals. Residents are encouraged to submit their PLP to their Advisor in advance of any scheduled meeting in to allow the Advisor sufficient time to reflect on how best to assist you in achieving your learning goals. Academic Advisors will also thoroughly review resident progress prior to scheduled meetings and assist you to refine or expand your personal learning plan as necessary. Think of your Academic Advisor as a coach to help you refine your practice.

Competence Committee Review
The Competence Committee consists of the Program Director, the CBME Lead and Academic Advisors. The Committee will meet quarterly to review resident progress and make decisions on resident promotion or remediation. Residents will be notified in writing of Competence Committee decisions and recommendations.

Residency Program Committee Promotions and Appeals Subcommittee
The Competence Committee decision regarding resident promotion or remediation will be forwarded to the Residency Program Committee Promotions and Appeals Committee for discussion and/or endorsement.

See attached committee Terms of Reference
Revised June 2019
Queen’s EM Policy on Assessment, Promotions, Appeals and Remediation (Approved by RPC December 2018)

Outline
With the adoption of Competency Based Medical Education, our training program has changed the way we assess our trainees. The purpose of this policy is to outline the updated process for assessment adopted by the Residency Program Committee. It is intended as a supportive document to the policies that are in place at the PGME level (see next section).

Completion of Emergency Medicine Program
To complete the Emergency Medicine Program trainees must fulfil the following requirements:

- Successful completion of all Required Training Experiences (RTEs)
- Achievement of competence in all stage-specific Entrustable Professional Activities (EPAs)
- Successful completion of all Special Assessments (SAs) and acceptable performance on all examinations throughout training
- Promotion through all stages of training with successful resolution, as determined by the Competence Committee of any identified performance issues

1. Successful completion of all Required Training Experiences
Residents must successfully complete all assigned rotations and other RTEs. If a resident is determined by the Competence Committee to have been unsuccessful in completing an RTE, the resident will be assigned additional training experiences to enable successful completion of that RTE’s objectives. Residents will not be deemed incomplete due to an inadequate assessment if the resident has demonstrated a pattern of triggering assessments, which have not been completed by faculty. Depending on the nature of the incompletion, this may include a modified Personal Learning Plan or Remediation. At the discretion of the Competence Committee, additional training experiences may be completed concurrently with other rotations or be added as additional training time. In addition, it is expected that residents attend all teaching activities (Grand and Core Rounds, Journal Club, Simulation Rounds, and other activities of residency); but it is understood that occasionally external factors may prevent attendance. As a result, a minimum attendance standard of 75% of all activities must be met when a trainee is not on a rotation outside of the Kingston vicinity.

2. Achieve competence in all stage-specific Entrustable Professional Activities
There are 28 EPAs defined for the Queen’s University RCPSC EM Training Program. A trainee must be deemed “competent” in all EPAs to be eligible for program completion. The designation of “competent” for an EPA is determined by the Competence Committee based on a comprehensive review of all available performance information. A ‘required minimum’ number of successful assessments per EPA has been suggested (RCPSC Entrustable Professional Activities for Emergency Medicine v1.0 2018) and it is expected that typically a trainee will acquire this number of assessments per EPA prior to being promoted between stages. It is recognized that the ‘required minimum’ number may be challenging to obtain for some EPAs, but the Competence Committee will not consider promotion until at least 90% of the ‘required minimum’ number of assessments is completed for all EPAs within a stage. Similarly, the ‘required minimum’ number of assessments does not preclude the Competence Committee determining the need for additional assessment information to inform decision making. In determining if the threshold of competence has been met, the Competence Committee will consider qualitative aspects of assessment data including but not limited to: narrative feedback, case mix, and diversity of assessors. Further, the Competence Committee will review assessments with a ‘red flag’ bias such that one concerning assessment may be weighed differently than a ‘successful’ assessment. When a particular learning need is identified, the Competence Committee may be more prescriptive about assessment requirements (for example the number, type and breadth of assessments required).
3. Successful completion of all Special Assessments and acceptable performance on all examinations

There are nine special assessments (SAs) defined for the Queen’s University RCPSC EM Training Program. A trainee must have completed all SAs successfully to be eligible for program completion. Further, a trainee must perform to a minimum standard on examinations throughout training as defined below. Should an exam performance be below the minimum standard, an in-depth performance review will be performed by the Competence Committee, a personal learning plan will be developed and repeat exam performance will be considered.

- Canadian In Training Examination (CITE): > 10% percentile for year of training
- Simulation-based OSCE: minimum entrustment of ‘indirect supervision’ on all scenarios for PGY3-5

4. Promotion through all stages of training, with successful resolution of identified performance issues

Promotion through each of the four stages of training (Transition to Discipline, Foundations of Discipline, Core of Discipline, Transition to Practice) occurs when the trainee has completed all the RTEs of the stage, been deemed competent in all of the stage-specific EPAs and satisfactorily completed all the Special Assessments and relevant examinations in that stage.

With closer assessment, it is normal and expected that particular performance issues will be identified for different residents. These may or may not be directly related to EPAs or other learning objectives. Performance issues identified by the Competence Committee must be addressed by the resident satisfactorily in the judgment of the Competence Committee in order to complete training. For identified performance issues, the program is responsible for providing residents with a plan and resources to address the issue. This process is approached as a partnership for learning between the program and the resident. Most performance issues may be initially addressed via the trainee’s personal learning plan with subsequent follow-up. If the performance issue is still identified by the Competence Committee after subsequent performance review, then a modified education plan may be required.

When significant concerns about performance emerge, the Competence Committee will identify the need for a Modified Education Plan. The plan will outline both the areas of concern and a prescriptive plan to address these. A Modified Education Plan may include but is not limited to: courses, assignments, reading plans, simulation, presentations, certain electives, specific numbers and types of EPA assessments or other required training experiences. The Modified Education Plan is developed by the Competence Committee with input from the trainee. The Modified Education Plan will have a specific duration at which point resident progress will be reviewed by the Competence Committee. Upon review of resident progress, the Competence Committee may determine the Modified Education Plan is (1) completed adequately; (2) requires additional time; or (3) referred for formal remediation.

Remediation is a formalized process governed by the PGME Assessment, Promotions and Appeals Policy. The initial determination to refer a trainee for formal remediation will be made by the Competence Committee. If the trainee has any concerns about being referred for remediation, the first level of appeal for the trainee is the EM Residency Program Committee. If this Committee supports the Competence Committee recommendation for formal remediation, the case will then be referred on to the PGME office and proceed in accordance with PGME policies. Trainees will be considered for referral for remediation by the Competence Committee if they meet any of the following criteria:

- Unsuccessful Modified Education Plan
- Patient safety concern
- Professionalism concern

Revised June 2019
**PGME Assessment, Promotions and Appeals Policy**

Formal remediation and probation periods are organized in consultation with the resident, PGME office and take place in accordance with the Queen’s University PGME Assessment, Promotion and Appeals policy available at: http://meds.queensu.ca/education/postgraduate/policies/apa

NOTE: The PGME policy is currently being reviewed to align with the CBME Curriculum Model.

**Resident Responsibility in Programmatic Assessment**

Residents are asked to participate in the evaluation of all aspects of the residency training program. These systematic evaluations are essential for our training program to maintain full accreditation and the results are used to guide curriculum development and program improvements.

**Evaluation of the Residency Training Program**

Residents are asked to complete a detailed evaluation of the training program on a semi-annual basis. Evaluations will be distributed and collected through MedTech electronic platform. These evaluations will inform the Residency Program Committee’s annual curriculum review.

**Resident Evaluation of Faculty and Emergency Medicine Rotations**

Residents will be required at the end of each block to evaluate their EM rotation as well as staff physicians they have worked with in the Department. Evaluations will be distributed and collected through MedTech electronic platform. These evaluations will be shared anonymously with the faculty member, Department Head and the Program Director and will be included in the annual performance review for all faculty.
Residency Program Committee

Promotions and Appeals Committee Terms of Reference (Updated June 2019)

Mandate
The Promotions and Appeals Committee is a sub-committee of the Residency Program Committee (RPC). The purpose is to demonstrate our accountability as medical educators to the public, that our graduates will provide high quality, safe care to our patients and maintain the standards of the health care system. The committee is responsible for decisions regarding resident promotion and the need for remediation.

Membership
FRCP Program Director (Co-Chair)
CCFP(EM) Program Director (Co-Chair)
FRCP Assistant Program Director
CCFP(EM) Assistant Program Director
CBME Lead
Ultrasound Director
Simulation Director
Resident Research Director
Director of Trauma Services
Wellness and Career Sustainability Lead
Faculty Member-at-Large

Responsibilities
- Review each resident’s progress and the recommendation of the FRCP Competence Committee usually quarterly. For FRCP residents in the CBME track, reviews will occur at least once during each stage of training.
- Synthesize the results from multiple sources to make decisions related to:
  o promotion of residents to the next stage of training
  o review and approval of individual learning plans developed to address areas for improvement, in consultation with the PGME Education Advisory Board
  o readiness to challenge the Royal College examinations
  o readiness to enter independent practice on completion of the transition to practice stage
  o the determination that a trainee is failing to progress within the program
- Monitor the outcome of any learning or improvement plan established for an individual resident in conjunction with the Program Director and Academic Advisor (when appropriate).
- Follow the defined Queen’s University PGME Appeals Process
  o 1st level Appeal – Residency Program Committee
  o 2nd level Appeal – Postgraduate Associate Dean (ARB)
  o 3rd level Appeal – Dean School of Medicine (Tribunal Board)

Terms
Terms of membership will be determined by the terms of each member’s applicable positions.

Frequency of Meeting:
Meetings will be held four times per year in conjunction with the Residency Program Committee meetings.

Quorum
Minimum of 50% of voting membership

Revised June 2019
**Decision Making**
By consensus whenever possible

**Minutes**
The agenda is to be circulated prior to the meeting. The minutes of the meeting are to be recorded and prepared by the EM Program Assistant. Due to the confidential information documented, minutes will not be distributed but will be maintained in the EM Program Assistant’s office for review by committee members as required.
Section 9: Competency Based Medical Education (CBME)

Competence by Design (CBD) is a Royal College of Physicians and Surgeons of Canada initiative to transition Canadian postgraduate medical education into a model of competency based medical education. CBD organizes residency into four stages: Transition to Discipline, Foundations of Discipline, Core of Discipline and Transition to Practice. At each stage, learners are guided by stage-specific outcomes and promotion between stages may occur when those outcomes have been met. While CBD will use time as a framework rather than the basis for progression, the duration of training is expected to remain at five years for the majority of trainees.

The Emergency Medicine Specialty Committee at the Royal College has approved:

- **Entrustable Professional Activities (EPAs)** – These are cardinal competencies required to become an emergency physician. EPAs are stage-specific, targeted learning observations and involve frequent, formative assessments within the clinical workplace to ensure residents are progressing and receiving feedback on the skills they need. They form the basis of evaluation and promotion decisions in the CBD model.

- **Required Training Experiences (RTEs)** - These determine which rotations and experiences residents must undertake in each stage of training and may be linked to Special Assessments to document competence in key, discrete skills and/or knowledge related to Emergency Medicine. RTEs replace the previous Royal College Standards of Training Requirements for Emergency Medicine.

With approval from the Royal College, Queen’s University underwent an institution-wide implementation of CBME in July 2017. Although Queen’s EM transitioned to CBME one year earlier than other EM training programs, our CBD curriculum fully aligns with framework approved by the EM Specialty Committee at the Royal College.

The duration of the CBD stages in our program are:

- Transition to Discipline (PGY1) – 3 blocks (3 months)
- Foundations of Discipline (PGY1) – 10 blocks (9 months)
- Core of Discipline (PGY2-4) – 39 blocks (36 months)
- Transition to Practice (PGY5) – 13 blocks (12 months)

The Royal College certification exam will take place at the end of Core of Discipline (PGY4) rather than at the end of residency.
Section 10: Emergency Medicine Curriculum Map

Emergency Medicine Competence by Design Curriculum Map

<table>
<thead>
<tr>
<th>PGY 1</th>
<th>Emergency Medicine</th>
<th>Anesthesiology</th>
<th>Pediatrics (COPC)</th>
<th>Pod EM (CHEO)</th>
<th>EMS (EMs)</th>
<th>Emergency Medicine</th>
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<tbody>
<tr>
<td>C1-2</td>
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<tr>
<th>PGY 2</th>
<th>Critical Care</th>
<th>Obstetrics</th>
<th>Internal Medicine</th>
<th>Ortho MSK</th>
<th>Plastic Surgery</th>
<th>General Surgery</th>
<th>Psychiatry</th>
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<tr>
<td>C1-3</td>
<td>C1-2</td>
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<tr>
<th>PGY 3</th>
<th>Pod EM (CHEO)</th>
<th>Toxicology</th>
<th>Trauma</th>
<th>Cardiology</th>
<th>Community EM</th>
<th>Advanced US</th>
<th>Emergency Medicine</th>
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<tr>
<td>C1-4</td>
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<th>PGY 4</th>
<th>Emergency Medicine</th>
<th>ED Administration</th>
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<td>C1-5</td>
<td>C1-5</td>
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<table>
<thead>
<tr>
<th>PGY 5</th>
<th>Emergency Medicine</th>
<th>Area of Concentrated Expertise (ACE)</th>
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</thead>
<tbody>
<tr>
<td>C1-4</td>
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<td>C1-4</td>
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Revised June 2019
Section 11: Level of Responsibility and Performance Criteria for Residents in the Emergency Department

The majority of clinical rotations will be spent in Emergency Medicine during the residency. Residents will spend a total of 14 blocks in PGY1 and 2 in the ED as a junior resident and as many as 34 blocks in the ED in PGY3-5 year as a senior resident.

Emergency Medicine rotations will take place either at the HDH Urgent Care Centre or the KGH Emergency Department. In PGY1 and 2, residents will spend time equally between the two departments. In PGY3-5, the majority of training will take place in the tertiary care setting at KGH to provide exposure to a high volume of acute and critical care cases. Senior residents will continue to work occasionally at the HDH UCC where there is typically a high volume of lower acuity patients requiring many procedures. This exposure offers the senior resident a chance to work in a community hospital setting and to develop skills in running a high-volume department.

Levels of Training

Although in the Competence by Design framework, the distinction between junior and senior residents no longer exists, our training program is structured so as to maintain that distinction for scheduling purposes and teaching responsibilities. There are separate sets of responsibilities, supervision rules and performance expectations for residents at each level of training.

- Residents at the PGY1 and PGY2 levels are considered to be junior residents. This maps to residents in the Transition to Discipline, Foundation of Discipline and early Core of Discipline stages of training.
- Residents at PGY3-5 levels are considered senior residents. This maps to the Core of Discipline and Transition to Practice stages of training.
- The resident in the latter half of the PGY5 year is at the level of a graduating resident and will be working on the training experiences in the Transition to Practice stage.

Graded Responsibility and Staff Supervision

Graded responsibility and staff supervision are linked and discussed as a single entity. It is expected that residents will take on increasing levels of clinical responsibility with less supervision as they progress through the five years of the program.

The junior resident in Transition to Discipline is supervised closely. The staff physician will confirm history and physical findings with the resident prior to ordering tests, treatment or discharge. The staff physician will directly observe the resident doing clinical duties. The resident early in PGY1 is encouraged to deal with only one or two patients simultaneously. Residents at the junior resident level are required to be present for all resuscitation cases in the department and will act under the supervision of the attending staff or senior resident. Junior residents are encouraged to perform as many simple procedures as possible with staff supervision.

As the junior resident progresses through Foundations of Discipline (PGY1) and into the Core of Discipline stage (PGY2) more independence is given. There is less staff observation and the resident is encouraged to examine the patient and order initial investigations and treatment independently. In Foundations of Discipline, residents are encouraged to perform simple
procedures independently and is permitted to see an increasing volume and number of patients simultaneously. Junior residents in the must discuss all cases with the attending staff physician prior to discharge.

The senior resident in the Core of Discipline and Transition to Practice stages of training is given an increasing degree of independence and responsibility. No other resident intervenes between the staff physician and the senior resident. The senior resident is expected to take an increasing, graduated independent role in all clinical situations including critical care, resuscitations, EMS patches and Emergency Department management. Staff supervision will remain close and the resident is expected to review all cases with the staff physician. The resident should discuss all referrals with the attending staff physician. Senior residents are expected to see patients in all sections of the department when on shift; i.e. the senior resident should pick up new patients in sections of the department other than their “assigned” section particularly on the night shift in a manner similar to the Emergency Physician on duty.

Senior residents will participate in the department’s Quality Assurance processes for laboratory and radiographic studies (see Guide to Look Ups). Senior residents are responsible for presenting Grand Rounds, Resuscitation Drills and Journal Club. Staff supervisors will be assigned on a rotational basis by the Resident Research Director.

Junior and senior residents will be observed and evaluated in the CanMEDS competencies using the workplace-based EPAs and milestones.

All residents are involved in clerkship teaching as outlined in our “Clerkship Manual” https://emergencymed.queensu.ca/academics/undergraduate-medicine

### Performance Criteria

We realize that all residents develop skills and learn at different rates. We have developed performance criteria for the junior, senior and graduating resident in the following areas:

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Junior Resident (PGY1/2)</th>
<th>Senior Resident (PGY3/4)</th>
<th>Graduating Resident (PGY5)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Knowledge and Basic Science</td>
<td>Good general knowledge in common clinical problems</td>
<td>Excellent knowledge base in common clinical problems, developing knowledge in uncommon problems</td>
<td>Excellent knowledge base in common and uncommon problems</td>
</tr>
<tr>
<td>Clinical Knowledge and Skills</td>
<td>Able to diagnose and manage common clinical problems consistently</td>
<td>Able to diagnose and manage common and complex clinical problems</td>
<td>Able to diagnose and manage common, complex and uncommon clinical problems</td>
</tr>
<tr>
<td>Procedural Skills</td>
<td>Able to perform basic procedures relevant to EM</td>
<td>Understands and can perform all relevant ED procedures</td>
<td>Understands, performs and teaches all ED procedures with expertise</td>
</tr>
<tr>
<td>Judgement and Decision Making</td>
<td>Good clinical judgement in common problems</td>
<td>Good clinical judgement in common and complex problems</td>
<td>Excellent clinical judgement in all types of problems at the consultant level</td>
</tr>
</tbody>
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Revised June 2019
### Criteria

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Junior Resident (PGY1/2)</th>
<th>Senior Resident (PGY3/4)</th>
<th>Graduating Resident (PGY5)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Resuscitation Skills</td>
<td>Recognizes sick patients, able to outline management and works as part of the team.</td>
<td>Good knowledge base and procedural skills, developing leadership skills in resuscitation</td>
<td>Provides expert management and leadership concurrent with a teaching role in resuscitation</td>
</tr>
<tr>
<td>Communication Skills</td>
<td>Effective and appropriate, learning to deal with complex issues.</td>
<td>Effective and appropriate, able to communicate effectively in difficult situations.</td>
<td>Excellent skills in dealing with patients, and coworkers, understands racial, cultural and gender issues</td>
</tr>
<tr>
<td>Teaching Skills</td>
<td>Motivated, able to give a good presentation, developing one-on-one teaching skills.</td>
<td>Motivated, good bedside and group teaching.</td>
<td>Superb bedside and group sessions, has real concept of teaching methodology</td>
</tr>
<tr>
<td>ED Management</td>
<td>Understands concepts of ED management, begins to take ownership of patient flow in designated sections of the department</td>
<td>Runs department efficiently under normal circumstances.</td>
<td>Superb leadership can run department and teach on difficult shifts, aware of risk management and QA issues</td>
</tr>
<tr>
<td>Professional Attitudes</td>
<td>Responsible, reliable, motivated and organized.</td>
<td>Always responsible, reliable, motivated, organized with minimal supervision.</td>
<td>Always responsible, motivated, organized, reliable with very little supervision, superb leadership skill</td>
</tr>
</tbody>
</table>

### Documentation on Patient Charts

All residents are required to complete patient documentation in a timely manner. **Junior residents (Transition to Discipline and Foundation of Discipline stages) must document on each patient’s chart immediately after completing an assessment.** Senior residents (Core of Discipline or Transition to Practice stage) may delay documentation during clinical shifts if the focus of learning is on managing patient volume, however, must document immediately on the chart for any complicated or seriously ill patient. Monitoring documentation is one strategy faculty use to supervise your clinical care and timely documentation is essential to facilitate an increasing level of responsibility. To facilitate billing, all residents must use the prepopulated procedure notes when documenting procedures performed.

### On-line Medical Direction for EMS by Senior Residents

Included in your list of responsibilities while working as a senior EM resident, is answering paramedic patch calls to Kingston General ED. Kingston Base Hospital is responsible for the training and supervision of six ambulance services in our region, including two services that
employ advanced care paramedics. Dr. Andy Reed is the Base Hospital physician for the Southeastern Ontario region.

It is mandatory that you familiarize yourselves with the standing orders, protocols, and medications used by paramedics. A copy of these standing orders will be issued to you. In addition, copies are available at the clerk’s desk in Section A of KGH. Finally, a short quiz is to be completed prior to you starting in the ED.

The paramedics are relying on you to know their capabilities and limitations. Please take the time to prepare for their calls. If you are interested in doing a ride-out with the paramedics that can be arranged by contacting Dr. Andy Reed.

**Role of Chief Resident**

The PGY4 resident is designated as the chief resident. All residents in their PGY4 will share in the chief resident duties for a portion of the academic year.

The chief resident is expected to:

- administer the residents’ schedule
- act as liaison between the residents and the Program Director and other faculty members
- provide leadership in the academic and social activities of the other residents
- serve as the academic conscience at teaching sessions and rounds
- participate in hospital committees as required
- deal with administrative problems that arise while on duty in the emergency department

**Role of the Elected Resident Representative on the Residency Program Committee**

Each year one resident will be chosen by the resident group to serve as the elected representative on the Residency Program Committee (RPC).

The resident representative is expected to:

- act as a liaison in regards to presenting issues or concerns of the entire resident cohort at RPC meetings
- communicate important information and decisions of the Residency Program Committee to the resident cohort
- participate in any administrative duties if a resident representative of the RPC is required by the PGME office
**Section 12: Shift Scheduling and PARO Agreement Leave Benefits**

The EM chief residents are responsible for making the resident schedules for the HDH UCC and KGH ED. As per the PARO-CAHO Agreement, the upcoming block’s schedule is posted on the website 14 days prior to the commencement of each block. Occasionally some last-minute revisions need to be made and all residents will be notified by email if a revised schedule is posted. Making the schedule is a difficult and time-consuming process so please take note of the following information.

As numbers of residents vary each month, the number of shifts worked in a month may vary to ensure adequate resident coverage. Residents typically are assigned 10-14 shifts per block and are scheduled to work two weekends each block.

The chief resident tries to achieve a balanced distribution of shifts between the two training sites to provide a comprehensive exposure to both acute and less urgent illness/injury. This may mean that resident have several consecutive days of work, or shifts may be spaced more widely apart. Residents are encouraged to contact the appropriate chief resident, indicated on each block schedule, with any questions or concerns related to the schedule.

Residents may trade shifts with another resident at the same level of training (i.e. junior or senior resident). Residents making the shift changes are required to notify the unit clerk at both sites and to note the changes on the master schedule located on the bulletin board on Victory 3. Do not send your shift changes to the scheduler. Residents are required to communicate shift changes with the attending staff assigned to that shift in advance.

**Freedom to Attend Academic Sessions**

The Department of Emergency Medicine academic day takes place every Thursday from 08:30 – 16:00 hours and residents from PGY1 – PGY5 are excused from clinical duties to attend. Residents are also excused from clinical duties to attend Journal Club, Junior Resuscitation Rounds on Friday mornings (PGY 1 and 2 residents), participate in oral examinations, complete quarterly reviews with the Program Director or Academic Advisor and when assigned teaching responsibilities through our program if indicated.

**Notification of Illness**

In the event that you suddenly become ill and are unable to work, please notify the chief resident as soon as possible, or arrange for someone else to cover your shift. If you are unable to do either please notify the staff physician on duty at that time.

**Requests for Vacation/ Education Leave**

In compliance with PARO Agreement, all requests for leave must be submitted on a Department Leave Request Form (available on the website) to the chief account, at least 30 days prior to the block in which leave is requested. Emailed or verbal requests are not acceptable. The type of leave requested (Vacation vs. Educational) must be indicated. Generally, only one week of vacation should be taken during a one block rotation. If the
requested dates fall between two blocks, please complete and submit two separate request forms.

We do our best to accommodate all requests that we receive by the specified deadline. In cases where requests conflict, priority for time off will be given to residents taking educational leave followed by vacation requests. We will notify you as soon as possible if your vacation request cannot be accommodated.

**PARO Policy on Vacation** *(Updated June 2019)*

http://www.myparo.ca/your-contract/#vacation

11.1

Residents shall be entitled to four (4) weeks paid vacation during each year.

11.2

Vacations may be taken by housestaff at any time, but, subject to article 11.4, the timing of vacation may be delayed only where necessary, having regard to the professional and patient responsibilities of the hospital department for the time the vacation is requested.

11.3

Housestaff may request their vacation to be taken in one (1) continuous period, in one or more segments of at least one (1) week in duration, or in segments of less than one week, which request will be scheduled provided professional and patient responsibilities are met.

11.4

Requests for vacation shall be submitted in writing to the department head at least four (4) weeks before the proposed commencement of the vacation. In addition each resident taking a certification examination in the Spring shall have until one month prior to the date of the examination to make a written request for one week of his/her vacation entitlement. Vacation requests submitted before March 1, or one month prior to the date of a certification examination, will be considered in priority to those submitted after that time. All vacation requests must be confirmed or alternate times agreed to, in accordance with Article 11.2, within two (2) weeks of the request being made. Where the hospital department rejects the vacation request, it will do so in writing and include the reasons for rejecting the original vacation proposal.

11.5

There will be no adjustment to vacation entitlement for up to seventeen (17) weeks in the case of pregnancy leave of absence and/or up to thirty-seven (37) weeks in the case of parental leave of absence. Where a resident is entitled to, takes pregnancy leave, is also entitled to, and takes parental leave, there will be no adjustment to vacation entitlement for up to an additional thirty-five (35) weeks. If an employee is on pregnancy or parental leave, any accrued vacation shall be taken immediately after the leave expires, or at such later date if agreed to between the resident and the hospital.

11.6

The Hospital shall not institute policies that restrict the amount of vacation that residents can take over a given rotation, it being understood that the hospital continues to have the right to

Revised June 2019
delay an individual resident’s request where necessary having regard to the professional and patient care responsibilities of the hospital department pursuant to Articles 11.2 and 11.3.

**PARO Policy on Professional Leave** (Updated June 2019)

http://www.myparo.ca/your-contract/#professional-leave

12.1

In addition to vacation entitlement, residents shall be granted additional paid leave for educational purposes. Such educational leave, up to a maximum of seven (7) working days per annum, shall be consecutive if requested by the resident, and shall not be deducted from regular vacation entitlement. Such leave may be taken by housestaff at any time, provided only that professional and patient responsibilities are met to the satisfaction of the hospital department head.

**PARO Policy on Professional Leave for Examinations** (Updated June 2019)

http://www.myparo.ca/your-contract/#professional-leave

12.2

Each resident shall be entitled to paid leave for the purpose of taking any Canadian or American professional certification examination; for example, Royal College examinations, LMCC, ECFMG, and CFPC. This leave shall include the exam date(s) and reasonable travelling time to and from the site of the examination. This leave shall be in addition to other vacation or leave.

12.3

a. Subject to operational requirements and at the request of a resident, a resident will not be scheduled for call duties for a period up to fourteen days prior to a CFPC or RCPSC certification exam.

b. Subject to operational requirements and at the request of a resident, a resident will be granted up to seven consecutive days off during one of the four weeks preceding a CFPC or RCPSC certification exam.

**PARO Policy on Statutory Holidays** (Updated June 2019)

http://www.myparo.ca/your-contract/#statutory-holidays

13.1

All housestaff shall be entitled to the following recognized holidays:

1. New Year’s Day
2. Family Day
3. Easter Friday
4. Victoria Day
5. Canada Day
6. August Civic Holiday
7. Labour Day
8. Thanksgiving Day
9. Christmas Day
10. Boxing Day
11. One (1) floating holiday

13.2

All housestaff shall be entitled to at least five (5) consecutive days off during a twelve (12) day period that encompasses Christmas Day, New Year’s Day and two (2) full weekends. These five (5) days off are to account for the three (3) statutory holidays (Christmas Day, Boxing Day, New Year’s Day), and two (2) weekend days.

13.3

If a resident is scheduled to work on a recognized holiday, he/she shall be entitled to a paid day off in lieu of the holiday to be taken at a time mutually convenient within ninety (90) days of the holiday worked.

PARO Policy on Pregnancy and Parental Leave  (Updated June 2019)
http://www.myparo.ca/your-contract/#pregnancy-and-parental-leave

15.1

A resident shall receive up to seventeen (17) consecutive weeks of pregnancy leave at her discretion. In no case will she be required to return to her duties sooner than six (6) weeks following delivery. A resident shall be required to give four (4) weeks’ notice of her intentions regarding timing of said leave in order to ensure that professional and patient care responsibilities are met. A resident who is eligible for a pregnancy leave may extend the leave for a period of up to twelve (12) months duration, inclusive of any parental leave.

15.2

A resident who is the parent of a child shall receive up to thirty-five (35) weeks parental leave if the resident took pregnancy leave, or thirty-seven (37) weeks if the resident did not take pregnancy leave, following the birth of the child or the coming of the child into custody, care and control of the resident for the first time at the resident’s discretion. Parental leave may begin no more than fifty-two (52) weeks after the day the child is born or comes into the custody, care and control of a parent for the first time. A resident shall be required to give four (4) weeks written notice of her/his intention regarding the timing of such leave in order to ensure that professional and patient care responsibilities are met. A resident who is eligible for a parental leave who is the natural father or who is an adoptive parent may extend the parental leave for a period of up to twelve (12) months duration, inclusive of any parental leave.

15.3

Pregnancy shall not constitute cause for termination of employment.

15.4

In the event that a resident takes pregnancy or parental leave, subsequent to the completion of the leave she or he shall be entitled to work for the same period as the leave in order to complete her or his year of post-graduate training.

Revised June 2019
15.5
All benefits and conditions of work concerning pregnancy/parental leave shall apply equally to the adoption of a child as to the birth of a child.

15.6
When a resident is absent on an approved leave of absence or because of disability, he/she shall be entitled to work for the same period of time as the leave in order to complete his/her training requirements as set out by the appropriate accrediting body and a suitable position shall be provided within twelve (12) months of the date the resident advises that he/she is ready and able to commence work.

15.7
Pregnancy Leave
On confirmation by the Employment Insurance Commission of the appropriateness of the Hospital’s Supplemental Unemployment Benefit (SUB) Plan, a resident who is on pregnancy leave as provided under this Agreement who is in receipt of Employment Insurance pregnancy benefits shall be paid a supplemental employment benefit. That benefit will be equivalent to the difference between eighty-four per cent (84%) of the resident's regular weekly earnings and the sum of the resident’s weekly Employment Insurance benefits and any other earnings. Such payment shall commence following completion of the two (2) week Employment Insurance waiting period, and receipt by the Hospital of the resident’s Employment Insurance cheque stub as proof that she is in receipt of Employment Insurance pregnancy benefits, and shall continue for a maximum period of fifteen (15) weeks. The resident’s regular weekly earnings shall be determined by multiplying her regular hourly rate on her last day worked prior to the commencement of the leave times her normal weekly hours.

Parental Leave
On confirmation by the Employment Insurance Commission of the appropriateness of the Hospital’s Supplemental Unemployment Benefit (SUB) Plan, a resident who is on parental leave as provided under this Agreement who is in receipt of Employment Insurance parental benefits shall be paid a supplemental employment benefit. That benefit will be equivalent to the difference between eighty-four (84%) percent of the resident’s regular weekly earnings and the sum of her or his weekly Employment Insurance benefits and any other earnings. Such payment shall commence following completion of the two-week Employment Insurance waiting period, and receipt by the Hospital of the employee’s Employment Insurance cheque stub as proof that she or he is in receipt of Employment Insurance parental benefits and shall continue while the resident is in receipt of such benefits for a maximum period of twelve (12) weeks. The resident’s regular weekly earnings shall be determined by multiplying her or his regular hourly rate on her or his last day worked prior to the commencement of the leave times her or his normal weekly hours.

15.8
It is understood and agreed that the hospital’s obligations for payment under the SUB Plan shall not extend beyond the period of the contracted appointment if the resident has completed her training requirements as set out by the appropriate accrediting body.
Resident Scheduling Rules (Updated June 2019)

1. The base number of shifts per block is 14.

2. Residents who request formal vacation will receive a shift reduction of three (3) shifts/week of vacation or education leave:
   - One-week vacation - shift reduction = 3
   - Two-week vacation - shift reduction = 6
   - Less than one week of vacation/leave = one (1) shift per every two (2) days of vacation/leave
   - The absolute minimum number of shifts per block is eight (8) in order to receive an evaluation

3. Unless approved by the Program Director (or designate) vacation will be limited to one (1) week per block in order to ensure there is an adequate clinical exposure to provide a meaningful evaluation of resident performance.

4. Residents who request their shifts be “stacked” but who do not take formal vacation will not receive a shift reduction. The decision to allow shift stacking is solely at the discretion of the Chief Resident as requests of this nature may create undo pressures for the scheduler. Abuse of this system will result in termination of this option.

5. Double senior resident coverage – during blocks where there is a relative surplus of senior residents (typically block 1 and 2), senior residents may be assigned to additional shifts in order of priority - KGH AB2, KGH DB1 KGH D2, in order to meet the minimum base shift count of 14 shifts/block. Overlap with an Emergency Medicine PGY 1/2 assigned to the KGH AB2 shift should be avoided when possible to maximize the learning experience in Section A for both learners.

6. Senior shift priorities - during months when there is a relative deficit in senior residents the priority for scheduling seniors will be: KGH night, HDH E, KGH A1, KGH D3, HDH D. When shifts must be eliminated due to resident numbers the shift reduction will start with the lowest priority senior shifts (i.e. HDH D) and progress in a reverse manner. The FRCP and CCFP-EM Program Directors must be notified in advance when shifts will be dropped for a given block.

7. Junior shift priorities – during months when there is a relative deficit in the junior resident coverage the order of priority for scheduling shifts will be: KGH night, HDH D, KGH DB1, KGH AB2, KGH AB3, KGH D2. When shifts must be eliminated due to resident numbers the shift reduction will start with the lowest priority junior shifts (ie KGH D2) and progress in a reverse manner. The FRCP and CCFP-EM Program Directors must be notified in advance when shifts will be dropped for a given block.

8. PGY5 (senior) teaching shifts – during months when there is a relative surplus of senior residents (usually block 1 and 2 or blocks when seniors are assigned less than 12 shifts excluding periods of shift reduction for exam preparation) PGY5s may be scheduled for a designated teaching shift that will occur on the KGH AB2 or AB3 (section A) shift when there is an Emergency Medicine PGY1/2 assigned to that shift. The purpose of these shifts will be for a mentored experience in teaching for the assigned PGY5 and enhanced bedside teaching for the assigned PGY1/2. A teaching shift will be counted toward the base number of shifts for the assigned PGY5 residents.
9. On Academic Days (Thursdays), an off-service junior resident will be assigned to the KGH A1 shift in lieu of the senior resident whenever possible.

10. On Fridays, a senior resident will be assigned to the KGH DB1 shift in lieu of a junior resident whenever possible.

11. With the exception of the mandatory senior residents shifts (Nk, Eh), any resident (junior or senior) can be assigned to remaining shifts to minimize gaps in clinical coverage. The chief resident will attempt to assign one resident to every shift within the guidelines of the PARO and Queen’s EM scheduling rules.

12. Ultrasound teaching shifts - Ultrasound shifts do not count toward the base shift count for CCFP-EM residents. The US shift may be included in the base shift count for FRCP residents only on months when the base count per senior resident equals or exceeds 12 shifts and when including the shifts would result in an excessive number of shifts per week (greater than five (5) shifts in a row including academic full day).

13. Shift reduction for PGY5 exam preparation - A shift reduction will be negotiated with the FRCP Program Director annually based on the timing of the examination. As this shift reduction is intended to provide residents with additional time to study, it is understood that if a resident chooses to use the shift reduction, they will not pick up any additional clinical work during this period. In general, the shift reduction will occur as:
   - No night shifts starting January (typically block 8 or equivalent block)
   - 12 shifts for block 8
   - 10 shifts for block 9
   - 10 shifts for block 10
   - 8 shifts for block 11 (block immediately before the exam)
   - 8 shifts for block 12 (block between written and oral examination)
   - Full complement of shifts (including nights) for block 13

14. Fellows - Residents completing the Resuscitation and Reanimation fellowship are to receive a maximum of eight (8) shifts per block.

15. Residents who are registered in the Resuscitation and Reanimation fellowship and who are not completing their FRCP training will be exempt from HDH shifts with prior approval of the Resuscitation and Reanimation Program Director and the FRCP Program Director.

16. Shift reduction for PGY4 special interest programs - PGY4s who are completing a master’s degree or equivalent will be scheduled for a maximum of ten (10) shifts per block. The shift reduction is to be negotiated with the FRCP Program Director prior to the start of the academic program.

17. The chief resident will attempt to distribute the shifts equitably among residents including the mix between KGH and HDH and the section D and Section A shifts. Residents are not allowed to self-schedule or identify preferences for shift patterns.

18. Unless approved by the Program Directors, academic days (conference, mandatory academic activities) do not count toward the base number of shifts for any given resident.
19. When required due to low senior resident numbers, PGY2 Emergency Medicine residents may be advanced onto the senior schedule once they have completed rotations in Critical Care and Anaesthesia. The FRCP Program Director must give prior approval for this scheduling option. The PGY2 resident will be assigned an equitable distribution of senior shifts. If assigned a senior night shift, the PGY2 resident must be paired with another Emergency Medicine PGY1/2 resident.

20. Consider an optional night float system in blocks with a higher distribution of nights/resident. The Chief Resident and Program Director may adjust total shift counts and/or academic responsibilities if necessary.

21. PGY5 exam days - PGY5s will receive two (2) days for the written examination and one (1) day plus one (1) travel day for the oral examination without the need to take either vacation or education leave. There is no corresponding shift reduction for these exam days unless formal leave (vacation, professional leave) is requested.

PGY 5 Shift Reduction Policy and Academic Responsibilities (Updated June 2019)

Shift Reduction

PGY5 residents will negotiate with the Program Director a reasonable shift reduction to facilitate additional study time. The shift reduction will be determined, in part, by the timing of the written and oral portions of the FRCP Certification Examination. See Schedule Rules above for typical shift reduction pattern.

Academic Responsibilities During PGY 5 Year

Given the multiples roles of PGY5 residents at rounds, journal club and other academic events, it is the expectation that they will attend all academic events until four (4) weeks in advance of the written exam and one week prior to the oral exam. This requirement does not apply if on a formal vacation or personal leave.

In the four (4) weeks prior to the written exam (and one (1) week prior to oral exam), PGY5 residents are encouraged to attend academic events however it will not be required. Attendance requirements return to normal following completion of the examination.

Any unique circumstances not outlined above will be considered on a case-by-case basis by the program director.

Resident Schedule Working Group for Double Cohort

Background

In 2020/21 academic year, the PGY4 residents (CBME curriculum) and PGY5 residents (traditional curriculum) will be completing their Royal College certification exam creating a double cohort. Queen’s EM traditionally provides a substantial shift reduction for residents during Blocks 8-12 of their exam year. The double cohort will result in a relative deficit of senior residents in the latter half of the academic year and therefore may create issues for senior resident coverage on the clinical schedule.

Revised June 2019
The mandate of the RSWG is to find workable solutions to optimize scheduling of senior residents during the 2020/21 year. It is expected any options would also be applicable at any time there is a relative deficit in senior resident clinical coverage.

The senior resident numbers for the double cohort year are currently:
- PGY 5 – 4 residents
- PGY 4 – 5 residents
- PGY 3 – 4 residents
- PGY 2 – 4 residents (2 residents will have completed ICU prior to Block 7, 3 residents prior to block 11)

**General Principles Considered During Planning**
1. The PGY4 and PGY5 resident cohorts should be treated equitably in all matters regarding scheduling, protected academic time, academic responsibilities and shift reduction amounts/timing.
2. PGY4 resident academic responsibilities for large group teaching will be adjusted.
3. Queen’s EM residency program will continue to honor the tradition of removing exam candidates from night shifts in Blocks 8-12 (or whichever block the exam concludes if earlier). Residents who feel they wish to continue nights are allowed to do so.
4. Shift reductions for exam candidates will continue to be determined by the timing of the Royal College Exam and will be negotiated with the Program Director on an annual basis.
5. Current shift priorities for senior residents remain unchanged but can be revisited if faculty staffing patterns change. The current order of shift priority for senior residents is Nk* Eh*, A1, D3, Dh. (* denotes mandatory coverage)
6. With the exception of the mandatory senior residents shifts (Nk, Eh), any resident (junior or senior) can be assigned to remaining shifts to minimize gaps in clinical coverage. The Chief Resident will attempt to assign one resident to every shift within the guidelines of the PARO and Queen’s EM scheduling rules.
7. Consideration of advancing a PGY2 resident onto the senior schedule can be made once the resident has completed ICU and the resident is in good academic standing. This assignment is not tied to promotion in his/her training program and will be determined by the Chief Resident and Program Director on a block to block basis. It is expected PGY2 residents who take on an early senior role will receive mentoring and graduated independence as is typical for residents transitioning to a senior role.

**Potential Impact of the Double Cohort on Resident Schedule**

**Pros**
- In the CBME curriculum, the fellowship/elective year occurs following the exam. Unlike recent academic years, all senior residents (PGY 3-5) will be primarily assigned to EM rotations.
- Advanced planning regarding rotation schedules can mitigate some of the expected scheduling issues

**Cons**
- It is expected the largest impact of the double cohort will be on the number of night shifts. In blocks with optimal senior coverage, this effect will be effectively unchanged from the typical base of three night shifts/block. In blocks with fewer seniors, it can extend to 4-5 nights.
- There may be diminished capacity to accommodate late requests for changes to the rotation schedule
Possible Solutions Identified

1. Alter the traditional shift reduction schedule - initiate the shift reduction earlier in the academic year (block 6/7) with a less dramatic reduction in blocks 8-12.
2. Whenever possible move the PGY3 off service rotations (CHEO, cardiology, Community EM) to blocks 3-9 to optimize senior resident numbers in the ED.
3. Work with CCFP-EM Program Director to schedule the EMS and ophthalmology weeks into EM rotations during block 1-7 to reduce schedule conflicts from these protected days.
4. Work with the CCFP-EM Program Director to schedule residents (including Cornwall residents) preferentially into Blocks 8-12 whenever possible given the limitations of the master rotation schedule for the CCFP-EM training requirements.
5. Work with the Resuscitation Fellowship Program Director regarding scheduling of fellows for EH shifts in block 8-12.
6. Consider an optional night float system in blocks with a higher distribution of nights/resident. The Chief Resident and Program Director may adjust total shift counts and/or academic responsibilities if necessary.
7. PGY2 residents who have completed the ICU rotations and are in good academic standing may be advanced onto the senior resident schedule upon approval of the Program Director. PGY2 residents would receive an equitable senior shift distribution.
Section 13: Rounds and Teaching

QCARE

Queen’s Postgraduate Medical Education has introduced a common academic half-day into the postgraduate training program for all PGY1 residents to address key topics in the intrinsic CanMEDs roles such as physician wellness, financial management, ethics, skill development in teaching and evaluation and clinical documentation. These sessions are mandatory for all PGY1 residents with limited exception (i.e. post-call or out-of-town rotation) and residents are excused from their clinical duties to attend.

QCARE+

Queen’s Postgraduate Medical Education offers a common academic half-day twice a year that is mandatory for all residents in their final year of training. These sessions address issues related to transition to practice and career management including financial wellness, contract negotiation, practice management and managing medico-legal risk. Residents are excused from their clinical duties to attend.

Formative Practice OSCE for the MCCQE Part 2 Exam

Queen’s Postgraduate Medical Education provides a formative OSCE for all PGY1 or 2 residents in preparation for the MCCQE Part 2 Clinical Examination held annually in the fall or spring depending on which session you have applied for. Residents are excused from clinical duties to participate in the OSCE.

Summer Series (July – August)

The Summer Series is an eight-week curriculum of key topics and skills essential to the practice of Emergency Medicine and is mandatory for all EM residents throughout their training program. Topics include trauma management, prehospital care, procedural sedation and analgesia, and pediatric resuscitation. Sessions are offered on physician wellness and the humanities are also included. Specific procedural skills include suturing, slit lamp examination central lines, casting/splinting, airway management, thoracentesis and paracentesis, fracture reduction, nerve blocks and lumbar puncture. Point of Care Ultrasound will be taught and it is expected that by the end of the summer most residents will have completed the required 50 scans in each of the primary domains required for certification. At the end of summer, residents will participate in a formative OSCE examination on a high-fidelity patient simulator. OSCE examinations will be videotaped to provide the residents with an opportunity for self-reflection and assessment.

For PGY1 residents, the Summer Series will provide a “bootcamp” orientation experience to ensure that all incoming residents have a standard skill set on which to build their clinical expertise in Emergency Medicine. In the PGY2-5 years, residents will again be exposed to these skills with the expectation that they achieve greater levels of competency as they advance in training. By the PGY4/5 years, it is expected that residents will assume a teaching role in the summer series, thereby expanding on both their clinical competence as well as their
consultant level CanMEDs competencies in professional, communication, scholar and collaborator roles.

**Cadaver Training**

Residents will participate in two (2) half-day sessions/year to practice airway management and rare/invasive procedural skills of the head, neck and thorax on cadavers. Procedures that will be performed include airway procedures, cricothyroidotomy, percutaneous jet ventilation and thoracotomy.

Residents participate in a didactic teaching session for the indications and technique of the various procedures the week prior to each cadaveric skills lab. During the airway skills lab residents will practice airway skills on the cadaver, have the opportunity to use airway rescue equipment and complete a surgical cricothyroidotomy. Residents will also take part in oral exam style questions and practice cricothyroidotomy skills on a mannequin during the airway session.

During the invasive procedures skills lab residents will practice chest tube insertion, pericardiocentesis and ED thoracotomy.

**Academic Rounds Template (Sept – June)**

<table>
<thead>
<tr>
<th>Week</th>
<th>Wednesday</th>
<th>Thursday</th>
<th>Friday</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>FRCP Practice Orals</td>
<td>• Grand Rounds 0830 – 1000&lt;br&gt;• Core Rounds 1000 - 1200&lt;br&gt;• Simulation Rounds 1330 - 1530&lt;br&gt;• Critical Appraisal/Clinical Reasoning Series 1300 – 1500</td>
<td>• Junior Resuscitation Rounds 0800 - 1000</td>
</tr>
<tr>
<td>2</td>
<td></td>
<td>• Grand Rounds 0830 – 1000&lt;br&gt;• Core Rounds 1000 - 1200&lt;br&gt;• Simulation Rounds 1330 - 1530</td>
<td>• Junior Resuscitation Rounds 0800 - 1000</td>
</tr>
<tr>
<td>3</td>
<td>Journal Club 1900 -2100</td>
<td>• Grand Rounds 08:30 – 1000&lt;br&gt;• Core Rounds 1000 - 1200&lt;br&gt;• Simulation Rounds 1330 -1530</td>
<td>• Junior Resuscitation Rounds 08:00 - 10:00</td>
</tr>
<tr>
<td>4</td>
<td>Trauma Rounds 0730 - 0830</td>
<td>• Grand Rounds 0830 – 1000&lt;br&gt;• Core Rounds 1000 - 1200&lt;br&gt;• Simulation Rounds 1330 -1530</td>
<td>• Junior Resuscitation Rounds 0800 - 1000</td>
</tr>
</tbody>
</table>

Locations of the activities are:
- FRCP Practice Oral Exams – Staff offices, Kingston General Hospital
- Grand Rounds – Richardson Amphitheatre L104
- Core Rounds – Simulation Centre, New Medical Building
- Simulation Rounds – Simulation Centre, New Medical Building
- Junior Resuscitation Rounds - Simulation Centre, New Medical Building
- Journal Club – Hosting Faculty member’s home
- Trauma Rounds – Etherington Hall

**Department of Emergency Medicine Grand Rounds**

Revised June 2019
Attendance at Grand Rounds is mandatory for all residents on Emergency Medicine rotations. Residents who are rotating off service are strongly encouraged to attend rounds whenever possible.

Senior Emergency Medicine residents will be assigned to present Grand Rounds on a rotational basis. A faculty member will also give a brief case presentation at the session. Topics to be presented should be discussed with the faculty member assigned to supervise rounds that week. Rounds may be case specific, address a topic relevant to EM or explore an area of evolving evidence or controversy. A review of current relevant literature is expected. The rounds provide the resident with an excellent opportunity to develop teaching skills and feedback should be given and sought.

Infographics on how to select a topic and present the ideal Grand Rounds are included at the end of this section of the manual.

**Core Rounds**

Attendance at Core Rounds is mandatory for residents when completing an Emergency Medicine rotation and whenever possible during off-service rotations.

A detailed curriculum list is provided in Section 15 of this manual. Core Rounds take place following Grand Rounds on Thursdays and it is the responsibility of the faculty member assigned to the rounds to present the rounds to the residents. Residents are strongly encouraged to prepare in advance by reviewing the objectives and completing the recommended reading.

Topics are presented in a two-year cycle; year one covers “Disorders of the Body Systems” and year two covers trauma, special populations, toxicology, environmental emergencies and prehospital care. The topic breakdown comes from the Core Content Listings in Rosen’s Emergency Medicine as well as the RCPSC Objectives of Training and Competencies of Training. Topics have been narrowed down to specific relevant aspects in each area to allow a more focused approach. We can’t cover everything in these rounds and you will need to read to fill in the gaps.

**ECG Rounds**

ECG interpretation is taught by a faculty member from the Division of Cardiology. Rounds occur approximately three times per year on Monday mornings. Attendance is mandatory for residents on an EM rotation and is encouraged for all residents off-service.

**Teaching of Non-Medical Expert CanMEDS Competencies**

Teaching of the non-medical expert competencies (Communicator, Collaborator, Manager, Scholar, Professional and Health Advocate) occurs in formal teaching sessions integrated into the Core Rounds curriculum cycle. The general headings for these sessions include:

- ED Administration
- Ethics and The Law
- Advanced Communication Skills
- Physician Wellness and Career Management
- Critical Appraisal

Revised June 2019
• Crisis Decision Making and Leadership in Critical Care
• Violence, Abuse and Crisis Intervention
• Preventative and Population Health

In addition, specific learning goals and objectives for these competencies are established for rotations throughout the Resident Training Program (see Rotation Specific Goals and Objectives).

Residents will be evaluated on each of these competencies in the clinical setting, during practice written, oral and OSCE examinations, simulation rounds and at the FRCP certification examination.

EMS Bootcamp

Each year residents participate in the EMS bootcamp. For the last several years, the bootcamp has been offered as a collaborative event with the University of Ottawa EM residents. Residents become familiar with the paramedic standing order protocols, equipment available to paramedics, prehospital triage and mass casualty medicine.

Simulation Rounds

Attendance is mandatory for residents when completing a rotation in Emergency Medicine and encouraged whenever possible during off-service rotations. Although all residents are encouraged to attend, Simulation Rounds are geared to higher level learners in order to provide challenging scenarios with which to hone their resuscitation skills.

These rounds are intended to allow EM residents opportunities to develop crisis resource management skills and learn/refine their management approach to cardinal acute patient presentations in resuscitation and critical care, including clinical presentations, which may be rarely encountered in actual clinical practice.

The curriculum consists of a weekly two-hour session on Thursday afternoons, facilitated by one of a small group of faculty instructors. Each session focuses on a cardinal emergency presentation (e.g. – hypotension, tachycardia, dyspnea, altered level of consciousness). Using a high-fidelity patient simulator in a realistic clinical environment, trainees are presented with a series of acute patient scenarios in which they must, as a clinical team, perform patient assessments, order and interpret investigations, formulate and implement management plans, and respond to unexpected clinical events. Following each simulated patient encounter, a debriefing session is held in which both the team’s medical management and their communication, leadership and teamwork are discussed. This is often followed by a brief didactic presentation by the instructor focusing on a key element of resuscitative care or crisis resource management highlighted by the simulated case.

Junior Resuscitation Rounds

Attendance at rounds is mandatory for PGY1/2 residents while completing rotations in Emergency Medicine and encouraged whenever possible during off-service rotations. PGY2 residents are expected to take on a mentored teaching role during rounds and to design and supervise one higher level simulated case at the end of the session for EM trainees.
The aim of this eight week course is to introduce junior learners to simulation and cardiac resuscitation in a safe, energetic, and supportive environment. Diverse learners from the Schools of Nursing and Medicine (clinical clerks and junior residents) work together as they practice basic ACLS principles. Residents will be expected to lead an inter-professional cardiac arrest team in a simulated patient care setting. Residents should already possess ACLS certification and will be expected to apply knowledge learned in the ACLS course to these scenarios.

Specific objectives for knowledge, skills and attitudes has been developed for each topic:

**Week 1: Introduction to Simulation**

**Week 2: Communication, Teamwork & Roles**

**Week 3: Tachycardia**

**Week 4: Pulseless Electrical Activity**

**Week 5: Introduction to Simulation Part 2**

**Week 6: Communication, Teamwork & Roles Part 2**

**Week 7: Bradycardia**

**Week 8: Resuscitation Ethics and Special Circumstances**

### Pediatric Simulation Rounds

Pediatric Simulation Rounds take place approximately three times per year. These rounds are offered in collaboration with the Department of Pediatrics to allow residents an opportunity to practice common pediatric resuscitation scenarios using a high-fidelity simulator. Debriefing and brief didactic teaching occurs following each resuscitation scenario to highlight high yield teaching points. Attendance is mandatory for residents while completing rotations in Emergency Medicine and encouraged whenever possible during off-service rotations.

### Trauma Rounds

Faculty Trauma Team Leaders present varied topics related to trauma care. Attendance at these sessions is encouraged on all rotations.

### Journal Club

Attendance at Journal Club is mandatory for residents while completing rotations in Emergency Medicine and encouraged whenever possible during off-service rotations.

Two senior residents (one FRCP and one CCFP(EM)) will be assigned on a rotational basis to present an article of interest in Emergency Medicine literature and lead a discussion on critical appraisal appropriate to the type of research study chosen. Residents will also facilitate a higher-level discussion on the integration of the evidence in an emergency medicine practice.

Senior resident responsibilities are:

- The assigned residents coordinate the article(s) chosen.
- At least one week prior to Journal club, forward your articles AND your objectives to the Program Administrator for distribution to all faculty and residents.
- Plan the learning activities for your Journal Club (large group or breaking into small groups, quizzes, Jeopardy, panel discussions, exercises, etc.).
- Conclude by highlighting the teaching points of your session and any clinical take-home messages.
• Collect attendance and evaluation forms. These will have been provided to you prior to your Journal club and must be returned to the Program Administrator.

A faculty host will briefly present a second recent article of interest and lead a discussion on the impact of the article on changing practice.

**Critical Appraisal and Clinical Reasoning/EBM Series**

PGY1 residents will learn critical appraisal skills and clinical reasoning/evidence based medicine in a seminar series focused on eight cardinal emergency department presentations. The cardinal presentations are: shock, syncope, chest pain, headache, shortness of breath, altered level of consciousness, abdominal pain and vertigo. Each block, residents will complete self-directed learning, formative reading around the cardinal presentation for that block and a brief written assignment. On the first Thursday afternoon of each block, residents will participate in a seminar that highlights cognitive biases, risks and potential pitfalls in the diagnosis and management of the cardinal presentation assisting residents to develop and evidence based approach to that presentation. During the second half of the seminar, residents will critically appraise a landmark emergency medicine related study that focuses on cardinal presentation. The studies chosen cover the key research methods and critical appraisal concepts. Each block residents will complete a quiz to demonstrate competency in the skills and knowledge covered. Attendance is mandatory for PGY1 residents.

**Ultrasound**

Ultrasound is offered longitudinally over the course of residency during the summer series, integration into core rounds on a two-year rotating curriculum and through an advanced ultrasound rotation in the PGY3 year. There are defined goals and objectives for ultrasound training activities included with the Rotation Specific Goals and Objectives. Queen’s EM Sonogames happen once per year and is a fun opportunity to practice image acquisition and interpretation skills.

**TMTL Rounds**

Work life balance is essential for a long sustainable emergency medicine career. TMTL Rounds are held once a year following the Winter Resident Retreat. During the rounds, staff and residents present a brief topic of anything of interest or importance to their lives outside of medicine. These rounds help us maintain our collegial working environment and remind us that TMTL (There’s More to Life)

**Awesome & Amazing Rounds (A&A Rounds)**

Paired with our Morbidity & Mortality Rounds, the A&A rounds recognize positive deviance in residents, faculty or our medical/allied health colleagues who have demonstrated exceptional skill in clinical care, advocacy or teamwork.
6 Steps to Creating an EPIC Grand Rounds

**STEP 1**
6 weeks before
Brainstorming: 2-3 topics of interest
- what cases have puzzled me?
- what is happening in different ways?
- what is being talked about?

**STEP 2**
5 weeks before
Mulling: Which topic would be best?
- It has some or all of:
  - local interest
  - cutting edge
  - some controversy or equipoise
  - common or rare

**STEP 3**
4 weeks before
Choosing: Staff input & Further Research
- ask staff for input. If no responses, ask Louise, Heather, Karen or Joey.
- further research avoids unexplored topics like EMR/E, EM Basics, blogs until you have formed your own ideas

**STEP 4**
3 weeks before
Big Idea & Storyboarding: what’s my "so what?"
- write out the big idea in a sentence with a verb.
- story board: brainstorm concepts, identify what if/what could be, order elements, add moments of connection cases, personal stories, humour

**STEP 5**
2 weeks before
Media/Slide Deck
LESS IS MORE: think interest us enough to learn more, don’t cover every detail
- minimize bullets
- choose images where possible
- simplify data
- check in with staff

**STEP 6**
the week before
Practice your presentation:
- Am I Comfortable? Dynamic?
- Empathetic?
- use a mirror or phone
- know the first & last 5 min well enough to do it without slides
- change slides deck when it’s not working

@RangLouise. Created for @QEmerg 2019

Revised June 2019
Idea Sparkers for Grand Rounds

What is managed in several different ways? What are the subtleties of management of X, depending on age or symptoms or comorbidities?

Update on a topic/drug/diagnostic pathway/procedure with recent research studies or “buzz”

What cases scare me? What cases would I prefer to avoid? What do I feel like I know nothing about?

5 things to know about X: a disease, lab or imaging test, medication, treatment, or procedure

Things we see all the time and forget the subtleties of things we see rarely and forget the details of diagnosis or management

Connect things in a new way: treatments or test results: take an administrative or QI slant on a topic

Things I learned while off-service or away: invite a colleague from another specialty

Less is More!
You don’t need to tell us every detail. Make us curious enough to learn more on our own.

@RangLouise Created for @QEmerg 2019

Revised June 2019
Section 14: Summary of Other Aspects of the Academic Program

Medical Education

We believe that residents need to be competent educators to be fellowship trained Emergency Physicians and encourage the development of teaching skills by various means. Residents learn teaching methodology in the core curriculum and are given graded responsibility for teaching in one-on-one settings, small group and large group settings as they progress through training. PGY5 residents will participate in designated teaching shifts where they are paired with a junior Emergency Medicine resident on shift. The PGY5 resident will be responsible for all clinical supervision, didactic and bedside teaching for the junior resident and will, in turn, be supervised and mentored in their teaching role by the faculty member on duty. All residents are supported to achieve instructor status in PALS, ACLS, and/or ATLS and are encouraged to teach these programs during residency and after graduation. Residents are encouraged to register for the faculty development sessions (formerly Residents as Teachers) through the Postgraduate Medical Education Office. The tuition for these sessions is waived by the PGME office. Residents may participate in clinical skills or didactic teaching sessions in the School of Medicine undergraduate program. Residents will be given feedback from faculty and course participants in all of these areas. Coaching sessions on presentation skills are provided annually for our PGY1/3 residents. Residents are provided with mentored teaching opportunities in the simulation lab including scenario development and debriefing strategies.

Trauma

KGH is the designated lead trauma facility for the Southeastern Ontario region. KGH has an infrastructure consisting of readily available Trauma Team Leader and Trauma Team, Trauma Medical Director, Trauma Coordinator, and a Data Analyst. KGH receives on average 380 patients with an Injury Severity Score of 15 or above. Emergency Medicine residents are automatically members of the trauma team when doing Anaesthesia and General Surgery and are expected to be involved with trauma care during those rotations. Emergency Medicine residents are involved with the Trauma Team during all ED rotations when on duty in the department. PGY3-5 residents act as the Trauma Team Captain on an on-call basis and direct the trauma resuscitation under the supervision of the Trauma Team Leader. The KGH trauma Program audits performance of the trauma team and the patient care given. Our residents take part in teaching ATLS. This enhances teaching skills, trauma knowledge and while providing the resident insight into the problems faced in the community setting. Residents desiring enhanced trauma experience have done electives in American Trauma Centers and Sunnybrook Hospital and these can be arranged if desired. Dr. Chris Evans is the Director of the Trauma Service and several of our faculty are staff Trauma Team Leaders.

Pediatric Emergency Medicine

Skills and knowledge in Pediatric Emergency Medicine are crucial for emergency physicians. Residents will spend three (3) months at CHEO but will also gain exposure to pediatrics during the pediatrics rotation at the Children’s Outpatient Clinic in PGY1. Exposure to a pediatric patient population will also occur during core rotations in General Surgery, ICU, Anaesthesia, Plastic Surgery, Orthopedic Surgery and Psychiatry as KGH looks after all tertiary pediatric care for Southeastern Ontario.

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There is a significant pediatric experience during Emergency Medicine Rotations at both HDH and KGH as up to 15% of the total Emergency visits are for patients 18 years of age and younger. We are fortunate to see such a high volume of pediatrics in our program.

**Prehospital Care**

EMS is covered in the Summer Series and during the EMS month in PGY1. PGY 3 residents will receive an orientation to on-line medical direction in the summer series before they are assigned base hospital physician numbers and allowed to answer the paramedic patch phone.

**Quality Assurance and ED Administration**

**Administration Curriculum**

Formal teaching in this area takes place during two half-day sessions/year. ED administration bootcamps are offered in Foundations of Discipline (PGY1) and Transition to Practice (PGY5) to teach leader competencies relevant to the resident’s stage of training. A one month rotation in ED Administration is also offered in the Core of Discipline stage (PGY3). Details of the rotation are included in Section 14: The Administrative Curriculum.

**Discrepancy Process**

Managing laboratory and radiographic discrepancies and taking ownership for the follow-up of investigations ordered is a key responsibility for emergency physicians and often one of the more difficult aspects of practice to navigate. Starting in PGY3 year, residents begin to take responsibility for managing the emergency department discrepancy process for radiographic and laboratory studies. The senior resident on the HDH D shift will spend the first half hour of the shift reviewing the discrepancies on the Unresolved Issues track on EDIS. The resident will determine the need for follow-up of the discrepancy and will contact the patient (or substitute decision maker as appropriate) to discuss the discrepancy, arrange appropriate follow-up studies or consultation and document appropriately on the patient’s chart. The faculty on duty will provide assistance and supervision for this process.

See Section 14: Guide to ED Look Ups

**Quality Improvement and Patient Safety (QIPS)**

Formal teaching on QIPS occurs in the core curriculum as one half-day per year and also in the administration curriculum. Residents may be asked to participate in the hospital Critical Incident Review process if they have been involved in the clinical care of a patient who suffers significant harm. There are goals and objectives for Patient Safety.

**Morbidity and Mortality Review**

In the PGY3 year, each resident is required to complete one Morbidity and Mortality review of one critical incident or a case in which an actual or potential patient safety risk occurred. The resident Residents are encouraged to select a case in which they had personal involvement whenever possible. The Ottawa 3M model for morbidity and mortality rounds is used to assist the resident in the analysis of the system and human factors that contributed to the negative patient outcome. During the grand rounds session, the resident will present the case with attention to maintaining patient confidentiality, outline his/her analysis of the event and then lead the group discussion. Following the rounds, the resident will submit a summary of the key

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issues and potential solutions/remedies to the Department Head as part of our department processes for patient safety.

**Disaster Medicine and Mass Gathering Medicine**

Formal teaching on disaster preparedness and planning is included in the core curriculum and EMS Bootcamp. Topics will vary annually to cover the breadth of this field including: Incident Command, Triage, Hazard Assessment and Risk Mitigation, Mass Gatherings, Bioterrorism and Chemical Weapons and Specific Environmental Disasters. These sessions may run as paper or table top exercises. All residents are encouraged to review the Disaster section of the Emergency Procedures Manual in the KGH Emergency Department. Resident participation is expected at future hospital and community disaster exercises. Residents are encouraged to participate in the planning or clinical aspects of any mass gatherings that occur in our region.

An online module that addresses key concepts for disaster planning and preparedness is available at: [https://meds.queensu.ca/central/community/disasterpreparedness](https://meds.queensu.ca/central/community/disasterpreparedness)

**Ethics and Medicolegal Issues**

Formal teaching on ethics and medicolegal issues occurs in the core curriculum and the administration curriculum. Residents will be mentored in responding formally to any patient complaints. Senior residents may be asked to draft medicolegal reports if they have been involved in cases requiring this documentation. There are goals and objectives for Ethics and the Law.

**Communication Skills**

Excellent verbal and written communication skills are essential in Emergency Medicine. Communication skills are taught formally in the summer series, wellness curriculum, core curriculum as well as during the various simulation rounds. Communication skills are evaluated in EPA workplace based assessment, multi-source feedback, direct observation and OSCEs.

**Career Counselling**

Sessions to help with career counselling and fellowship opportunities are offered formally in the core curriculum. One of the purposes of the quarterly review process with the Program Director is to assist with career planning and finding a job. Resources for career planning are posted on a bulletin board in the resident library.

**Financial Planning**

Sessions on individual financial planning and billing techniques are offered by the PGME Office in QCARE+ sessions during which the CMA and MD Management offer a Practice Management session for Queen’s residents on an annual basis. These sessions are mandatory once for
residents in their PGY 4/5 year. A Session on financial management is also included in the wellness curriculum.

Community Experience

Residents have the opportunity to do community Emergency Medicine elective rotations in the Core of Discipline (PGY3). Residents complete the Obstetrics & Gynecology rotation in the Lakeridge Health Oshawa hospital. Shifts at the HDH offer a community Emergency Medicine experience for the resident as well.
Section 15: Guide to ED Look Ups (Discrepancy Process)  
(Reviewed June 2019)

General Principles

- Responsibility for the discrepancy process will be shared, whenever possible, by the Nurse Practitioner (NP), senior resident and attending physician. Senior residents should initiate a discussion with all parties to determine who is most able to address the discrepancies in a timely manner (i.e. patient care takes priority)
- Do this at the beginning of your shift. It should take less than 30 min. At HDH, it should be the day shift. At KGH it will be the DB1 attending or the KGH A1 senior resident who completes the UI track
- For missed fractures: When you call patients remember that how you approach it affects how the patient feels about their missed finding. Be polite, honest and apologize—and aim to make their return visit (if needed) as efficient as possible. (see below) If true, emphasize how undisplaced the fracture is.
- Leave a message simply to call back about their results, rather stating what those results are. Tell them your name, KGH or HDH emergency department phone number, when you are working until, and that if they call back after this, they should say they are a “call back about results” to streamline their interaction with the unit clerk. Also try the work number but don’t leave a message here.
- If a message has been left yesterday, then try calling next of kin today to see if they have another contact number for patient. Don’t disclose results to NOK. (unless a child)
- If no contact x 2 days, try family MD if possible to see if they have other phone numbers for them.
- If no contact x 2 days, then talk to staff. For non-urgent things, simply fax the report to the FD with a note stating that we have been unable to contact the patient about this report.
- Make a note in the EDIS chart to say what you have done. If you have sorted it out then MD disposition it from the UI track by clicking on MD Dispo>>remove from track and send updated report.
- If it is not sorted, leave it on the UI track and use the Message column in EDIS with the date and your initials to show what you have done. (eg. 19 Sep + strep. LM. LR) LM= left message
- Some discrepancies are not—they were recognized. If this is the case, simply MD Disposition the chart off the UI track with no further record update.
- Delete the x-rays from the PACs folders when it is sorted it out. (Right click>>remove from folder) Double check that the unit clerk has given you the info from BOTH discrepancy folders for the site you are at. (one is called follow up and one is called discrepancy).
- If the patient is admitted, talk to the admitting service about the result. Don’t assume that reports are always checked.

Specific Cases

Missed fractures

- **Avulsions etc. that need nothing more**—call patient to let them know the result and that there will be a longer healing time but there is no change in management.
- **Fracture present, but already splinted**—call patient to let them know, organize fracture clinic follow up by typing in the EDIS DC page field you would normally. Print it and give it to unit clerk.
• **Fracture present but not splinted, needs to come back for splinting**—try to make this efficient by telling them to say at triage they are a callback. Tell the triage RN to call you when they get there. At KGH, tell the unit clerk to add them to the en route list. Watch the track and try to get them brought in as fast as possible. At HDH, tell these patients to come in through the ambulance doors and report to charge RN. Tell the charge RN that they are coming.

• **Fracture present, needs a CT**—call and tell the patient, and tell them CT will call them with a time. They should go directly to Imaging Department and then back to ED for results after. Going to CT first avoids them waiting at triage for us to see them and order the ct. Fill out outpatient CT requisition on the EDIS DC tab, print it and have unit clerk send it AND call CT to emphasize that it is for today. Tell the triage RN to call you when the patient arrives. At KGH, tell the unit clerk to add them to the en route list. Watch the track.

• **Needs a repeat x-ray in X days**—call the patient and tell them the plan. Give them option of doing this thru their FD or coming back for an x-ray and then back thru ED for results. If they come back thru ED, try to get them to come in the morning and never on a HDH Monday. Tell them to go to HDH imaging department first for their x-ray, and then back to UCC. (Ideally do this thru HDH) Fill out the outpatient x-ray requisition on the DC tab, print it and have unit clerk send it to Imaging at whichever hospital you have sent the patient to.

• If you are not sure what the treatment for this fracture is then talk to your staff.

**Things that need further testing within days/week or two (e.g. significant lung mass)**

• Call the patient; tell them that we need to do some further testing, and that we will organize the test. They will get a phone call to come in for a scan, and then they should make an appointment for a few days later with their FD for results.

• Fill out outpatient CT requisition on the EDIS DC tab, print it and have unit clerk send it to radiology. CT will then call patient with a time to come in.

• Call the FD to tell them the concern, and ask them to follow the testing. If no family MD, talk to your staff about which clinic to get them into for follow up.

**Things that need following in X weeks or months (e.g. pneumonia, lung nodules, ovarian cysts etc.)**

• Call the patient, tell them what needs to be done and ask them to do this via FD.

• Have the unit clerk fax the report to the FD with a note on it asking them to order and follow.

• If you have a chance, call the FD also. If they have no FD then talk to your staff.

**Labs**

• If they were seen and DC by a consulting service, check the consult sheet in PCS—it might have the information about antibiotics etc. Page the consulting service and ask them to follow up with the patient where appropriate.

• **Blood cultures**—Gram negative rods are always bad. Call these patients as soon as you get the result. They will almost always need to come back to the ED for a recheck that day. Tell the triage RN to call you when they get there. Write orders for basic labs + VBG + lactate + blood cultures at triage. Tell the unit clerk to add them to the en route list. Watch the track and try to get them brought in as fast as possible. If you can’t get hold of these people talk to your staff.

• **Other blood cultures**—The issue is whether the culture results reflect a contaminant vs real bacteremia. If these are positive quickly (<24h after drawn) or are in more than one (1) bottle, it is more likely real and follow the above. If not, the result is more likely due to a contaminant—look at the patient’s story (history of immunosuppressed/chemo,
etc.) and if high risk, act as above. If not, then call the patient and see if they have had more fevers etc. If the patient remains febrile or symptomatic, follow the above. If they are feeling well then it is safe to wait for the speciation tomorrow.

- **Urine cultures** - check DC tab for what they were treated with. If it was a fluoroquinolone, you can call the lab to get the sensitivity. If you need to change the prescription, call the patient and ask if they are better, since in vivo sensitivity may be better. If they are then don’t bother changing. If not, tell them you will change it and ask which pharmacy is best. Have the unit clerk fax a prescription (you can do this on paper or on the DC tab and print.) Note in EDIS what you used.

- **Throat swabs, stool cultures** — ask the patient first if they are better. They might not need antibiotics. If they are not then fax a prescription into the pharmacy of their choice and make a note in EDIS as to what you used.

- **Skin swabs** — can almost always be ignored except if MRSA present. Talk to your staff if they are not known to be MRSA +

- **Mono spot** — remember to tell them about possibility of splenic rupture—signs and symptoms to watch for, avoid contact sports for 6 weeks.

- **Bacterial Vaginosis** - only treat if they are symptomatic.
Section 16: Core Content Curriculum

There are two key components to the formal teaching curriculum in the Emergency Medicine Residency Program at Queen's – the Core Content and the Non-Medical Expert CanMEDS Competencies. These sessions cover the breadth of knowledge in Emergency Medicine. The sessions are given in a two-year cycle so residents will have had a chance to cover the material at least once or twice before completion of training. These rounds are part of the Academic Day and residents from PGY1 – PGY5 are released from clinical responsibilities to attend.

Medical Expert CanMEDS Competency

- Thursday mornings from Sept-June following Grand Rounds
- Topics are taken from Core Content of Emergency Medicine and are all clinical topics.
- Year 1 topics cover “Disorders of Body Systems” and include mostly Internal Medicine Related topics. Investigative modalities are discussed in the context of each clinical disorder.
- Year 2 topics include all other clinical areas: trauma, special populations (pediatrics, geriatrics), toxicology, environmental emergencies, prehospital care, disaster medicine and manipulative procedural skills.
- It is impossible to cover absolutely everything in the Core Content Series related to each general topic. You will note that the sessions cover the important aspects of each topic as they relate to Emergency practice but leave out other less important aspects that can be covered by self-study and review of the standard texts.

Non-Medical Expert CanMEDS Competencies

Teaching of the non-medical expert competencies (Communicator, Collaborator, Manager, Scholar, Professional and Health Advocate) occurs in formal teaching sessions integrated into the Core Rounds curriculum cycle. The general headings for these sessions include:

- ED Administration
- Ethics and The Law
- Communication Skills/Teaching
- Physician Wellness
- Career Management
- Critical Appraisal Skills
- Crisis Decision Making and Leadership in Critical Care
- Violence, Abuse and Crisis Intervention
- Preventative and Population Health

In addition, specific learning goals and objectives for these competencies are established for rotations throughout the Resident Training Program (see the Rotation Specific Goals and Objectives).

Residents will be evaluated on each of these competencies in the clinical setting, during practice written, oral and OSCE examinations, simulation rounds and at the FRCP certification examination.
### Core Content Topics (Choosing Wisely recommendations included where applicable)

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<th>YEAR 2</th>
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<td>Respiratory: Asthma, COPD</td>
<td>Crisis Resource Management</td>
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<td>CV: ECG Interpretation</td>
<td>Principles in Critical Care and Resuscitation of the Critically Ill Patient</td>
</tr>
<tr>
<td>CV: Cardiac Arrhythmias</td>
<td>Trauma: Neurotrauma (include imaging)</td>
</tr>
<tr>
<td>CV: Acute Coronary Syndromes / CHF</td>
<td>Trauma: Multiple Trauma (include imaging)</td>
</tr>
<tr>
<td>CV: Physical Exam of CV System</td>
<td>Trauma: Face and Neck Excluding Spine (include imaging)</td>
</tr>
<tr>
<td>CV: Hypertension and Pharmacological Agents in CV Disorders</td>
<td>Trauma: Abdominal (include imaging)</td>
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<tr>
<td>CV: Disorders of the Aorta, Arteries, Veins, SBE, Myo/pericarditis</td>
<td>Trauma: Musculoskeletal and Spine (include imaging)</td>
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<tr>
<td>Dental and ENT Emergencies</td>
<td>Trauma: Hand, Wrist and Soft Tissue Injuries/Compartments (include imaging)</td>
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<td>Procedural Skills: Miscellaneous (Ophth, ENT, Dental, Foreign Bodies)</td>
<td>Trauma: Urogenital (include procedures/imaging)</td>
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<td>Ophthalmology Emergencies</td>
<td>Trauma: Chest and CV System (include imaging)</td>
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<td>GI: Hepatobiliary Disorders, GI Bleeds, Vomiting, Diarrhea</td>
<td>Critical Appraisal Part 1 – Stats Review</td>
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<td>GU: STD’s, Vaginal Bleeding (non-pregnancy), Sexual assault</td>
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<td>Peds: Vomiting, Diarrhea, Dehydration, Respiratory Distress</td>
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<tr>
<td>GU: Nephrolithiasis</td>
<td>Peds: Approach to Fever and Seizures</td>
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<tr>
<td>Dermatology Emergencies</td>
<td>Peds: Infectious Disorders in Childhood</td>
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<tr>
<td>Career Management</td>
<td>Peds: MSK/Ortho Injuries (include imaging)</td>
</tr>
<tr>
<td>Hematology/Oncology Emergencies</td>
<td>Violence and Abuse</td>
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<tr>
<td>Core Content Topics (Choosing Wisely recommendations included where applicable)</td>
<td>YEAR 1</td>
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<tr>
<td>Neuro 1 - Neuroanatomy, Neuro Exam, Neuro Imaging</td>
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<tr>
<td>Neuro 2 – Headache, Cerebrovascular Disease</td>
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<td>Neuro 3 – Seizures and CNS Infections</td>
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<td>Neuro 4 – Coma, Dizziness</td>
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<tr>
<td>Endocrine Emergencies – Disorders of the thyroid, adrenal system and glucose metabolism</td>
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<tr>
<td>MSK – MSK Exam and Anatomy</td>
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<td>MSK Non-traumatic MSK disorders</td>
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<tr>
<td>• Neck, thoracic, lumbar pain</td>
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<td>• Rheumatology</td>
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<td>• Disorders of Bursa and Joints</td>
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<td>• Shoulder Pain</td>
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<tr>
<td>Allergy &amp; Immunology – Allergic Reactions, HIV</td>
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<tr>
<td>Acid Base, Fluid and Electrolyte Disorders</td>
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<tr>
<td>Psychiatry 1 – Axis I and Axis II Disorders, suicide assessment</td>
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<td>Psychiatry 2 – Psychotropic Medications</td>
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<td>Psychiatry 3 – Substance Abuse and Harm Reduction Strategies</td>
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<tr>
<td>Emergency Medicine Ethics and The Law</td>
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<tr>
<td>Physician Wellness</td>
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<tr>
<td>Communication Skills – Giving Bad News, Crisis Intervention</td>
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Revised June 2019
Section 17: Leader Competency Curriculum  (Updated June 2019)

Overview

Residents will participate specific bootcamp style small group teaching twice during their residency in the Foundations of Discipline (PGY1) and Transition to Practice (PGY5) stages of training. These sessions will address administrative and Quality Improvement & Patient Safety content and competencies most relevant to a particular stage of training. Each year residents will receive teaching on a variety of topics in two half-day seminars. Topics will be chosen to address key content in greater detail. Each half day will include one topic related to ED Administration and one related to Quality Improvement. Residents will also complete one block in ED administration in the Core of Discipline (PGY3).

Curriculum Design

Foundations of Discipline Bootcamp
- Relevant legislation (MOT, reportable disease, CPSO)
- Privacy and confidentiality
- Patient safety principles
- Patient complaints process

Core of Discipline
- Morbidity & Mortality Rounds - each PGY3 resident will conduct on M+M review using the Ottawa 3M model and submit a summary document of recommendations to the QI Lead (Dr. Stuart Douglas) for review
- One faculty journal club article per year will be dedicated to a relevant Quality Improvement publication
- Residents who are interested in Quality Improvement and Patient Safety are encouraged to participate in projects underway in the department. A QIPS project will fulfill the requirements of the scholarly project required of all residents.
- Residents will participate in the clinical discrepancy management processes
- Monthly ED return visit information will be distributed to residents for self-reflection
- ED Administration rotation (combined ED/Admin) – residents will receive a 50% shift reduction to allow adequate time to complete the rotation objectives
- Residents will complete one mortality audit during their ED Administration rotation. The audit must be submitted to the rotation supervisor (Dr. Gord Jones) for the rotation to be considered complete.

Transition to Practice Bootcamp
- Bedside teaching strategies
- ED flow strategies
- Principles of negotiation
- Career planning – CV and teaching dossier development
- Academic medicine
- Handover
- Shadow billing
ED Administration Rotation

The ED Administration rotation is a one month block usually done the Core of Discipline (PGY3). The resident will do approximately 50% clinical shift load for that month and in addition will:

a) Do independent reading around the topics listed below and meet weekly with the physician leader of the Admin block to discuss
b) Participate in chart mortality review for patients presenting DOA or DIE in the Emergency Department
c) Prepare and present one morbidity and mortality grand rounds for emergency medicine (may be presented earlier or later than actual admin month)
d) Participate in one departmental Clinical Care and Quality Assurance meeting
e) Attend one hospital MAC meeting and one Emergency Department Program Council meeting
f) Optional – participate in one departmental quality assurance activity or other structured activity related to ED function, patient safety, etc.

Topics for independent reading and review with Administration rotation supervisor:

1. **Patient Safety**
   - Discuss the principles of patient safety in the hospital environment
   - Demonstrate use of the hospital Safe Reporting System
   - Discuss the format and function of a critical incident review and critical incident debriefing
   - Discuss the indications for notification of the coroner

2. **Quality Assurance**
   - Discuss 5 different categories of quality assurance activities and give one example of each as it pertains to the Emergency Department
   - Describe pay for performance metrics for Emergency Departments

3. **Structure and Function of the Health Care System**
   - Discuss the role of various levels of government in the functioning of the health care system and the Emergency Department (i.e MOHLTC, LIHN, SEAMO)
   - Outline the role of various professional organizations as it pertains to practice in Emergency Medicine (i.e. CMPA, CPSO, RCPSC, CAEP, OMA)
   - Discuss the administrative structure of a hospital and the role of physicians in the administrative function of the hospital (i.e. Board of Directors, CEO, VP medical, MAC and subcommittees, MSA)

4. **ED Funding Models and Physician Remuneration**
   - Discuss models of ED physician funding (FFS, EDAFA, Academic AFA)

5. **ED Patient Flow and ED Management**
   - Discuss options to enhance patient flow in the ED, specifically describing a RAZ unit, Fast track, physician at triage and RAFT unit
   - Describe the format and purpose of the Canadian Triage and Acuity Scale
   - Describe the function and give examples of medical directives, patient care protocols at triage and patient care plans
   - Discuss the causes and management strategies for ED overcrowding
   - Outline five personal strategies a physician can use to improve ED patient flow and patient care.
   - Give examples of how an Emergency Department can be “senior friendly”
6. Role of the ED Physician as a Consultant
   - Outline the principles of inter-hospital patient transfer
   - Discuss the principles for giving advice over the phone
   - Discuss the principles and options for both consultations and patient handover

7. Dealing with Complaints from Patients, Family or Colleagues
   - Describe the role of the hospital and the ED program in addressing patient complaints.
   - Outline the common causes and reasons for patient complaints as they pertain to Emergency Medicine
   - Outline the responsibilities of the physician for dealing with patient complaints
   - Describe the role of the CMPA and the CPSO in dealing with patient complaints or adverse outcomes

8. Resource Allocation and Cost Appropriate Care
   - Describe the Choosing Wisely campaign as it pertains to Emergency Medicine
   - Give examples of how strategies for monitoring or reducing utilization can lead to improvement in cost appropriate care.

9. Miscellaneous
   - Discuss the principles of dealing the police in the ED. (i.e. disclosure to the police, mandatory notification of events)
   - Give five tips for running a meeting.
   - Describe the different levels of hospital and academic medical appointments
# Section 18: Critical Appraisal Curriculum

<table>
<thead>
<tr>
<th>Study Type</th>
<th>Possible Concepts to Address</th>
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<tbody>
<tr>
<td>Therapy / Harm</td>
<td>AR, ARR, RRR, NNT, NNH</td>
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<td>RR, OR</td>
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<td>Types of studies and hierarchy</td>
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<td>Random errors; biases</td>
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<td>Concealment; blinding</td>
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<td>Intention-to-treat analysis</td>
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<td>Surrogate markers</td>
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<td>Drug-class effect</td>
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<td>p value, Type I and II errors, CI</td>
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<td></td>
<td>Applicability issues</td>
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<td>Diagnosis</td>
<td>Sensitivity; Specificity, PPV, NPV</td>
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<td>SpIN, SnOUT</td>
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<td>+LR, -LR, Fagan nomogram</td>
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<td>Gold standard</td>
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<td>Representative enrollment</td>
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<td></td>
<td>Bias</td>
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<td>p value, CI</td>
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<td>ROC curve</td>
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<td>Agreement coefficients (kappa)</td>
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<td>Applicability issues</td>
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<td>Clinical Decision Rules</td>
<td>Levels of rules</td>
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<td></td>
<td>Sensitivity; Specificity, PPV, NPV, LR</td>
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<td>Impact analyses</td>
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<td>Applicability issues</td>
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<td>Systematic Review / Meta-analysis</td>
<td>Contrast between syst review and meta-analysis</td>
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<td>Jaddad score</td>
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<td>Funnel plots</td>
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<td>Fixed-effect models</td>
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<td>Blobbagrams</td>
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<td>OR, CI</td>
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<td>Applicability issues</td>
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<tr>
<td>Prognosis</td>
<td>Difference between prognosis and risk factors</td>
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<td>Importance of homogeneity</td>
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<td>Outcome measure</td>
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<td>Correlation, Regression</td>
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<td>Survival curve</td>
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<td>Applicability</td>
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Section 19: Scholar Competency Curriculum (Updated June 2019)

Resident’s Responsibilities for Academic Contribution

All residents are required to complete at least one academic project during their training. While this requirement has traditionally been considered to represent a formal research project, various additional projects could be used to fulfill this requirement. Such projects might include (but not be limited to):

- conduct of a high-quality audit of clinical care that will include recommendations for enhancement of quality or efficiency of clinical care
- development of a clinical practice guideline for consideration of use within Kingston emergency departments
- development of an educational instrument for use in an undergraduate or postgraduate medical education setting

The Departmental expectation is that this project will, in the minimum, lead to presentation of this work at the Department of Emergency Medicine Research Day but residents should strive for presentation at a national level meeting and/or publication of the project in a peer-reviewed journal

Overview of the Resident Scholar Competency Curriculum

Transition to Discipline
As part of the summer seminar series, PGY1 residents will have an orientation session by the Resident Research Director (Melanie Walker) that describes the research program as well as expectations for performance.

Foundations of Discipline (PGY1)
In the first year of the residency program, trainees will complete a critical appraisal and clinical reasoning seminar series related to cardinal emergency medicine presentations. Each tutorial session will include the completion of an assignment that will be assessed by the faculty facilitator.

The critical appraisal and research methodology covered includes:
1. Introduction to the research program
2. Data variables and management
3. Introduction to statistics
4. Observational study designs
5. Diagnostic tests
6. Systematic reviews and meta-analysis
7. Randomized controlled trials
8. Clinical decision rules

Core of Discipline (PGY2-4)
In their PGY2 year, residents will receive an orientation to the expectations around the completion of a critically appraised topic (CAT) project, identify an appropriate faculty supervisor for the project and then progress through the following milestones:

- Receive an introduction and orientation session on CAT projects (Summer-Fall of academic year)
- Provide CAT question to Resident Research Director (Fall of academic year)
• Provide list of articles identified through literature search to Resident Research Director (December of academic year)

• Submit completed CAT project report to Resident Research Director (February of academic year)

• Present completed CAT project at Department of Emergency Medicine Research Day (April of academic year)

Building on their understanding of research methods and using the critical appraisal skills developed during their earlier years of residency, all PGY3/4 residents will be expected to develop further scholar competencies through additional teaching and administrative opportunities, including:

• Undertaking a further academic project based on their clinical interests and career goals. As discussed in the introduction, the project may be a research study, clinical audit, development of a clinical practice guideline, a novel educational intervention, or others, pending approval by the resident’s Academic Advisor, Program Director, or Resident Research Director. Residents will present their project at the Department of Emergency Medicine Research Day in both the PG3 and 4 years (see table below).

• Acting as the resident presenter/facilitator for one departmental Journal Club per academic year.

• Presenting one Grand Rounds presentation on a “Morbidity and Mortality” topic that highlights opportunities to improve care based a structured literature review, critical appraisal, and clinical guidelines, where appropriate. Where possible, this will be scheduled during the Administration block.

### Emergency Medicine Scholar Curriculum – competencies and expected outcomes

<table>
<thead>
<tr>
<th>Stages of Training</th>
<th>Transition to Discipline</th>
<th>Foundations</th>
<th>Core</th>
<th>Transition to Practice</th>
</tr>
</thead>
<tbody>
<tr>
<td>First 3 months</td>
<td>PGY 1</td>
<td>PGY 2-4</td>
<td>PGY 5</td>
<td></td>
</tr>
<tr>
<td>Key and Enabling Competencies</td>
<td>Scholar Enabling Competencies CanMEDS 2015 - 2.4, 2.5, 2.6, 3.1, 3.2, 3.3, 3.4, 4.1, 4.2, 4.3, 4.4, 4.5</td>
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<tr>
<td>Required learning experiences/exposure</td>
<td>Orientation to scholar competency requirements and curriculum</td>
<td>Complete online research training modules</td>
<td>Receive orientation on CAT project (summer)</td>
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<tr>
<td></td>
<td></td>
<td>Attend research skills tutorial sessions</td>
<td>Complete a CAT project (written report and presentation at research day of PGY2)</td>
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<tr>
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<td></td>
<td>Undertaking an additional academic project based on their clinical interests and career goals.</td>
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<td></td>
<td>Presenter/facilitator for one departmental journal club per academic year.</td>
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<td></td>
<td>Present one grand rounds presentation on a “Morbidity and Mortality”</td>
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</table>
Assessments tools & completion requirements (Performance evidence)  

Research training module assignments  

Evaluate effective review of co-resident rounds and presentations  

Research day presentations:  
CAT project submission  
PGY3: Proposal/methodology for academic project  
PGY4: Results/outcomes of academic project  
Academic project presented at national academic meeting and/or publication in peer-reviewed journal  
Satisfactory journal club feedback peer-review  
Satisfactory rounds feedback peer-review

**Evaluation of Academic Project**

Each resident’s progress towards and success in completing an academic project will be reviewed on an ongoing basis during meetings with their Academic Advisor, the Program Director, and the Resident Research Director. The Competency Committee will make the final decision on whether the resident has completed all of the requirements for the “Scholar” portion of the training program, including the academic project.

**‘Academic’ Electives**

Some residents may wish to devote a period of focused academic time to completing their academic project. This would be in the form of a formal “Academic” elective ranging in time from one to three (six-week) blocks, the latter time period for particularly rigorous academic projects.

Academic electives must be planned out well in advance of the anticipated date of starting them (i.e. in general at least 3 months). Residents who wish to take an academic elective will need to coordinate a meeting involving their Academic Advisor, the Program Director, and the Resident Research Director to discuss their proposed activities for the elective. They will also need to develop a proposal for the academic elective including a description of their academic project, the rationale for taking the elective, and the specific measurable goals and outcomes for the elective period. This proposal will be reviewed by the Academic Advisor, the Program Director, and the Resident Research Director before approval is granted for any academic electives.
Section 20: The FRCP Examination and How to Prepare

The purpose of completing the Emergency Medicine Residency program is to learn the skills to become an Emergency Physician. You must also pass the Royal College of Physicians and Surgeons of Canada Specialty exam in Emergency Medicine.

The exam in its current form takes place yearly in April/May (written) and May (oral).

There is a formal process that needs to be completed to be eligible for the exam including an official RCPSC Assessment of Training and completion of various forms by the Program Director and the resident. **Please watch for deadlines closely, as it is your responsibility to return documents and exam fees on time.**

The Exam

The exam consists of a written and an oral component.

- The written exam consists of two short answer papers; each of three hours duration. The exam takes place in Kingston. Questions will cover the depth and breadth of Emergency Medicine including relevant anatomy, pathophysiology, pharmacology, clinical management, systems administrator, recent literature and research methodology.
- The Multiple Station Oral Exam Component will be approximately 2 hours in duration in Ottawa and will consist of approximately five examination rooms. Exam rooms are staffed by one examiner, Candidates are asked questions dealing with the breadth and depth of Emergency Medicine and relevant basic science. This is achieved utilizing single or multiple real case scenarios and by direct questioning. Candidates may encounter visual stimuli, such as x-rays, EKGs, laboratory data and pictures during these sessions.

How to Prepare

The Core Content seminars provide an excellent framework for formal study. While not all areas can be covered in the sessions, you are advised to read beyond the material for each session during your preparation. Most residents use the standard Emergency textbooks to guide their study. It is expected that the resident will have completed Tintinalli by the end of PGY3 and concentrate on Rosen’s Emergency Medicine text in PGY4 and PGY5.

You cannot study all the time. Take days off and pace yourself. It is common in the last six months to feel overwhelmed with the amount of information you need to know and feel you have to study all of the time. Remember – most of the questions are clinically based and cover things you see and deal with every day. You can break up your studying by looking at the Atlases in the library (pictures, ECGs, x-rays etc). Solving case problems in the various texts and looking at the many cases now available on the Internet are also fun and meaningful ways to study.

A final note on exam preparation – the best way to put it all together is using this knowledge while you are looking after patients in the ED or teaching your knowledge to students and junior learners.
Section 21: Addendum

Core Content Listings


Objectives of Training and Specialty Training Requirements in Emergency Medicine

http://www.royalcollege.ca/rcsite/documents/ibd/emergency_otr_e.pdf

Royal College Competency Training Requirements for Emergency Medicine