

UC Davis Medical Center
Office of Graduate Medical Education
Resident Roles and Responsibilities ~ Emergency Medicine

Last Reviewed: January 2016

SUBJECT: Emergency Medicine Resident Roles and Responsibilities

REVISED: April 2013

PURPOSE: To provide a general overview of the roles, responsibilities and functions of EM residents while on rotation in the UC Davis Medical Center Emergency Department. This is meant to address issues relating to degrees of supervision of clinical practice; interactions with, and supervision by faculty; performance of procedures; and interactions with, or supervision of, other housestaff and medical students. It is expected that residents will demonstrate ongoing competence during each training year and will progressively transition into the next level of training by the end of the previous academic year. However, individual residents may progress at different rates and, therefore, may be granted increasing degrees of independence at different stages in their training. Residents rotating through the emergency department will have separate requirements regarding procedural competency as determined by their training program director(s).

POLICY: In general, the roles, responsibilities and functions of EM residents, per training year, are as follows:

PGY-I

- See a broad spectrum of undifferentiated patients on all shifts, in order of presentation or assignment by attending physician or senior resident.
- Emphasis will be on quality of patient evaluation and care.
- In-depth discussion of all cases with the attending physician or senior EM resident prior to initiation of all but the most basic diagnostic studies or therapeutic interventions.
- Are not to provide supervision of other residents or medical students.
- Common ED procedures must be done under approval and supervision of attending physicians. Selected procedures may be supervised by more senior residents.
- Will assist with identifying and entering patients into EM clinical research studies.

PGY-II

- Continue to see full spectrum of patients in order of presentation or assignment by attending physicians. May exercise some selectivity in patient cases while serving as most senior level resident in certain treatment areas of the Emergency Department.
- Emphasis on gaining experience with full spectrum of emergency medical procedures and honing proficiency.
- Emphasis on balancing quality of patient evaluation and care with improved overall efficiency.
- In-depth discussion of all cases with the attending physician. May initiate usual diagnostic studies and therapeutic
- Specialized diagnostic studies, uncommon therapeutic interventions, and use of consultants must be discussed with the attending physician prior to initiation.
- Procedures must be done with attending supervision and approval.

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- Discuss cases with interns or medical students and generate an initial treatment plan, with attending physician approval, while serving as most senior level resident in Pods B, D, and E, and Up Front Care.
- Assist the attending physician with the supervision of procedures by more junior housestaff and students.
- Run "board rounds" when acting as most senior level resident in a treatment area of the ED.
- Will assist with identifying and entering patients into EM clinical research studies.

PGY-III

- Continue to see broad spectrum of ED patients, but with emphasis on those with highest acuity or greatest critical illness.
- Emphasis on time, resource, and efficiency management. Goal is to gain competence in managing administrative tasks, patient flow and team coordination activities, as well as continuing direct primary care of multiple patients concurrently.
- Optimize proficiency with full range of emergency medical procedures. Particular emphasis will be placed on airway management skills, including highly complex and difficult airways.
- Primarily manage critical trauma patients as delineated in triage protocols and as assigned by charge attending physician.
- Must discuss all cases with the attending physician prior to disposition decisions, or involving consultants. May initiate most diagnostic studies and common therapeutic interventions prior to attending physician discussion.
- May discuss cases with more junior housestaff and medical students and assist in their patient care management with attending physician approval.
- May attempt or initiate the full range of ED procedures with attending physician approval.
- May assist with the attempt or initiation of procedures by more junior level housestaff with attending physician approval.
- Responsible for running "board rounds" at change of shift and for providing a teaching discussion presentation at morning board rounds.
- Responsible for handling necessary medical command of EMS calls with attending backup.
- Will be involved in the PI review process via PI meetings and Morbidity and Mortality conferences.
- Will assist with identifying and entering patients into EM clinical research studies.

POLICY:

Resident Designated Procedures

In general, most Emergency Department procedures should be performed in the presence of a supervising attending physician. This is necessary to optimize both patient care and resident education. As per UCDHS policy, "in emergent situations where the patient's survival is at risk, or there is a risk of serious impairment to bodily functions or serious dysfunction of any bodily organ or part, the best-trained, immediately-available physician will provide the necessary treatment." Given sufficient prior experience, residents at a specified PG level may perform certain procedures without an attending physician being physically present (see table below), however, attending physician presence

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is usually preferred. The requisite number of required procedures to obtain competency is further identified.

PROCEDURE NAME	Required #	Anticipated PGY Level		
		End of PGY-1 orientation	By start of PGY-2	By start of PGY-3
ABG	2	X		
Cardiac Monitor Placement	1	X		
ECG Performance	2	X		
Foley Catheter Insertion	2	X		
Laceration Repair	3	X		
Local anesthesia (e.g. Field block)	3	X		
IM Injection	2	X		
Nasogastric Tube Placement	2	X		
Pelvic Exam & Cervical Cultures	2	X		
Peripheral IV Insertion †	3	X		
Slit Lamp Examination	2	X		
Spine: In-line Immobilization	1	X		
Venipuncture	2	X		
Anoscopy	1		X	
Anterior nasal packing or cautery	2		X	
Application of Cast/Splint	3		X	
Central Venous Catheter Insertion †	5		X	
FB removal: ear, nose or wound †	2		X	
Fiberoptic Nasopharyngoscopy	2		X	
I&D dental abscess	2		X	
I&D skin abscess †	2		X	
Regional Nerve Block †	3		X	
Tonometry/Tonapen for IOP	2		X	
Emergency POC Ultrasound*	10		X	
Abdominal Paracentesis †	3			X
Arterial Catheter Insertion †	3			X
Arthrocentesis †	3			X
Laceration Repair, Complicated	5			X
Lumbar puncture †	3			X
Needle I&D Peritonsillar Abscess †	2			X
Saline Arthrogram	3			X
Thoracentesis †	3			X
Vaginal Delivery	5			X

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*ACEP¹ has identified core applications of emergency department sonography (US). Implicit to the idea of these core areas is the concept that ED-based US is limited in scope, point-of-care (POC), and generally results in binary clinical decisions made at the time of interrogation (e.g. presence or absence of free fluid, presence or absence of intrauterine pregnancy). The UC Davis Emergency Medicine residency curriculum incorporates all of the core applications as well as additional, non-traditional applications including: Abdominal Aorta, FAST and e-FAST for Trauma, Biliary/Right Upper Quadrant, Central Venous Catheter (CVC) Placement, Lower Extremity DVT, Foreign Body/Soft Tissue, Fracture Reduction, Pelvic (pregnant and non-pregnant females), Peripheral IV Access, Renal, Appendix, Ocular, Limited Cardiac, IVC/Undifferentiated Hypotension, and Scrotal. Residents may perform independent, diagnostic sonography on any stable patient; however, all clinical treatment decisions and procedures require attending supervision unless otherwise specified or if the patient requires immediate resuscitation/stabilization and the resident is the most qualified clinician available.

†In addition to the core applications listed above, Emergency Medicine residents are trained in the use of US for assistance and guidance with certain procedures including Abdominal Paracentesis, Thoracentesis, Pericardiocentesis, Abscess localization and drainage (including peritonsillar abscess), Arterial Catheter placement, Regional nerve anesthesia, and Lumbar Puncture. It is highly recommended, given availability of and access to a working US machine as well as patient stability, that sonography be used to assist with CVC placement, Abdominal Paracentesis, and Thoracentesis. US may be used for other procedures when appropriate.

1. American College of Emergency Physicians. Policy Statement: Emergency Ultrasound Guidelines. 2008.