

| | Expectations | Expectations | Expectations |
|---|--|--|---|
| Emergency Stabilization (PC1) | Does not timely initiate appropriate antibiotics | IV Fluids initiated; Appropriate antibiotics given | IV Fluids and pain control given; Diagnosis zeroed in on quickly |
| Performance of Focused History and Physical Exam (PC2) | Does not evaluate patient thoroughly | Abdominal pain is solicited; focused history questions related to potential causes of abdominal pain | Evaluates for serious causes of abdominal pain; quickly appears to ascertain significance |
| Diagnostic Studies (PC3) | Blanket orders labs; Orders CT scan initially | Orders labs in thoughtful manner, including lipase Orders plain films first | Quickly considers perfr viscus. Orders plain films quickly; |
| Diagnosis (PC4) | Does not diagnose perforated viscus, or does so slowly | Diagnoses perforated viscus quickly | Diagnoses perforated viscus quickly; acts upon it |
| Pharmacotherapy (PC5) | Does not give pain meds, or inadequate pain meds given; antibiotics late | Gives adequate pain medication and antibiotics | Gives pain medication and appropriate antibiotics early in case |
| Observation and Reassessment (PC6) | Does not reassess | Reassesses effects of pain medication and antibiotics | Reassesses effects of medications; considers deterioration |
| Disposition (PC7) | Admits to hospital floor, no surgical or slow surgical consult | Admits to hospital bed with surgical consult | Consults surgery quickly, argues for OR |
| Medical Knowledge (MK) | Does not understand presentation or causes of perforated viscus | Understands presentation or causes of perforated viscus | Understands need for quick reaction to perforated viscus |
| Professional Values (PROF1) | Does not introduce self | Introduces self | Asks patient about care beliefs related to treatment |
| Accountability (PROF2) | Does not recognize limitations of knowledge and care | Recognizes lapses in knowledge and care | Recognizes lapses in knowledge and care; seeks answers |
| Patient Centered Communication (ICS1) | Does not communicate with patient | Elicits from patient their concerns | Communicates with patient addressing concerns |
| Team Management (ICS2) | Communicates pertinent information to colleagues | Ensures transitions of care are communicated | Resolves difficulties with consultants |

| Critical Actions | Yes/No |
|---|--|
| 1. Diagnose perforated viscus | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 2. Orders upright CXR and/or complete Abd. series | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 3. Consults Surgery | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 4. Begins antibiotics prior to OR | Yes <input type="checkbox"/> No <input type="checkbox"/> |

Figure 1. Sample clinical scenario scoring sheet. IV, intravenous; CT, computed tomography; OR, operating room

76 The Use Of Voice-over Internet Protocol (VoIP) for Residency Interviews: The Wave of the Future?

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Introduction: Residency applications along with interview travel and hotel expense require increasing funds for the average residency applicant. Emergency medicine (EM), in particular, is currently among the more competitive specialties. EM candidates feel pressure to apply to a higher number of programs in order to match. In addition, the Electronic Residency Application Service (ERAS) has a crescendo fee schedule that penalizes the applicant with more than ten applications. This environment challenges the EM residency applicant to survive the interview season without incurring debt.

Educational Objectives: Our research survey examines the use of Voice-over Internet Protocol (VoIP) methods such as FaceTime or Skype for residency interviews.

Curricular Design: All interview candidates were anonymously surveyed at an urban EM program with 36 positions after the rank order lists were submitted. The survey revealed that on average the candidates applied to 59 programs and interviewed at 16 programs. It also showed that 38% of the respondents had financial constraints during interview season. Fifty-five percent of those who replied said they would consider VoIP for interviewing and 32% said that they would select a residency without a physical visit.

Impact: Our results indicate that VoIP interviews are an effective means of assisting programs with high meal

and hotel costs. More importantly, our survey indicates that student applicants strapped with the increasing financial burden of escalating application fees and travel expense would find VoIP an attractive adjunct to the in-person interview.

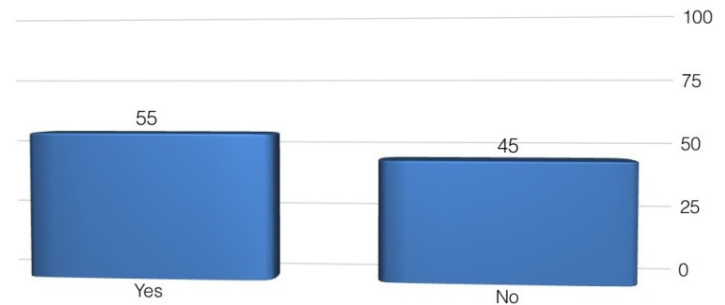


Figure 1. Percentage of candidates who reported they would consider VoIP as a form of interviewing.

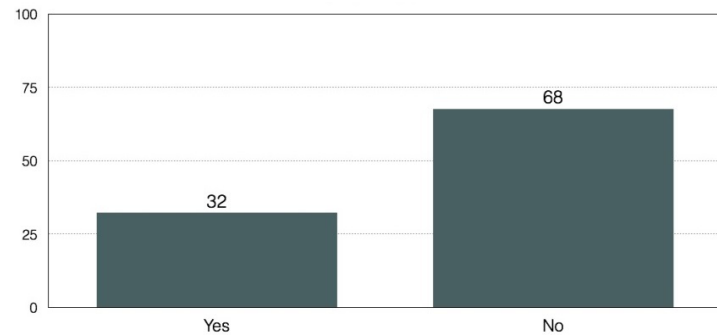


Figure 2. Percentage of candidates who reported they would select a residency program without a visit.

77 Ultrasound Mini Fellowship

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Introduction/Background: Training in the use of emergency ultrasound (EUS) is an Accreditation Council for Graduate Medical Education requirement for all emergency medicine (EM) residency programs. There are many EM residency programs with EM faculty who have limited to no training in the core EUS applications. A lack of proficiency by EM faculty is an obstacle to adequate EUS training for residents, and a barrier to the use of ultrasound in daily practice.

Educational Objectives: Increased capability and comfort-level of EUS performed by EM faculty; improved EUS training of EM residents by EM faculty; increased EUS credentialing of EM faculty; increased utilization of clinical EUS by EM faculty; increased EM faculty productivity; and, increased patient safety and patient satisfaction.

Curricular Design: The mini-fellowship is a 4-week comprehensive, skill-building curriculum (see Figure 1). It focuses on developing competency in core EUS applications