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WELCOME FROM THE PROGRAM DIRECTOR

Congratulations and welcome to McGill Emergency medicine – the oldest Royal College Emergency medicine program in Canada! You are among a very few select and privileged individuals to be training in one of North America’s top Emergency Medicine programs.

During your trek through the 5-year Program, you will find it to be both a very exciting yet demanding experience as you strive for excellence and aspire to become a leader in this unique specialty.

During your residency you will be “traveling” across many different specialty areas of medicine and surgery. This will enable you to learn about the urgent and non-urgent problems of each specialty.

In addition to your experiences across these subspecialties, you will also be traveling across emergency departments at various McGill hospital sites. Each Emergency Department has its own special character and strengths. Immerse yourself in the EDs and learn what makes them special, what makes them tick. Your trek will also include crossing the border to the USA for trauma and toxicology rotations (which have always been favorites of the residents). In essence, as you travel through your 5 years of residency, you will be acting as “ambassadors” for McGill Emergency Medicine!

During your trek, you will come across what are called “non-negotiables.” Wednesday mornings are for you! This is protected time for your teaching rounds. Likewise, journal clubs (on the last Wednesday of every rotation) are non-negotiable. You must attend. So, arrange your call schedule accordingly. Unless you are on vacation or on an out of town rotation.

The goal of the McGill Program is not only to make you excellent emergency physicians, but also to help mold you into the future leaders of Emergency Medicine, whether in Montreal, Quebec, the rest of Canada, or abroad. Our graduates can be found across the country and abroad in various leadership positions. As a result our Program has a great reputation locally, nationally, and internationally.

Have fun and work hard.

Carine Haggar
Program Director
McGill University, Royal College Emergency Medicine Training Program

Resident Health and Safety Policy

Preamble.

The environment in the Emergency Department poses many potential threats to the personal safety of Emergency Medicine residents and staff Emergency Physicians. These risks are due to inherent risks of communicable disease, potential threat of physical violence, intimidation and harassment, risk of harm related to shift work, and risk of legal action by patients and families.

The safety and security of all Emergency Medicine residents is of the utmost importance to the McGill Emergency Medicine Program. The Royal College of Physicians and Surgeons of Canada and the College of Family Physicians of Canada have collaborated in developing national standards for evaluating sites used for residency education. Standard “A2.6” states that:

All participating sites must ensure resident safety at all times, particularly considering hazards such as environmental toxins, exposure to infectious agents transmitted through blood and fluid, radiation, and potential exposure to violence from patients and others.”

Furthermore, The Collective Bargaining Agreement (CBA) between the Federation of Medical Residents of Quebec (FMRQ) and the Quebec Provincial government outlines requirements that all hospitals must have in place necessary measures to ensure the safe working environment for all medical residents.

The Emergency Departments of all teaching sites are responsible for ensuring the safety and security of residents training in their facilities in compliance with existing employee safety and security policies/procedures as well as the requirements outlined by the FMRQ and the McGill Post Graduate office.

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. This document also aims to provide residents with references to obtain furthermore information regarding all aspects of safety within their EM training.

Resident Personal Safety:

Residents should adhere to the standards of universal precautions and wear appropriate protective gear during high risk patient interactions (trauma patients, airway management procedures, bleeding patients, and patients presenting with possible infectious illnesses) when necessary. Residents should adhere to hospital Infectious Disease prevention and reporting policies. Residents should keep their immunizations up to date, and should seek advice of the hospital’s Occupational Health and Safety department to obtain appropriate immunization prior to and during rotations abroad.
Residents must possess adequate knowledge of technical skills and practice appropriate technique to protect themselves and others from needle-stick injuries. Residents must recognize the importance of reporting adverse events and be aware of the indications for post exposure prophylaxis.

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). Residents should be aware of emergency procedures if they feel threatened by a patient in the examining room. Examination of potentially psychotic or violent patients should be done in an area where help can be summoned quickly.

If a resident feels that his or her personal safety is threatened, he or she should remove him or herself from the situation in a professional manner and seek immediate assistance. The McGill Emergency Medicine Training program will provide, or a regular basis, special training to residents on how to manage these potentially difficult situations.

Residents must understand the threats related to shift work including signs of physician burnout or substance misuse, impact of shift schedules (ie. Short shifting) and the impact of shift work on interpersonal as well as doctor-patient relationships. Residents are advised to seek assistance from available resources (Program Director, Occupational Health, the PAMQ, or the FMRQ representative) if they are experiencing negative effects of shift work.

Residents should be aware of the importance of safe transportation to and from work. Residents are expected to take precautions when walking alone at night. The request for a security escort to transportation home (e.g., parking lot, bus stop) especially after evening shifts is encouraged.

Residents are advised to have a chaperone for pelvic, breast and rectal exams on women and selected male patients. Residents are advised to ask for a witness during anticipated or developing difficult patient encounters and the importance of careful documentation of these encounters.

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

Threatening behaviour, harassment, and intimidation are never acceptable; whether the source be a patient (or family member), a colleague, an allied health professional, or a supervisor. The McGill EM program holds strong a zero-tolerance policy with respect to this behaviour. We encourage all residents to be fully aware of the Faculty policy on intimidation, and should be made aware that they may report such behaviour without fear of reprisal. The McGill Post Graduate policy on intimidation and harassment can be found at: http://www.mcgill.ca/harass/

Pregnant residents should be aware of specific risks to themselves and their fetus in the training environment, and request accommodations when indicated. Residents are encouraged to consult the FMRQ CBA for specific guidelines with respect to their safety.
Residents are encouraged to review the following guidelines established by the Postgraduate Medical Education office and the FMRQ:


The McGill Post Graduate policy on Resident health and safety: TBA


I. THE CanMEDS ROLES

The Royal College of Physician and Surgeons of Canada has adopted and developed the concept of CanMEDS. It stands for “Canadian Medical Education Directions for Specialists.” It is a description of the well-rounded physician. It describes the ideal roles and competencies a specialist is expected to fulfill. Consequently, these have been incorporated into the McGill Emergency Medicine Royal College training program, and are used as the framework for the overall goals of the residency program. There are 7 CanMEDS roles: Medical Expert, Communicator, Collaborator, Manager, Advocate, Scholar, and Professional. All McGill residents in a Royal College program will be evaluated (and potentially examined) based on these roles.

The following table is a brief description of these roles:

<table>
<thead>
<tr>
<th>CanMed Role</th>
<th>Activity</th>
</tr>
</thead>
</table>
| 1. Medical Expert | • The central role  
                      • Demonstrate diagnostic and therapeutic skills for ethical and           
                          efficient patient care  
                      • Access and apply relevant information to clinical practice  
                      • Demonstrate effective consultation services with respect to patient care, education, and legal opinions |
| 2. Communicator  | • Establishes therapeutic relationships with patients and families  
                      • Obtains and synthesizes relevant history and information from patients, families, and health care team  
                      • Formal presentations at medical conferences  
                      • Communication with allied health staff and consultants |
3. **Collaborator**
- Effectively consults with other physicians and health care professionals.
- Effectively works within an inter-disciplinary health care team, including patients, colleagues and other health care professionals.
- Collaborative care and shared decision making.
- Conflict resolution.

4. **Manager**
- Utilizes time and resources effectively to balance patient care, learning needs, outside activities.
- Allocates finite health care wisely.
- Utilizes information technology to optimize patient care, continued self learning and other activities.

5. **Health Advocate**
- Identifies important determinants of health affecting patients.
- Contributes effectively using their expertise and influence to advance the health and well being of patients, communities and populations.
- Recognizes and responds to those issues where advocacy is appropriate.

6. **Scholar**
- Critically appraises sources of medical information.
- Facilitates learning of patients, students, residents and other health care professionals.
- Contributes to the development of new knowledge.
- Develops, implements and documents personal education strategy.
- Present research at medical conferences.

7. **Professional**
- Delivers the highest quality of care with integrity, honesty and compassion.
- Exhibits appropriate personal and interpersonal professional behaviours.
- Practices medicine ethically consistent with the obligations of a physician.

A more detailed description of the CanMEDS roles can be found on the Royal College Web site:
rcpsc.medical.org/canmeds/index.php
# McGill Emergency Medicine

## Program Goals and Objectives

The Royal College Emergency Medicine program at McGill follows closely the objectives of training (OTRs) and Specialty Training Requirements as outlined on the Royal College website. The following table demonstrates how the CanMEDS objectives are addressed and used as a framework for the overall Goals and Objectives of the McGill emergency medicine program:

<table>
<thead>
<tr>
<th>CanMed Role</th>
<th>Activity</th>
</tr>
</thead>
</table>
| 1. Medical Expert | • Clinical Rotations  
• Specialty rotations outside the Country (trauma in Miami, Toxicology in NY)  
• Academic Half day (strictly protected time)  
• Interactive sessions – monthly core textbook sessions  
• Annual In-training exams (CITE, ABEM, Interactive) as a means to identify knowledge gaps  
• Journal Club  
• Medical simulation  
• Medical conference attendance  
• Area of Interest |
| 2. Communicator   | • CPC competition for Junior residents  
• Journal Club presentations  
• Medical Simulation sessions  
• Grand Rounds presentations (R2-R4)  
• Clinical Rotations  
• Residency Research Day  
• Mock Oral exams (R5)  
• Clinical Teaching Unit rotation (R4)  
• Formal presentations at medical conferences |
| 3. Collaborator   | • Clinical rotations  
• Simulation Centre session  
• Mock Codes  
• Special Academic days |
| 4. Manager        | • Medico-Administration rotation (R4)  
• Clinical Rotations (with graded responsibility)  
• McGill seminar on Practice Management  
• Special Academic Days |
| 5. Health Advocate| • Clinical rotations (role modeling)  
• Special Academic Days/Grand Rounds  
• Medical Simulation |
<table>
<thead>
<tr>
<th>6. Scholar</th>
<th>7. Professional</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Clinical Rotations</td>
<td>• Clinical Rotations (role modeling)</td>
</tr>
<tr>
<td>• Journal Watch</td>
<td>• Special Academic Sessions/grand rounds on medical ethics and professionalism</td>
</tr>
<tr>
<td>• Journal Club</td>
<td>• McGill faculty initiatives/seminars on professionalism</td>
</tr>
<tr>
<td>• Grand Rounds</td>
<td>• Role modeling</td>
</tr>
<tr>
<td>• Epidemiology course</td>
<td></td>
</tr>
<tr>
<td>• ED/Journal Club rotation</td>
<td></td>
</tr>
<tr>
<td>• Clinical Research Project</td>
<td></td>
</tr>
<tr>
<td>• Subscriptions to on-line EM resources</td>
<td></td>
</tr>
<tr>
<td>• Medical conference attendance</td>
<td></td>
</tr>
<tr>
<td>• Area of Interest</td>
<td></td>
</tr>
</tbody>
</table>
II. PROGRAM & ACADEMIA
# EMERGENCY MEDICINE 5-YEAR CURRICULUM

## Rotations per year:

<table>
<thead>
<tr>
<th>Rotations</th>
<th>Year 1</th>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
<th>5 year Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult ED</td>
<td>3</td>
<td>3</td>
<td>7</td>
<td>2</td>
<td>6</td>
<td>21</td>
</tr>
<tr>
<td>Pediatric ED</td>
<td>1</td>
<td>1.5</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>6.5</td>
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<tr>
<td>Trauma Service</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Sports Medicine</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Obs/Gyn</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Short stay unit</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Critical Care/ICU</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
<td>3</td>
</tr>
<tr>
<td>Anaesthesia</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Psychiatry</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Epidemiology</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>ED/Journal Club</td>
<td>1</td>
<td></td>
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</tr>
<tr>
<td>Toxicology</td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>Cardiology Consults</td>
<td>1</td>
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<td>1</td>
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<tr>
<td>CCU</td>
<td>1</td>
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</tr>
<tr>
<td>Pediatric ICU</td>
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<td></td>
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<tr>
<td>Pediatric Anesthesia</td>
<td>0.5</td>
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<tr>
<td>MSK/Ortho</td>
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<tr>
<td>ED/Ultrasound</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Community/Rural ED</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Electives</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Neurology</td>
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<tr>
<td>Neuro ICU</td>
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<tr>
<td>EMS</td>
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<tr>
<td>Area of Interest</td>
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<tr>
<td>CTU (Clinical Teaching Unit)</td>
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</tr>
<tr>
<td>Internal Medicine Consult Service</td>
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<td></td>
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</tr>
<tr>
<td>Medico-Administration</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Research*</td>
<td>(1)</td>
<td>(2)</td>
<td>(1)</td>
<td>(1)</td>
<td>(5)*</td>
<td></td>
</tr>
<tr>
<td><strong>Yearly Total:</strong></td>
<td>13</td>
<td>13</td>
<td>13</td>
<td>13</td>
<td>13</td>
<td>65</td>
</tr>
</tbody>
</table>

* Over the 5 years, there are 20 weeks dedicated to research time. When requested, these weeks are deducted from the adult emergency medicine rotations
Academic Half Day

Every Wednesday from 8h30 to 12h00, we hold our Academic Rounds. This is your protected time! Thus, attendance at Rounds is mandatory. Rounds are based at the Royal Victoria Hospital, room M3.30. They are also held at the Jewish General Hospital in the Nurses’ Lecture Hall, room A1.39, the first week of each period as well as at the McGill Simulation Centre. The third Wednesday of every period, academic rounds are followed by Interactive Rounds. Interactives have been instituted to help the resident study and prepare for the final exam. For the Junior Residents (R1 – R2), will cover the text *Emergency Medicine: A Comprehensive Study Guide* by Judith Tintinalli. The entire textbook will be covered over a two-year period. The resident is expected to have read the chapters in advance. Residents will be quizzed in an open and interactive format. Note that there is an exam at the end of each year. The Senior Residents will cover the text *Rosen’s Emergency Medicine: Concepts and clinical Practice*.

- Week 1: JGH (with the CCFP-EM residents)
- Week 2: RVH
- Week 3: RVH (Interactive Rounds in afternoon)
- Week 4: RVH (with CCFP-EM residents)

Content of rounds may include Grand Rounds presentations by faculty or residents, CPC case Presentations, M&Ms, Simulation Days and special event days. Three times per year, each Adult Emergency Department organizes a “site day” where a special guest(s) are invited to present on cutting edge Emergency Medicine.

**Please note: attendance at Rounds is mandatory. It is viewed as being the same as showing up to an Emergency shift or clinical responsibilities on the wards. Absence from Rounds will result in sick days being deducted.**
JOURNAL CLUB
and
Critical Appraisal Topic (CAT)

Essential Details

When: Monthly Academic Rounds

Where: RVH, JGH

Who: FRCPC and CCFPEM residents. These sessions are core protected time, so attendance is mandatory. Staff and invited guests are strongly encouraged to attend.

Article Distribution:
1. Critical Appraisal Topics (CAT) is under the responsibility of the CCFP-em program. A resident is assigned to provide a review and critical appraisal of recent topic in emergency medicine.
2. Journal Club. The article(s) are chosen by 2 FRCP residents. Residents are encouraged to review their article(s) with their assigned mentors or other faculty members. The article(s) chosen must then be sent via the McGill EM ListServ distribution list, 1 WEEK PRIOR to the Journal Club

Summary: Provide a written summary, less than 1 page, on what was learned. Also, provide access to reference articles/resources. This summary should be also be submitted to the listserv (within 1 week of the Journal Club.

Food Budget: When ordering food, the Program will cover a maximum of $350. The receipt should be promptly submitted to Elisa at the RVH room A4.61.

Goals

SCHOLAR

1. To keep residents and staff abreast of current cutting edge literature and best literature.
2. To learn the techniques of critical appraisal as they apply to different study designs.
3. To learn the three general critical appraisal skills of evaluating the validity of study methods, appreciating the strength and precision of results and applying the results with an eye to changing practice or informing decision-making.
4. To learn and apply the EBM concepts and skills.
5. To learn skills and habits that will allow lifelong reading behaviour and learning habits.
6. To become aware of important publications outside the EM literature.

**MEDICAL EXPERT**
1. To develop knowledge on key topics and the supporting literature.

2. To improve clinical practice consistent with the latest research findings and critically appraised best evidence.

3. To integrate critically appraised best evidence into decision making through considerations that include values and perspectives that relate to the ethical, managerial, professional and health advocate dimensions of an emergency physician.

**COMMUNICATOR**
1. To develop and hone interactive teaching and presentation skills.

2. Based on the knowledge and insights gained, to effectively and impressively communicate with your patients and colleagues in other specialties on critical and up to date issues.

3. Consideration should be given to reaching a wider audience of EM colleagues through peer-reviewed publication of your Journal Club summaries (posting on website, writing letters to editors, publishing summaries).

**COLLABORATOR**
1. To work as a team with other residents (both FRCPC and CCFPEM).

2. To invite and interact in a dynamic learning environment with special guests who are experts on the topic or issues being presented.

**Format**
Over the year, one half of the Journal Clubs will be dedicated to teaching some of the principals of EBM (evidenced based medicine) while the remainder will be “theme” based (where a selection of current cutting edge articles are presented on a topic).
If you are doing an EBM format, choose 1 article that highlights the EBM concept that you want the residents to learn. The article should not be more than 2 years old. A good EBM reference is JAMA’s “Users’ Guide to the Medical Literature: A Manual for Evidenced-based Clinical Practice”. At the end of your session, please provide a brief summary, either written or distributed on-line. This should highlight the concept taught and indicate on-line references for review.

If you are assigned to do a topic or “theme” you will present and critically appraise 2 or 3 cutting edge and up to date articles. In addition to presenting the articles, you should briefly present your search strategy. The resident is strongly encouraged to invite a guest to JC who can act as an expert on this topic. A brief summary should be provided at the end of the session, either written or on-line. This summary should be sent to Dr. Joel Turner to put on our web site.

To facilitate learning small group interactions are beneficial. Experience has shown us that ideally there should be at least 4 groups. Be creative. Consider pre-arranging the groups with articles and questions so that each group arrives already prepared on a specific article.

For the FRCPC residents, consult your mentor well in advance. They can provide you with ideas and help review topic itself, the objectives, content and educational strategy of your presentation. Let him/her know the date and that you are counting on their support!
Program Evaluation Templates
**McGill University**  
FRCP EM

**Evaluated By:** evaluator's name  
**Evaluating:** person (role) or mentor's name (if applicable)  
**Dates:** start date to end date

* indicates a mandatory response

---

# ROTATION FEEDBACK FORM

<table>
<thead>
<tr>
<th></th>
<th>N/A</th>
<th>1 Poor</th>
<th>2 Fair</th>
<th>3 Good</th>
<th>4 Very Good</th>
<th>5 Excellent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Orientation</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
</tbody>
</table>

**Workload & environment**

<table>
<thead>
<tr>
<th></th>
<th>N/A</th>
<th>1 Poor</th>
<th>2 Fair</th>
<th>3 Good</th>
<th>4 Very Good</th>
<th>5 Excellent</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>Nursing Support</em></td>
<td></td>
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</tr>
<tr>
<td><em>Clerical Support</em></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><em>ED Attending Staff Support</em></td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td><em>Consultative Support</em></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><em>Number of cases per resident</em></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><em>Level of clinical responsibility</em></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><em>Educational opportunities vs. service demands</em></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**(R3-R4 ONLY) Teaching responsibilities of:**

<table>
<thead>
<tr>
<th></th>
<th>N/A</th>
<th>1 Too light</th>
<th>2 Too heavy</th>
<th>3 Good</th>
<th>4 Very Good</th>
<th>5 Excellent</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>Junior ED Residents</em></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>N/A</th>
<th>1 Poor</th>
<th>2 Fair</th>
<th>3 Good</th>
<th>4 Very Good</th>
<th>5 Excellent</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>Off-service Residents/Students</em></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Comments:

---

**Lectures**

<table>
<thead>
<tr>
<th></th>
<th>N/A</th>
<th>1 (1-3)</th>
<th>2 (3-6)</th>
<th>3 (6-9)</th>
<th>4 (9-12)</th>
<th>5 (&gt;12)</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>Attendance</em></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>N/A</th>
<th>1 Poor</th>
<th>2 Fair</th>
<th>3 Good</th>
<th>4 Very Good</th>
<th>5 Excellent</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>Quality of presentations:</em></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>N/A</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>&gt;4</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>(R3-R4 ONLY) Number you taught?</em></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Comments:

---

**Clinical Teaching**

<table>
<thead>
<tr>
<th></th>
<th>N/A</th>
<th>1 Poor</th>
<th>2 Fair</th>
<th>3 Good</th>
<th>4 Very Good</th>
<th>5 Excellent</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>Amount of teaching</em></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

---

*Page 1*
Resident Daily Evaluation

Please evaluate TWO or THREE areas where the resident made an impression on this shift. Please also provide specific written comments and provide examples when possible. All rankings of "1", "2" & "4" must be justified.

**MEDICAL EXPERT**

<table>
<thead>
<tr>
<th></th>
<th>N/A</th>
<th>1 Unsatisfactory</th>
<th>2 Needs Work</th>
<th>3 At Level</th>
<th>4 Particular Strength</th>
</tr>
</thead>
<tbody>
<tr>
<td>Basic scientific knowledge</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>Basic clinical knowledge</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>History &amp; physical exam</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>Interpretation &amp; utilization of information</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>Clinical judgment &amp; decision making</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>Safely performs procedural skills appropriate for level</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
</tbody>
</table>

Comment:

**COMMUNICATOR**

<table>
<thead>
<tr>
<th></th>
<th>N/A</th>
<th>1 Unsatisfactory</th>
<th>2 Needs Work</th>
<th>3 At Level</th>
<th>4 Particular Strength</th>
</tr>
</thead>
<tbody>
<tr>
<td>Communication with patients and families</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>Communication with physicians and other allied health professionals</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>Written (charting, orders)</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
</tbody>
</table>

**COLLABORATOR**

<table>
<thead>
<tr>
<th></th>
<th>N/A</th>
<th>1 Unsatisfactory</th>
<th>2 Needs Work</th>
<th>3 At Level</th>
<th>4 Particular Strength</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interacts &amp; consults effectively with all health professionals by recognizing &amp; acknowledging their roles &amp; expertise</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>Delegates effectively</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
</tbody>
</table>

**MANAGER**

<table>
<thead>
<tr>
<th></th>
<th>N/A</th>
<th>1 Unsatisfactory</th>
<th>2 Needs Work</th>
<th>3 At Level</th>
<th>4 Particular Strength</th>
</tr>
</thead>
<tbody>
<tr>
<td>Understands &amp; uses information technology</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>Uses health care resources cost-effectively</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>Organization of work &amp; time management</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>R3-S manages flow</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
</tbody>
</table>

**HEALTH ADVOCATE**

<table>
<thead>
<tr>
<th></th>
<th>N/A</th>
<th>1 Unsatisfactory</th>
<th>2 Needs Work</th>
<th>3 At Level</th>
<th>4 Particular Strength</th>
</tr>
</thead>
<tbody>
<tr>
<td>Advocates for community</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>Advocates for patient</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
</tbody>
</table>
I worked with the following staff:

**MUHC Staff**
- Alam, Naveed
- Bank, Ilana
- Beique, Marc
- Bernadin, Bruno
- Bhattacharjee, Farhan
- Bhatt, Mala
- Borreman, Stephane
- Boucher, Gilbert
- Boutin, Manen
- Bridges, Eileen
- Cardona, Caroline
- Carvalho, Anna
- Cermignani, Monica
- Chalut, Dominic
- Daignault, Peter
- Dankoff, Fred
- De Champlain, Francois
- Delaney, Scott
- Diksic, Dubravka
- Doucet, Alison
- Doyle, Ken
- Drummond, Bob
- Dubrovsky, Sasha
- Dufresne, Francois
- Eisman, Harley
- Eldaoud
- Enco, Michael
- Ferrarotto, Domenic
- Font, Jorge
- Foxford, Robert
- Gilbert, Francois
- Gosselin, Sophie
- Gosselin, Anne-Marie
- Greenstone, Ilana
- Guy, John
- Haggard, Carine
- Hedrei, Philip
- Kumka, Gillian
- Lacroix, Vincent
- Laliberte, Martin
- Lam, Margaret
- Larsy, David
- Le Van, Mai-Anh
- Lee, Gary
- Levine, Zach
- Liesegang, Nadine
- Lisanu, Mesfin
- MacDonald, Suzanne
- Mah, Rick
- May, Richard
- McGillivray, David
- Melanson, Pat
- Meyers, Christine
- Millar, Catherine
- Nemeth, Joe
- Persson, Megan
- Plotnick, Laurie
- Poirier, Vincent
- Primavesi, Robert
- Rigault, Aude
- Robert, Sawoniak
- Rohe, Phillippe
- Roper, Mark
- Ryder, Arthur
- Mydz, Emilia
- Saluja, Sanjeet-Singh
- Shulman, Mitch
- Sigman, Eric
- Soos-Kaposy, Eva
- Stewart, Jessica
- Stolovitz, Cynthia
- Su, Jean
- Troquet, Jean-Marc
- Turnbull, Jennifer
### SCHOLAR

<table>
<thead>
<tr>
<th></th>
<th>N/A</th>
<th>1 - Unsatisfactory</th>
<th>2 - Needs Work</th>
<th>3 - At Level</th>
<th>4 - Particular Strength</th>
</tr>
</thead>
<tbody>
<tr>
<td>Motivation to read &amp; acquire knowledge</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>Critical appraisal skills</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>Teaching skills (especially R3-5)</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
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</table>

### PROFESSIONAL

<table>
<thead>
<tr>
<th></th>
<th>N/A</th>
<th>1 - Unsatisfactory</th>
<th>2 - Needs Work</th>
<th>3 - At Level</th>
<th>4 - Particular Strength</th>
</tr>
</thead>
<tbody>
<tr>
<td>Integrity &amp; honesty</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>Responsibility &amp; self-discipline</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>Sensitivity &amp; respect for diversity</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>Shows compassion &amp; empathy in dealings with patients and families</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>Ethical awareness in clinical situations</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>Recognition of own limitations, seeks advice when needed</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
</tbody>
</table>

### NEEDS IMPROVEMENT MEETS ABOVE EXPECTATIONS

<table>
<thead>
<tr>
<th></th>
<th>Needs to catch up to expected level</th>
<th>As expected</th>
<th>At least one year beyond expected level</th>
</tr>
</thead>
</table>
*OVERALL PERFORMANCE COMPARED TO EXPECTED LEVEL

General Comments

Feedback on procedures

The following will be displayed on forms where feedback is enabled...
(for the evaluator to answer...)

*Did you give feedback at the end of the shift/rotation? / Avez-vous donné de la rétroaction au stagiaire à la fin du stage?*

- Yes/Oui
- No/Non

(for the evaluatee to answer...)

*Did you receive feedback at the end of the rotation? / Avez-vous reçu de la rétroaction à la fin du stage?*

- Yes/Oui
- No/Non

*Are you in agreement with this assessment? / Etes-vous d'accord avec cette évaluation?*

- Yes/Oui
- No/Non

Please enter any comments you have (if any) on this evaluation. / Si vous le désirez, s.v.p nous donner vos commentaires plus bas.
*1. What was the best thing about this rotation?


*2. What was the worst thing about this rotation?


*3. Comments and suggestions for improvements:


*OVERALL EVALUATION


1) A: If yes, please check all that apply to the mistreatment /intimidation/harassment:

☐ Verbal Abuse
☐ Racial Remarks
☐ Sexual Remarks
☐ Sexual advances
☐ Physical Abuse/Violence
☐ Threatening language

If yes is selected, please provide comments:


*1) Were you subjected to mistreatment /intimidation/harassment by this supervisor?

Avez-vous fait l'objet de maltraitance/d'intimidation de la part de ce superviseur?  
☐ No  
☐ Yes

If yes is selected, please provide comments:


Page 3
JOURNAL CLUB EVALUATION FORM

CONTENT OF JOURNAL CLUB:

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neutral</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>The learning objectives were clearly identified</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>This session facilitated understanding of an EBM skill or technique</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>OR</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The articles selected and discussion facilitated understanding of a core EM issue/topic using EBM skill set.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>The content was appropriate for my level of EBM knowledge.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>The learning objectives were met</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
</tbody>
</table>

DELIVERY:

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neutral</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>The presentation was clear/well organised.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>The presenter adequately answered my questions</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>Effectively facilitated group discussion(s).</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>The length of the presentation was appropriate</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
</tbody>
</table>

SUPPORT MATERIALS:

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neutral</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>Use of handouts (if any) were helpful.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>Use of AV material was appropriate and aided presentation.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
</tbody>
</table>

*COMMENTS:

[Blank space for comments]

The following will be displayed on forms where feedback is enabled...
(for the evaluator to answer...)

*Did you give feedback at the end of the shift/rotation? / Avez-vous donné de la rétroaction au stagiaire à la fin du stage?
○ Yes/Oui
○ No/Non

(for the evaluatee to answer...)

*Did you receive feedback at the end of the rotation? / Avez-vous reçu de la rétroaction à la fin du stage?
○ Yes/Oui
○ No/Non

*Are you in agreement with this assessment? / Etes-vous d'accord avec cette évaluation?
○ Yes/Oui
○ No/Non

Please enter any comments you have (if any) on this evaluation. / Si vous le désirez, svp nous donner vos commentaires plus bas.
If Other, please specify:
Autre : Veuillez spécifier

Comments about the mistreatment/intimidation/harassment:
Commentaires

*2) Are you aware of the mechanism of filing complaints with regards to mistreatment of learners?
Êtes-vous au courant du mécanisme de dépôt des plaintes pour les apprenants qui font l'objet de maltraitance ?
○ No
○ Yes

Please view this link for more details on the mechanism of filing complaints: http://www.mcgill.ca/medsra/

The following will be displayed on forms where feedback is enabled...
(for the evaluator to answer...)

*Did you give feedback at the end of the shift/rotation? / Avez-vous donné de la rétroaction au stagiaire à la fin du stage?
○ Yes/Oui
○ No/Non

(for the evaluatee to answer...)

*Did you receive feedback at the end of the rotation? / Avez-vous reçu de la rétroaction à la fin du stage?
○ Yes/Oui
○ No/Non

*Are you in agreement with this assessment? / Etes-vous d'accord avec cette évaluation?
○ Yes/Oui
○ No/Non

Please enter any comments you have (if any) on this evaluation. / Si vous le désirez, svp nous donner vos commentaires plus bas.


**FACULTY EVALUATION FORM**

*indicates a mandatory response*

**Instructions to residents:**

The ED site-coordinator will provide you with the names of 2-3 staff that you will evaluate. Complete 1 form per staff. Please give specific examples of what you believe the Staff does well, in addition to suggestions for improvement. Your comments must be submitted typed and sent electronically to the E.M. Residency Program Coordinator by the first Wednesday of the next period (following the ED rotation).

Why are we doing this? Like the resident, the staff deserves constructive feedback so that we can improve upon our performance. The staff also uses these evaluations as part of their teaching portfolio in order to gain academic promotion within the University. At the end of the academic year, the program coordinator will compile the evaluations. The final report will be sent to the program director and the staff. If there are any problems, the program director will deal with it through either the site director or the ED directors. The process is designed to be entirely anonymous!

**MEDICAL EXPERT:**

<table>
<thead>
<tr>
<th></th>
<th>N/A</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neutral</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>Demonstrates depth and breadth of knowledge and applies in the clinical setting.</em></td>
<td></td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td><em>Demonstrates technical skills (intubation, casting, lines etc.).</em></td>
<td></td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
</tbody>
</table>

**COMMUNICATOR:**

<table>
<thead>
<tr>
<th></th>
<th>N/A</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neutral</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>Is approachable.</em></td>
<td></td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td><em>Demonstrates effective communication with emergency colleagues and other allied health professionals.</em></td>
<td></td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td><em>Demonstrates effective communication with patients and families.</em></td>
<td></td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
</tbody>
</table>

**COLLABORATOR:**

<table>
<thead>
<tr>
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<th>N/A</th>
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<tr>
<td><em>Interacts effectively with all health professionals (nurses, residents, students, support staff, consultants).</em></td>
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**MANAGER:**

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<td><em>Demonstrates / teaches cost effective resource utilization.</em></td>
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<td><em>Demonstrates effective organization and management of work and time.</em></td>
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<td><em>Encourages house staff to take appropriate level of responsibility</em></td>
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<td><em>Allows management skills of &quot;running&quot; the ED (R5).</em></td>
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**HEALTH ADVOCATE:**

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<tr>
<td><em>Demonstrates appropriate intervention on behalf of the patient (tests, consults, admission, and habit/life-style changes).</em></td>
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**SCHOLAR:**

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McGill Emergency Medicine - Clinical Pathological Cases Competition

Presenter Judging Sheet

Presenter’s name: ___________________________ Discussant’s name: ___________________________

Is the case of high quality and appropriate for the CPC?

| Poor case, too simple for discussion, not appropriate for the CPC, not solvable | Good quality, interesting case, appropriate for CPC, average degree of Solvability | High quality case, intriguing, very good CPC case, challenging but solvable |
| 1 point | 2 points | 3 points |
| 4 points | 5 points |

Points: ________ x 3 = __________

Was the information provided to the discussant complete?

| Information appears to be withheld, too much “give away” information | Sufficient information to allow thorough discussion but missing some key data | All relevant data presented, no critical data missing or withheld, no misleading data presented |
| 1 point | 2 points | 3 points |
| 4 points | 5 points |

Points: ________

Was the discussion section of high quality and well organized?

| Poorly organized, disjointed presentation, did not demonstrate solvability or relevance, weak discussion of final diagnosis. | Good organization conveyed both solvability and relevance, good discussion of final diagnosis. | Well organized, clearly demonstrated EM relevance and solvability, high quality discussion of final diagnosis. |
| 1 point | 2 points | 3 points |
| 4 points | 5 points |

Points: ________ x3 = __________

How were the AV Materials?

| Slides difficult to read, spelling errors, distracting and irrelevant slides. | Good Slides, readable, minimal errors, adhered to “good slidemaking” rules | Nice, clean, easily read slides, slides added to presentation, no errors |
| 1 point | 2 points | 3 points |
| 4 points | 5 points |

Points: ________

How was the presentation style and clarity?

| Misspoke, too much jargon, poor eye contact, monotone, mumbled, distracting movements | Good presentation skills, minimal missteps, good tone, good speed, good eye contact | Engaging, interesting, well rehearsed, great speaker mechanics |
| 1 point | 2 points | 3 points |
| 4 points | 5 points |

Points: ________

Time Penalty

| More than 60 seconds over | 30-60 seconds over | Less than 30 seconds over |
| 0 points | 3 points | 5 points |

Points: ________ ** Subtract 5 points from total score if more than 90 seconds over, presentation terminated by coordinator.

Total number of points: __________

Comments to go to presenter. Use back side if needed.
*Teaches using evidence-based medicine.  

*Provides quality practical teaching (bedside, use/interpretation of investigations).  

*Provides quality formal teaching (daily teaching).

PROFESSIONAL:

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<th>N/A</th>
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<th>Disagree</th>
<th>Neutral</th>
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<tr>
<td>*Is a good role model as a physician/teacher.</td>
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*Demonstrates knowledge of principles of ethics and applies to the clinical situation.

**Comments:**

1) *Were you subjected to mistreatment/intimidation/harassment by this supervisor?*

   *Avez-vous été victime de maltraitance/d'intimidation de la part de ce superviseur?*

   - No/Non
   - Yes/Oui

   1) A: If yes, please check all that apply to the mistreatment/intimidation/harassment:

   *Si oui, veuillez cocher toutes les cases qui ont rapport à la maltraitance/d'intimidation/au harcèlement:*

   - Verbal Abuse / Abus verbal
   - Racial remarks / Commentaires raciaux
   - Sexist remarks / Commentaires sexistes
   - Sexual advances / Avances sexuelles
   - Physical Abuse/Violence / Abus physique-Violence
   - Threatening language / Langage menaçant
   - Other (please specify) / Autre (veuillez préciser)

   If Other, please specify:

   *Autre : Veuillez spécifier*

   Comments about the mistreatment/intimidation/harassment:

   *Commentaires*

2) *Are you aware of the mechanism of filing complaints with regards to mistreatment of learners?*

   *Êtes-vous au courant du mécanisme de dépôt des plaintes pour les apprenants qui font l'objet de maltraitance?*

   - No/Non
   - Yes/Oui

   Please view this link for more details on the mechanism of filing complaints: [http://www.mcgill.ca/medsra/](http://www.mcgill.ca/medsra/)

The following will be displayed on forms where feedback is enabled...

*Did you give feedback at the end of the shift/rotation? / Avez-vous donné de la rétroaction au stagiaire à la fin du stage?*

   - Yes/Oui
   - No/Non

(for the evaluator to answer...)

*Did you receive feedback at the end of the rotation? / Avez-vous reçu de la rétroaction à la fin du stage?*
Industry Companies Funding Policy

1. The McGill Emergency Medicine Residency has a need to collect funds to help sponsor emergency academia and education of the residents. Consequently, the McGill Emergency Residency Education fund has been created. It is to be used for academic purposes that benefit the program as a whole (e.g. sponsoring speakers, educational equipment). It is not to be used for personal benefit (books, trips etc.) nor is it to be used for food.

2. (Pharmaceutical) companies may make unlimited donations (frequency and amount, with a suggested minimum of $750) to the Emergency Medicine Residency educational fund.

3. No obligations or conditions can be set by the pharmaceutical companies in exchange for the donations (however, the names of donors will be listed amongst the companies making donations).

4. In return, the companies will be allowed to attend up to 4 Journal Clubs per year. However, there will be only one company present per journal club. The company representative will set up their display outside the Journal Club room. They will not be allowed to give a formal presentation to those attending the JC. Residents and staff are free to politely interact with the company representative outside of the JC room.

5. Contributions will all go into a single fund, and the amount contributed will remain undisclosed to both the residents and the other pharmaceutical companies.

6. The Chief residents will continue to manage the fund, but expenditures greater than $100.00 will require consensus and approval by both Chiefs and the Program Director.
III. ROTATIONS GOALS & OBJECTIVES
ADMINISTRATION

Goals and Objectives
This four-week rotation is designed to teach effective management and administration skills as they relate to the practice of Emergency Medicine. The resident will be exposed to all levels of administration. The resident will be expected to learn basic principles of leadership and administration, develop an understanding of the function of the Emergency Department within the institution and its relationship with other departments. Other key objectives will include: understanding important medico-legal aspects of emergency medicine, understand aspects of quality assurance, professionalism, risk management, and crisis resource management.

The rotation supervisor is Dr. Joel Turner at the Jewish General Hospital, with participation of ED staff, DPS, MDs, coordinators and departmental chiefs.

Structure
1. During this rotation, the resident will receive lectures in ED administration and hospital topics covering interdepartmental protocols and policies. Some of the topics presented include:
   a. ED Design
   b. Information Technology and the Medical Health Record
   c. Canadian Triage System
   d. Trauma Systems
   e. Morbidity and Mortality Review Process
   f. Patient Complaints
   g. Quality Assurance
   h. Legal Aspects of Emergency Medicine
   i. Career Planning
   j. Time Management
   k. Protocol and Procedure development
   l. Overcrowding and Bed utilization
   m. Lean philosophy on patient flow
   n. Role of the DPS, Role of the Department Chief
   o. Negotiation and Conflict Resolution
   p. Practice Management seminar
2. The resident will familiarize themselves with the process of responding either to a patient complaint letter, or to investigating and completing a Morbidity and Mortality project investigating the various issues related to medical and system errors. Both projects are completed under the supervision of a faculty mentor and it is expected that the resident present his/her findings at Rounds.

3. The resident will participate directly in the ED as a flow coordinator at all three sites learning how to handle different flow situations and cases. Clinical responsibilities will include 2 shifts at each of the 3 adult EM sites.

**Evaluation**

Evaluation of the resident will be based on their attendance and participation in lecture, the feedback during their reassessment shifts in the ED, as well as their administrative project (M & M or patient complaint letter).

**MEDICAL EXPERT**

The resident will be expected to 1. participate in the management of difficult cases, 2. Learn efficient decision making in cases of unclear disposition, 3. deciding on admissions/discharge vs. consultations. 4. The resident will focus on re-assessment of cases already present in the ED, and learn the evolution of the patient stay and decide on appropriate work-up based on their current state which may have evolved during the patient’s stay in the ED. 5. The resident will be required to learn the key protocols and policy guidelines as they apply to each of the ED sites.

**COMMUNICATOR**

The resident will learn to deal effectively with patients and families in increasingly difficult and challenging patient encounters. He/She will need to be able to communicate effectively at meetings. The resident will also need to provide effective written response to a patient complaint letter or M+M case.

**COLLABORATOR**

The resident will be expected to become comfortable communicating and collaborating with residents, other health care providers, consultant staff physicians.

**MANAGER**

The resident will be expected to demonstrates organizational skills in ED administration; learn to organize, manage and lead committees both on an ED level and a hospital level. This may includes budgeting and staffing according to objective measures.
**HEALTH ADVOCATE**

The resident will be expected to be able to recognize the determinants of illness and injury seen in the Emergency Department and able to act on these findings; advocating for the patients in the ED, sometimes through a long stay in the emergency.

**SCHOLAR**

The resident will be expected to familiarize themselves with the concepts of medical and system errors, and how to determine the roles they play in undesirable patient outcomes. A Mandatory project will be required to be completed. This will includes either a response to a patient complaint letter, or to an M+M case. Residents are encouraged to read academic EM material relevant to topics addressed.

**PROFESSIONAL**

The resident will be expected to treat patients and fellow staff with non judgmental respect, prepare for meetings and learning encounters, exhibit professional demeanour (appearance, punctuality, work ethic). He/She will be required to exhibit the following qualities: reliability, honesty, maturity, respect for others, accept constructive criticism and demonstrate sincere concern for others. The resident will need to demonstrate understanding of physician wellness issues and be aware of ethical considerations of Emergency Medicine practice.

**Supervisor:** Dr. Joel Turner  
**Administrative Coordinator:** Ms. Debbie Pollack ([emacademics.jgh@mail.mcgill.ca](mailto:emacademics.jgh@mail.mcgill.ca))  
**Telephone:** 514-340-8222, ext. 3898
ADULT EMERGENCY MEDICINE

The General Role of an Emergency Specialist

The Specialist in Emergency Medicine is foremost a Clinician who uses the requisite knowledge and skills to diagnose and manage patients presenting with a wide spectrum of acute illness and/or injury including:

1. acute life threatening events
2. exacerbations of pre-existing or chronic conditions
3. common minor presentations.
4. psycho-social issues.

He/she uses highly developed clinical reasoning skills to care for patients with acute and undifferentiated problems, often before complete clinical or diagnostic information is available.

The Specialist in Emergency Medicine is also a Leader and Collaborator, interacting effectively with other medical professions, colleagues and systems. He/she facilitates the provision of prompt, efficient, high quality and cost effective acute medical care to individuals and communities.

The Specialist in Emergency Medicine is an Academic and Community Resource, providing leadership and the Administration of Emergency Medical Systems and Programs, and the conduct of relevant Research and Education. He/she assumes these roles with the goal of advancing knowledge and improving individual or community health outcomes.

In order to develop emergency medicine specialty skills, the McGill emergency medicine resident will complete a total of 21 months of adult EM. Following the standard grid, 15 of these months will be during senior years (R3-5) and 6 will be during junior years (R1-R2). The rotations will be spread equally among the 3 adult sites (MGH, RVH, JGH). One additional month will be located in a community based ED (Wakefield, Saint Mary’s Hospital).

The following other clinical rotations are also primarily based in the ED: Psychiatry, Toxicology, MSK/ortho, ED ultrasound, Clinical Teaching Unit (CTU), Medico-Administration, ED/journal club, internal medicine consults, cardiology consults, neurology consults, and trauma.

During the 5 years of residency, there is a graded level of responsibility as the resident becomes more senior. The first three years are conducted under a more direct supervision of the attending physicians than
subsequent years. The resident should focus on gaining clinical knowledge and acquiring technical expertise. By the end of the R2 year, the resident will have finished all the basic clinical rotations as well as most of the acute care or ICU rotations. Thus at this time the resident should have an approach to almost any problem that presents to the ED. The R4 year focuses on abilities to carry an increasing clinical load, concomitant management of several patients and development of teaching skills. By the end of the R4 year, the resident may be expected to run a section (either acute or ambulatory) of the ED. R5 level residents will be expected to manage flow, teach while managing their own patients. In general, during the last months of training, R5 residents will assume the attending physician role, while the attending will work "as a resident".

EM residents should be actively studying around the cases they see. Depth of knowledge will be expected to increase as the resident does more literature searches. It can not be stressed enough that the Emergency Medicine resident should be orienting his/her learning around 1) clinical presentations; 2) pathophysiology and 3) the best evidence that exists in the current literature. Critical thinking is strongly encouraged so that the resident understands how to make appropriately safe evidence based clinical decisions.

It is obviously very difficult to identify specific areas of knowledge for each year of the residency. During the monthly interactive sessions, the EM resident will have read all of Rosen and Tintinalli. Consequently, all of the core topics will have been covered at least twice during the residency. The resident can also refer to the objectives of the various core rotations to use as guides of what he/she should know and be able to do.

**MEDICAL EXPERT**

1. Possesses the basic scientific and clinical knowledge necessary to rapidly assess and manage a full spectrum of patients of all ages, with acute or undifferentiated illness and/or injury, ranging from the life threatening to common minor presentations.

2. Performs appropriately selective, accurate and well organized history and physical examinations.

3. Presents the history and physical in a concise, organized approach, including all relevant information.

4. Must have an approach to and be able to develop a differential diagnosis to the common presenting complaints.
5. Be able to develop a work-up plan, understanding the indications, interpretation and limitations of:
   a. laboratory tests
   b. radiologic investigations
   c. ECGs.
6. Be able to develop a comprehensive care plan for the patient to the point of disposition (discharge, admission, consult).
7. Demonstrate an understanding of the natural history, pathophysiology, and treatment of the acute and common disorders that present to the ED.
8. Selects and performs medical procedures (indications, contraindications and complications) in an appropriate, safe and skillful manner with due attention to minimizing patient risk and discomfort. The technical skills include, but are not limited to:
   a. Vascular access (peripheral and central)
   b. Wound Management (examination, anaesthesia, irrigation, debridement, closure techniques)
   c. Anaesthesia (local, nerve blocks, procedural sedation)
   d. Orthopedic procedures (reduction, immobilization, splinting and casting, arthrocentesis)
   e. Abdominal procedures (NG insertion, abdominal paracentesis)
   f. Arterial Blood gas
   g. Lumbar puncture
   h. Airway management (oxygenation and ventilation techniques, RSI, rescue techniques)
   i. ACLS skills (CPR, cardioversion, defibrillation, pacemaker placement, pericardiocentesis)
   j. ATLS skills (RSI, tracheotomy, FAST, DPL, decompression of a pneumothorax including chest tube, thoracotomy)
   k. ENT procedures (anterior and posterior nasal packing; Foreign body removal from ear, nose, throat; hematoma drainage of ear, wick placement in canal)
   l. Ophthalmologic procedures (use of slit lamp, contact lens removal, eye irrigation, extraocular foreign body removal)
   m. Hand and Foot procedures (drainage of subungual hematoma and paronychia, removal ingrown toenail, extensor tendon repair)
   n. GU procedures (Foley catheter placement, suprapubic bladder aspiration, reduction of paraphimosis)
o. Rectal procedures (anoscopy, foreign body removal, pilonidal or perianal abscess drainage, evacuation of thrombosed hemorrhoid)

**COMMUNICATOR**

1. Demonstrates appropriately accurate, concise, timely and legible emergency charting, with follow-up notes. Charting should include interpretation/analysis of the lab and radiologic investigations.

2. Demonstrates effective verbal communication with and establishes positive (therapeutic and/or working) relationships with:
   a. Patients and their families
   b. Pre-hospital personnel
   c. Nurses, Respiratory Therapists, Unit Clerks, Patient Attendants, Social Worker
   d. Attending Physicians, Residents and Medical Students within the Department
   e. Consultants by telephone/in person

3. Demonstrate ability to effectively deliver “bad news” to patients/families in a professional manner.
4. The senior resident will be expected to handle conflict situations and facilitates their resolution.

**COLLABORATOR**

1. Interacts effectively as a member of the multi-disciplinary emergency health care team, acknowledging and facilitating their roles and expertise.
2. Respect the other members of the Emergency Department and seek out their opinions and skills when necessary.
3. Demonstrate flexibility in one’s role within the Emergency Department if the need arises.
4. Be capable of involving the patient and family in decision-making when appropriate.

**MANAGER**

1. Work at a pace that is appropriate for level. Senior residents should be able to manage several acutely ill patients concurrently. R5s should also be able to assist in flow management and teach junior residents and students.
2. Be able to triage multiple patients arriving in the Emergency Department and see patients in order of priority.
3. Show efficient and effective use of ancillary testing including but not limited to: Blood tests, cultures, diagnostic radiology.
4. Comprehend the importance of and manage the flow of patients within the Emergency Department.
5. Effective use of consultants and of follow-up visits (i.e. clinics).
6. Be cognizant of the role of the ED and the Emergency Physician with respect to the hospital’s disaster management plan.

**HEALTH ADVOCATE**

1. Understand that the patient’s well being is central to all medical care.
2. Demonstrate an understanding of how preventive medicine and health promotion may be integrated into the emergency care system.
3. Demonstrate an understanding of related public health issues.
4. Be the patient’s advocate at all times, particularly when they are unable to do so themselves.

5. Improves efficiency and performance through appropriate understanding and use of information technology.

**SCHOLAR**

1. Continuously seeking out new knowledge e.g. texts, journals and incorporate this into daily practice.

2. The resident will have the ability to use information technology to direct self-learning as well as patient care.

3. Apply the principles and skill set of evidence-based medicine in identifying and applying best research evidence to patient care.

4. The senior resident must be able to apply landmark studies to patient care.

5. Teaches colleagues and students effectively (Case presentations, grand rounds, journal club, daily teaching). Evaluates and gives constructive feedback using valid and reliable methods. (The senior resident will have the opportunity to further practice these skills on the CTU month).

6. Medical Simulation: Participate in and develop simulation based training exercises on core resuscitation competencies, as well as non clinical CanMEDs competencies and areas of interest.

**PROFESSIONAL**

1. Demonstrate awareness of the racial, cultural and social factors that influence the delivery of emergency care.

2. Show respect all times for the patient’s:
   a. Race/ethnic background
   b. Language
   c. Socio-economic level
   d. Religion/Belief system
e. gender/sexuality
f. Confidentiality

3. Be insightful of one’s own strengths and weaknesses, and recognize when to call for backup.

4. Be able to receive and accept constructive feedback.

5. Display ethical behaviour compatible with a physician at all times with respect to:
   a. Patients and their families
   b. Allied health staff
   c. Attending Staff, residents and medical students

6. Be a role model for medical students, residents, staff physicians, nurses.

7. Maintains a healthy and sustainable balance between personal and professional lives.

**Senior Residents**

1. Demonstrate acceptance of all actions committed under his/her supervision.

2. Display knowledge of the professional, legal and ethical codes binding physicians.

3. Demonstrate awareness of relevant legislation applicable to the practice of Emergency Medicine.

4. Be able to recognize (and intervene) when unprofessional conduct occurs in the resident’s midst as in accordance with government and professional regulations.

**Royal Victoria Hospital**

The RVH is a major referral center, with an annual census of over 31000 patient visits, and has active Transplant, Oncology and Cardiothoracic Surgery divisions, which gives us a more complicated, sicker patient population compared to that of other hospitals. Also, we are joined to the Montreal Neurologic Institute and therefore see a considerable number of their patients presenting with complex neurological or neurosurgical problems. The RVH is now the primary site for Obstetrics at the MUHC. This all makes for a different and challenging patient population.

A majority (sixty percent) of the attending physicians working in the RVH ED are Royal College
trained Emergency specialists; others are family physicians with extra training or many years experience in Emergency Medicine. All the attending physicians have a clear commitment to Emergency Medicine, with some having subspecialty expertise, for example in Sports Medicine, Toxicology, and Intensive Care.

The resident is assigned to either the Ambulatory care area, or Monitor Care Area and to a specific staff for the shift. Emergency residents will usually be scheduled to be the only Emergency resident on during shifts to maximize exposure. Case discussion, both at the bedside and during daily teaching sessions, encourages residents to question practices, identify weaknesses and foster self-directed learning. Responsibility is gradually increased throughout the years of training.

Shifts are eight hours, with forty-five minutes of didactic teaching at 15h00 on weekdays. Teaching is conducted by the evening shift attending physician or an EM resident during his/her clinical teaching rotations. These sessions are usually informal discussions geared to the level of the trainees in attendance and are intended to cover the major topics of emergency medicine.

**Site Director:** Dr. Christine Meyers ([christine.meyers@mcgill.ca](mailto:christine.meyers@mcgill.ca))
**Administrative Coordinator:** Ms. Gillian Frontin ([gillian.frontin@muhc.mcgill.ca](mailto:gillian.frontin@muhc.mcgill.ca))
**Telephone:** 514-934-1934, ext. 34277

**Montreal General Hospital**

The Montreal General Hospital Emergency Department is one of two trauma centers on the island of Montreal. In addition, the MGH is the largest orthopedic center in Quebec, is a regional Radiation Oncology center, serves as the sexual assault center for Anglophone Montreal, and has a special liaison with the native populations from around Montreal and from northern Quebec. The annual patient volume is over 36,000, of which 12,500 arrive by
Orientation to the Emergency Department will take place on the first day of the rotation at 08h00. At this time the resident will receive the goals and objectives for the rotation.

This rotation is designed to give the resident clinical exposure to allow him/her to acquire the appropriate knowledge, skills and attitudes consistent with the practice of emergency medicine at a consultant level. The resident’s shifts will be prorated to approximately 60% Monitor room and 40% ambulatory care shifts, with the total number of hours being 38 hours per week, or 16 to 18 shifts per month. Senior residents will be paired preferentially with FRCP or CPSQ staff, or exceptional teachers. The rotation will emphasize the differences between the Montreal General Hospital and other McGill University teaching hospitals, namely, its Tertiary Trauma Centre designation and its partnership with the Montreal Sexual Assault Centre.

Residents will be expected to manage trauma cases with the Emergency Physician. The level of involvement will depend on whether the Trauma Team has been activated. Even if the Trauma Team has been activated, the resident is expected to continue actively following this patient and be up to date on the status (hemodynamic, radiologic, labs, and disposition) of the patient.

Daily teaching sessions are mandatory from Monday to Friday 15h00 -16h00. Different Emergency Medicine related topics will be taught and reviewed. All residents, including off-service residents will teach one of these sessions during the rotation and be evaluated on their teaching skills by the staff working with them that day.

Residents are responsible to ensure that attending staff fills out daily evaluations. Should there be any concerns about the performance of the resident, a mid-rotation evaluation will be scheduled. At the end of the rotation, an In-Training Evaluation Form (ITER) will be completed and discussed with the resident who should sign the ITER and complete a rotation evaluation form.
Residents have a room B2.114.4 where they can leave their belongings. Memos or schedule changes will be posted in this room or on the door.

**Postgraduate Coordinator:** Dr. Monica Cermignani; monica.cermignani@mcgill.ca  
**Administrative Coordinator:** Ms. Anna DePalma; anna.depalma@muhc.mcgill.ca  
**Telephone:** 514-934-1934, ext. 42501

**Sir Mortimer B. Davis Jewish General Hospital**

The Sir Mortimer B. Davis Jewish General Hospital is a tertiary care academic institution whose Emergency Department is one of the busiest in Quebec in terms of acuity and the elderly population it serves. The SMBD JGH also houses a large number of Emergency Medicine specialists. Residents rotating through the Jewish General Hospital Emergency Department will be exposed to a wide range of acute medical and surgical cases. The hospital’s catchment area is characterized by a high proportion of elderly patients with a significant load of cardiorespiratory and neurological cases.

During the first three years, residents' primary responsibility will be the management of individual cases. The workload, i.e. volume and "case mix", will be increased as the resident progresses through the rotation. Residents at the R3 level will be introduced to flow management through the ED. Residents at the R4 level will work in conjunction with the attending staff and will have the responsibilities of resident and student teaching as well as management of the ED. Formalized feedback is provided to residents on a full spectrum of relevant clinical and professional skills.

The team of attending staff at the SMBD JGH constitutes one of the most established and dedicated groups of academic (research, teaching, administration and leadership) clinicians in Canada. Through exposure to a varied and heavy case mix of patients as well as a group of enthusiastic teachers, residents will enhance the development of their competence, confidence,
PAEDIATRIC EMERGENCY MEDICINE

Training in paediatric emergency medicine will take place at the Montreal Children Hospital (MCH). In this hospital, the emergency department is divided in two sections: medical emergency (MER) and surgical emergency (SER).

In the MER, the residents are supervised by either: emergency paediatricians, general paediatricians or emergency physicians. In the SER, the residents are supervised by either: emergency paediatricians, emergency physician or paediatric surgeons. This division of work allows the residents to focus on specific aspects of paediatric emergency care as well as being exposed to attending with a wide variety of interest and expertise.

Emergency medicine residents spend a total of 6.5 months in the MCH emergency department. This is spent equally between MER and SER. Responsibility is graded as in their adult emergency medicine rotations.

Goals and Objectives

A) PGY 1-2 years

MEDICAL EXPERT

1. Obtain a proper history and physical exam of the paediatric patient presenting to the Emergency Department.
2. Display skill in management of a critically ill paediatric patient.
3. Be knowledgeable of the indications, use and interpretation of:
a. Laboratory testing
b. EKG’s
c. X-rays
d. CT Scanning
e. Ultrasound *
f. Nuclear Medicine *
g. MRI *
* indication and use only

2. Construct an appropriate differential diagnosis of the paediatric patient’s presenting problems to the emergency department.

3. Explain the natural history, pathophysiology, anatomy, treatment and complications of both acute and common disorders that fall within the scope of paediatric emergency medicine.

4. Ensure comprehensive care of patients seen including following up of tests done on that visit, transfer of care and discharge planning.

5. Manage multiple (3-4) patients simultaneously.

6. Begin to lead and manage resuscitations.

7. Demonstrate competence of the following technical skills
   a. MER
      i. IV insertion
      ii. Lumbar puncture
      iii. BLS Airway skills/CPR
      iv. Defibrillation/Cardioversion
   b. SER
      i. Suturing of simple lacerations
      ii. Removal of foreign bodies
      iii. Abscess drainage
      iv. IV insertion

8. Recognize and know how to deal with suspected cases of abuse/neglect.

**COMMUNICATOR**
1. Be capable of communicating effectively with
   a. Patients and their families
   b. Nurses, Respiratory Therapists, Unit Clerks
   c. Attending Physicians, Residents and Medical Students within the Department
   d. Consultants by telephone/in person
2. Demonstrate ability to deliver “bad news” to patients/families in a manner a professional manner.
3. Display age appropriate communication with the paediatric patient.
4. Demonstrate appropriately concise and legible emergency charting, with follow-up notes and documentation/interpretation of lab, ECG and radiological investigations.

**COLLABORATOR**

1. Function as a member of the multi-disciplinary team that makes up Emergency Health Care.
2. Respect the other members of the Emergency Department and seek out their opinions and skills when necessary.
3. Demonstrate flexibility in one’s role within the Emergency Department if the need arises.
4. Be capable of involving the patient and family in decision-making when appropriate.
5. Respect and highlight the role of the patient’s primary physician e.g their family physician or paediatrician in their ongoing health care.

**MANAGER**

1. Manage 3-4 patients concurrently.
2. Effective use of consultants and of follow-up consultant visits (i.e. clinics).
3. Be able to triage multiple patients arriving in the Emergency Department and see patients in order of priority.
4. Show efficient and effective use of ancillary testing including but not limited to: blood work, cultures, radiology.
5. Comprehend the importance of patient flow within the Emergency Department.
6. The resident will have the skill in using the hospital computer database/information technology to help direct the individual patient’s care.
**HEALTH ADVOCATE**

1. Understand that the patient’s well being is central to all medical care.
2. Demonstrate an understanding of preventive medicine or harm reduction strategies that will influence patient health and well-being.
3. Be the patient’s advocate at all times, particularly when they are unable to do so themselves.

**SCHOLAR**

1. Continuously seeking out new knowledge e.g. texts, journals and incorporate this into daily practice.
2. Be able to apply landmark studies to patient care.
3. Apply Evidence-based medicine to ongoing Emergency Care.
4. The resident will have the ability to use information technology to direct self-learning as well as patient care.

**PROFESSIONAL**

1. Demonstrate awareness of the racial, cultural and societal facets that colour Emergency Care deliverance.
2. Show respect all times for the patient’s:
   a. Race/ethnic background
   b. Language
   c. Religion/Belief system
   d. Gender/sexuality
   e. Confidentiality
3. Be insightful of one’s own strengths and weaknesses, and recognize when to call for back-up.
4. Be able to receive and accept constructive criticism.
5. Display ethical behaviour commensurate with a physician at all times with respect to:
   a. Patients and their families
   b. Allied health staff
c. Attending Staff, residents and medical students

B) PGY 3-5 years

The resident will have been expected to have completed all the goals and objectives of the PGY1-2 years in addition to the following section:

**MEDICAL EXPERT**

1. Properly assess, diagnosis and treat multiple patients (>4) concurrently.
2. Will lead resuscitations and treatment of hemodynamically unstable patients.
3. Supervise and teach junior residents and medical students in the clinical milieu.
4. Display effective consultation to:
   a. Community family physicians and paediatricians
   b. Community emergency departments/physicians
   c. Other MCH physicians/departments
5. Employ Evidence based-medicine to ancillary test choice.
6. Develop mastery of the following skills:
   a. MER
      i. Airway management of medical patients
      ii. Difficult IV access
   b. SER
i. Airway management of trauma patients
ii. Difficult IV access
iii. Tube thoracostomy
iv. Complicated laceration repair
v. Reduction of fractures and dislocations
vi. Procedural sedation

2. Show knowledge of the medical-legal aspects of patient care including but not limited to the following:
   a. Do not resuscitate orders and advanced directives
   b. Mental competency and consent
   c. Age and consent
   d. Refusal of care
   e. Power of attorney and surrogate decision-making

**COMMUNICATOR**

1. Prove capable of leading teaching sessions to
   a. Medical Students
   b. Junior Residents
   c. Off-service residents
   d. Allied Health Care workers

2. Communicate effectively with consultants in the community and in the hospital.

3. Show ability to discuss end of life situations and advanced directives with patients and their families.

**COLLABORATOR**

1. Be aware and capable of accomplishing the skills of conflict resolution.

2. Be able to assume team leadership within the department and be an effective participant in this multi-disciplinary milieu.

3. Expertly work with EMS personnel by reviewing patient care with EMS upon their arrival to the department.
4. Coordinate transfer of patients from community hospitals and outlying regions for specialized emergent care.
5. Assist referring community emergency physicians in stabilization and treatment of paediatric patients at their centers.
6. Be capable of involving the patient and family in decision-making.

**MANAGER**

1. Manage multiple (>4) patients concurrently.
2. Assume leadership of the department while on shift.
3. Ensure proper flow of patient care through department.
4. Direct human resource allocation i.e. junior residents and students while acting as physician in charge.
5. Ensure evidence based efficient use of ancillary testing.
6. Coordinate immediate and follow-up consultant care.
7. Understand the organizational chart of the Emergency Department both internally and within the context of the hospital.
8. Elucidate and recognise instances of medico-legal risk and identify potential preventive and corrective steps.

**HEALTH ADVOCATE**

1. Be able to identify patients and populations at risk and implement interventions to assist these groups.
2. In particular recognition of suspected cases of abuse/neglect.
3. Understand the major determinants of health.
4. Recognize the instances, times and events when advocating on behalf of patients is required.

**SCHOLAR**

1. The resident will be able to integrate results from research into clinical practice.
2. Be able to provide constructive feedback to junior residents and medical students supervised.
3. Consolidate bedside teaching skills.

4. Apply the principal and skill set of evidence based medicine in identifying integrating the best research evidence to patient care.

**PROFESSIONAL**

1. Serve as a role model for junior residents and medical students.

2. The resident will demonstrate acceptance of all actions committed under his/her supervision.

3. Display knowledge of the professional, legal and moral codes binding physicians.

4. Demonstrate awareness of relevant legislation applicable to the practice of Emergency Medicine.

5. Be able to recognize and intervene when unprofessional conduct occurs in the resident’s midst as in accordance with government and professional regulations.

**Supervisor:** Dr. R. Gosselin/Dr. Laurie Plotnick

**Administrative Coordinator:** Ms. Alessandra Tedeschi: alessandra.tedeschi@muhc.mcgill.ca

**Telephone:** 514-934-1934, ext. 24475
ANAESTHESIA (ADULT & PAEDIATRIC)

Knowledge and skills concerning emergent airway management is core Emergency Medicine. The McGill Emergency resident will learn this core knowledge and technical skills on 2 core rotations: General Anesthesia (4 weeks) and Pediatric Anaesthesia (2 weeks). The resident will then be able to apply and master their knowledge and hone their skills on several other rotations: Adult and Pediatric Emergency Medicine, ICU (Medical, Surgical, Neurological, Pediatric, Cardiac), and Trauma. By the end of the Program, the resident must feel comfortable (both in knowledge and skill) with any emergency airway problem:

**MEDICAL EXPERT**

1. Anatomy of the upper and lower airways (both adult and pediatric).
2. Learn relevant pre-operative historical and physical exam considerations including evaluation of the airway difficulty.
3. Demonstrate the appropriate clinical judgment regarding the need for acute airway intervention.
4. Knowledge of the principles of both non-invasive ventilation and invasive mechanical ventilation.
5. Knowledge of hemodynamics, monitoring, fluid resuscitation and blood products.
6. Knowledge of the pharmacology (mechanism of action, indications, contra-indications, side-effects, complications and doses) of the various induction agents, paralyzing agents, pressors, and vasodilators, local anaesthetic agents, and those used for procedural sedation.
7. Knowledge of at least 6 different airway “rescue” techniques for the difficult airway.
8. Understand the principles of general, regional and local anaesthesia, as well as procedural sedation. The resident must be able to describe the appropriate anatomy of regional blocks.
9. Expertly demonstrate the following skills:
   a. Insertion of oral and nasal airways.
c. Techniques to open the airway (jaw thrust, chin lift).
d. Techniques for managing the obstructed airway.
e. Rapid sequence intubation (including manual in-line immobilization of the c-spine).
f. The skills required for at least 6 airway rescue techniques (Bougie, lighted stylet, LMA, combi-tube, retrograde intubation, fibre optic, digital manipulation).
g. Be able to assess successful intubation (including end tidal CO2).
h. Be able to adjust settings for both the mechanical vent and CPAP/BiPAP machines.
i. Surgical airway technique (cricothyroidotomy).
j. Peripheral and central venous catheterization and arterial line insertion.
k. Skills required for both regional and local anaesthesia.

COMMUNICATION
The resident must be able to display effective communication with:

a. Patients and families (in various situations including pre-op, post resuscitation).

b. Anaesthesiologists, surgeons, respiratory technicians, and nurses.

c. Colleagues and peers during (especially during acute resuscitation situations).

COLLABORATOR
The resident must be able to demonstrate:

a. The ability to work as team with anaesthesiologists, surgeons, respiratory technicians, nurses and orderlies.

b. The ability to work as a team both in the Emergency Department or ICU, when dealing with “semi-elective” airway issues or with the acute resuscitation.

MANAGER
The resident must be able to demonstrate:

1. An understanding of the role of and the appropriate consultation of the Anaesthesia service, and its role within the hospital.
2. Appropriate use of blood and blood products.

**HEALTH ADVOCATE**

1. Be able to discuss with patients and their families the risks and benefits of the various procedures and/or interventions, or be able to assist and direct them to the appropriate individuals who can inform and answer their questions or concerns.
2. Understand and act appropriately upon a patient’s advanced directives.
3. Understand and discuss with patients and families McGill’s levels of care.
4. Be the patient’s advocate at all times, especially when they are unable to do so themselves.

**SCHOLAR**

The resident must:

1. Keep abreast of the relevant and landmark studies.
2. Be able to critically appraise these landmark articles.
3. Be aware of web based Anaesthesia sites (see McGill emergency website for links).

**PROFESSIONAL**

The resident must be able to:

1. Be mindful of one’s own limitations and know when to call for back-up (by knowing and acknowledging your strengths and weaknesses).
2. Show respect at all times for the patient’s:
   a. Race/ethnicity
   b. Language
   c. Religion/Belief system
   d. Gender/sexual orientation
   e. Confidentiality
3. Be a leader in the acute resuscitation.
4. Display ethical behaviour commensurate with a physician at all times with respect to:
   a. Patients and their families
   b. Allied health staff
   c. Attending Staff, residents and medical students
5. Be a role model to fellow physicians, nurses, residents, and medical students.

**PAEDIATRIC ANAESTHESIA**

This is a 2-week rotation at the Montreal Children’s Hospital. This rotation will allow the resident to focus on the details of Pediatric Anaesthesia (airway anatomy, medication dosing, equipment sizes etc.).

**Supervisor:** Dr. Teresa Valois  
**Administrative Coordinator:** Ms. Roula Cacolyris ([roula.cacolyris@muhc.mcgill.ca](mailto:roula.cacolyris@muhc.mcgill.ca))  
**Telephone:** 514-934-1934, ext. 22464
AREA OF INTEREST

Emergency Medicine has evolved significantly over the last 20 years. Consequently there are many areas of subspecialty that now fall under the domain of EM. The McGill Emergency resident has the opportunity to pursue his/her interest in one of these areas. During 6 rotations (either consecutively or randomly) the resident will be able to develop an area of interest. These areas may be clinical (e.g. critical care, toxicology etc.) or they may be non-clinical (e.g. administration, education, informatics etc). The resident may also combine the area of interest with their research project.

In terms of goals and objectives, the ultimate goal of this block of time will be dependent on what the resident selects as his/her area of interest, and the objectives will be created to enable the resident to obtain his/her goal.

ROTATION LOGISTICS

1. Rotation Proposal: The resident will write a proposal of what he/she wants to do for this period. The proposal must be approved by the program director. The proposal should be written in CanMEDS format (medical expert, communicator, collaborator, manager, health advocate, scholar, professional). Depending on the project, certain CanMEDS roles will be emphasized over others.

2. Staff Mentor/Supervisor: The resident must select a staff to be his/her supervisor for the rotation. The staff will review the proposal and advise on how to progress. The mentor/ supervisor must inform the Area of Interest Committee that he/she is willing to take on that responsibility.

5. Incomplete Area of Interest: Should the resident not complete his/her proposal, the Program Director in consultation with the mentor and resident will evaluate the situation and whether or not satisfactory progress has been made. Should the committee decide that the rotation is ‘incomplete,’ the implications will be similar to any other incomplete rotation (as per McGill’s Promotion and Evaluation).
CARDIOLOGY AND CORONARY CARE UNIT (CCU)

The cardiac care curriculum consists of three four week rotations, one in the Cardiac Care Unit (CCU) and two with the Cardiology Consult Service. The goals and objectives for these two rotations are as follows:

MEDICAL EXPERT

The resident will develop expertise in the pathophysiology and management of acute and chronic cardiac disease. He or she will demonstrate knowledge of:

1. Principles of resuscitation of the patient in cardiac arrest and a mastery of ACLS protocols.
2. Immediate and long-term management of arrhythmias, including the pharmacology of anti-arrhythmic medications and indications for pacing.
3. Principles of hemodynamic monitoring and mechanical ventilation (both invasive and non-invasive) in the critically ill patient.
4. Diagnosis of acute coronary syndromes, including the roles of cardiac enzymes, resting and stress electrocardiography, echocardiography, nuclear studies, and angiography.
5. Management of acute coronary syndromes and their complications, including initial stabilization and ongoing monitoring; the roles of all medical treatment options including thrombolysis; the roles of primary and rescue PCI.
6. Diagnosis and management of acute and chronic congestive heart failure, hypertensive emergencies, endocarditis, pericarditis/myocarditis, cardiac tamponade, aortic dissection, and valvular emergencies.
7. A thorough differential diagnosis and a rational approach to investigation and management of the patient with undifferentiated chest pain, palpitations, dyspnea, or syncope.
8. Recognition and management of pacemaker problems.
The resident will also demonstrate the following skills:

1. ECG and plain chest radiograph interpretation.
2. Cardioversion and defibrillation.
3. External chest compressions.
4. Hemodynamic monitoring by Swan-Ganz catheterization and arterial line placement.
5. Temporary percutaneous and transvenous pacemaking.
6. Pericardiocentesis

**COMMUNICATOR**

1. Demonstrate ability to discuss the patient’s care and counsel regarding risk modification with the patient and family.
2. Demonstrate ability to deliver bad news in a sensitive, concise and understandable manner.
3. Show skill in explaining risks, benefits and obtaining consent for relevant procedures, in particular thrombolysis and PCI for acute coronary syndromes.
4. Demonstrate ability to discuss living wills, advanced directives and *do not resuscitate*/levels of care orders.
5. Communicate effectively with the multi-disciplinary team.
6. Communicate effectively with the cardiac arrest team during resuscitation.
7. Provide clear written documentation in the patient’s chart, including consults, progress notes, and orders.

**COLLABORATOR**

1. Recognition of the role of each health care team member with respect to the patient’s care.
2. Demonstrate ability to resolve common team conflict problems.
3. Demonstrate ability to work in a multi-disciplinary team.
4. Be capable of involving the patient and family in decision-making.
**MANAGER**

1. Demonstrate ability to allocate cardiac care resources to the patient and population served in an evidenced-based manner.

2. Recognize resources of tertiary care cardiac care centres and the use and rationalization of these for the individual patient and the population served.

3. Be able to manage competing interests of consults from other services, including the Emergency Department, with ongoing care of cardiac patients.

4. Be capable of managing multiple critically ill patients concurrently.

5. Comprehend the role of the Cardiology Consult service and Cardiac Care Unit with respect to the hospital and community as a whole.

6. Recognize medico-legal risk and identify potential preventive and corrective steps.

**HEALTH ADVOCATE**

1. Identify the determinants of health of the individual cardiac patient.

2. Be capable of discussing with patients risk and harm reduction strategies.

3. Be the patient’s advocate at all times, particularly when they are unable to do so themselves.

4. To be able to seek additional medical expertise when there is a conflict of opinion concerning patient care.

**SCHOLAR**

1. Demonstrate knowledge of landmark cardiac studies, to be able to critically appraise them and understand the subsequent applicability.

2. Be consistent in reading around clinical cases and improving cardiac knowledge base.

3. Demonstrate ability to formulate a clinical question and efficiently access information required to answer clinical questions in an evidence-based manner.

**PROFESSIONAL**

1. Demonstrate awareness of the racial, cultural and societal factors that may influence delivery of care to the cardiac patient.

2. Show respect all times for the patient’s:
a. Race/ethnicity
b. Language
c. Religion/Belief system
d. Gender/sexual orientation
e. Confidentiality

3. Be aware of one’s own strengths and weaknesses, and seek help when needed.
4. Be able to receive and accept constructive feedback.
5. Display ethical behaviour compatible with a physician at all times with respect to:
   a. Patients and their families
   b. Allied health staff
   c. Attending Staff, residents and medical students
6. Serve as a role model for colleagues and other health care personnel.

**Supervisor:** Dr. Dr. V. Nguyen (Cardiology)

**Administrative Coordinator:** Ms. Anna Ballarano
(anna.ballarano@mcgill.ca)

**Telephone:** 514-934-1934, ext. 36151
CTU is a four-week mandatory clinical rotation for senior Emergency Medicine residents, with the objective of developing the resident’s skill and confidence as a clinical teacher. The resident-teacher will apply principles of learner-centered instruction and techniques for teaching in a busy clinical environment while supervising junior trainees (clerkship through PGY-2) in the ED. Through group learning activities, practical experience, and self-reflection, the resident-teacher will acquire skills in interactive small-group lecturing, focused instruction during case review, effective bedside teaching and direct observation of trainee-patient interaction, the safe teaching of procedures, and giving constructive feedback.

Learning Objectives

The specific learning objectives of the CTU rotation are focused on the CanMEDs Scholar role (see table 1). At the same time, it is understood that to be an effective teacher and role-model in the busy clinical team environment of an Emergency Department, the resident-teacher must demonstrate excellence in all CanMEDs domains.

Instructional Strategies

1) Workshops: The senior residents will all be assigned to the CTU rotation at the same time to take advantage of the social aspects of learning by participating as a group in five half-day workshops (see table 2 for details).

2) Readings: Assigned articles on medical education will be available online through McGill’s WebCT (http://www.mcgill.ca/mycourses/). These articles should be read before each workshop and will be discussed as a group.

3) Reflective exercises: The CTU residents will each submit three brief essays in which they draw upon the material from their readings and from their clinical teaching shifts to reflect upon their performance as a clinical teacher.

4) Clinical teaching shifts: Each resident will spend ten shifts in the ED supervising and teaching one or two junior learners (clinical clerk to PGY-2). During these shifts, the resident will focus entirely on their role as teacher and will not be responsible for carrying their own patient load. However, an important goal during these shifts will be to adjust their teaching strategies to match the actual work-flow time-pressures of the ED. Residents will be matched to one of the three adult ED’s (JGH, MGH, and RVH) for the duration of the rotation.

5) Observed teaching encounters: Each resident is matched to an attending who will act as a mentor during the CTU rotation. During the teaching shifts, at least twice for a minimum of two hours each time, this mentor will directly observe the resident-teacher and provide coaching and feedback on his or her teaching skills.

6) Small group teaching: The resident-teachers will each conduct two one-hour small-group teaching sessions for a group of junior learners on duty in the department. The topics are to
be chosen by the CTU resident. During the workshops, the residents will learn how to prepare learner-centered objectives for these sessions and will have the opportunity to practice using interactive techniques while being videotaped and receiving feedback from their colleagues.

**Evaluation**

The CTU-resident will receive feedback from multiple sources. These will be collected and summarized in a final evaluation by the CTU instructor.

1) Daily written evaluations from learners and supervising attendings on teaching shifts.
2) Two detailed written assessments based on the observed teaching encounters.
3) Written feedback from the audience members at each small-group teaching activity they lead.
4) Self-assessments through the reflective essays.

**Course Instructor:** Dr Christine Meyers: christine.meyers@mcgill.ca

**Administrative Coordinator:** Ms Gillian Frontin: gillian.frontin@muhc.mcgill.ca

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<thead>
<tr>
<th>TABLE 1: EMERGENCY MEDICINE CLINICAL TEACHING UNIT OBJECTIVES</th>
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<tr>
<td><strong>GENERAL OBJECTIVES</strong></td>
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<tr>
<td>1) Integrates teaching into the ED environment.</td>
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<td>2) Uses a learner-centered approach to teaching.</td>
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<td>2.5 Assigns appropriate responsibility to the learner.</td>
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<td>2.6 Asks questions that promote critical thinking.</td>
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<td>2.7 Shows the learner general approaches to problem-solving.</td>
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| 3) **Uses a variety of efficient, effective clinical teaching techniques.** |
| 3.1 Uses the "One-Minute Preceptor" framework for case discussion. |
| 3.2 Chooses high-yield cases for teaching. |
| 3.3 Consolidates the teaching of several learners. |
| 3.4 Directly observes patient-learner interactions, providing focussed feedback on clinical skills. |
| 3.5 Teaches at the bedside when appropriate. |
| 3.6 Uses quick teaching techniques such as triggers, mnemonics, and pearls. |
| 3.7 Uses prepared materials when appropriate (e.g. teaching files, online tutorials, teaching scripts, educational prescriptions) |
| 3.8 Demonstrates an effective approach to teaching technical skills. |

| 4) **Gives constructive feedback.** |
| 4.1 Provides private, timely, specific and objective feedback. |
| 4.2 Limits feedback to few objectives at a time. |
| 4.3 Uses the "sandwich technique" for feedback. |
| 4.4 Encourages self-reflection in the learner. |
| 4.5 Counsels the learner on how to improve. |

| 5) **Lectures effectively to small groups.** |
| 5.1 Develops learner-centered objectives. |
| 5.2 Uses interactive techniques. |
| 5.3 Creates appropriate audio-visuals and handouts |
| 5.4 Evaluates effectiveness of lecture. |

| 6) **Teaches the learner communication skills** |
| 6.1 Teaches the student how to present a case using the "3-minute emergency medicine presentation" technique |
| 6.2 Knows the key communication skills of a physician and helps the student acquire them |
| 6.3 Teaches the student how to document cases appropriately for the ED setting |

| 7) **Role models active, life-long learning** |
| 7.1 Shows the learner how experts deal with knowledge gaps using the principles of EBM. |
| 7.2 Recognizes cognitive errors in self and others. |
7.3 Solicits feedback on teaching from the learner.
7.4 Reflects on own teaching style and strategies.

Reflective essay, teaching shifts, OTE
Reflective essay, debriefing during all workshops

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<tr>
<th>TAXONOMY TABLE FOR CTU LEARNING OBJECTIVES</th>
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<tr>
<td>KNOWLEDGE DIMENSION</td>
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<td>Factual</td>
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<td>Conceptual</td>
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<td>Procedural</td>
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<td>Metacognitive</td>
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EMERGENCY DEPARTMENT ULTRASOUND

Structure

This will be a 4 week rotation based at the Jewish General Hospital which will be broken down into eight 8-hr emergency shifts, as well as 9 4-hr ultrasound shifts. During this rotation, the resident will participate in didactic learning, bedside ultrasound training, and direct clinical
patient care. Residents must be paired up during their rotation.

During their time in the emergency department, the residents will be under the direct supervision of the attending clinic staff. The 4-hour ultrasound shifts will include didactic lectures on the use of bedside ultrasound as put forth by the Canadian Emergency Ultrasound Society (CEUS), direct one-on-one teaching of bedside ultrasound, as well as formal evaluations in the form of a written, oral, and practical exams. Each resident will be under the direct supervision of a CEUS-certified Independent Practitioner (I.P.), where they will be proctored while performing abdominal, cardiac, and pelvic ultrasound examinations on patients in the emergency department. Each exam will be logged and counter-signed by the proctoring I.P, to ensure the completion of each acceptable scan. During their 8-hr emergency shifts, they will be scheduled to work along side a CEUP IP. They will be responsible for the evaluation of all ED patients, and together with the attending staff, will make decisions regarding their management and ongoing emergency care. During this time, any bedside ultrasound examination performed by the resident may count towards their requirements only if it is reviewed by a CEUS I.P. During this training period, residents are encouraged to act if they see a positive scan, but must not draw any conclusions from a negative scan, unless they have been proctored by an I.P. The goal of this rotation will be to provide the resident with maximum exposure to bedside ultrasound in a clinical setting for the eventual goal of becoming a CEUS-certified I.P. To become an I.P, a resident must complete 50 scans of each of the relevant areas. Definitions of an acceptable scan are:

- **Heart**: entire pericardium visualized to detect pericardial effusion
- **Aorta**: vessel visualized from subdiaphragmatic region to bifurcation in transverse view to measure diameter
- **Abdomen**: hepatorenal and splenorenal interfaces swept to detect free fluid; diaphragm visualized in LUQ
- **Uterus**: uterus visualized to detect intrauterine pregnancy (IUP) (3 criteria)

During the course of obtaining the 200 required definitive scans, the residents will be required to successfully complete a written exam (100% passing grade), as well as a practical and visual exam. Should the resident be unable to complete any part of the requirements, extra shifts may be assigned by the supervisor in order to complete unfinished training. Once all components are
completed, the residents will be certified as a CEUS I.P. As part of the current Royal College requirements, the use of ultrasound guidance for vascular access will also be taught and demonstrated.

The rotation supervisor/coordinator will be Dr. Joel Turner
Tel: 514-340-8222, ext 3898
Email: joel.turner@mcgill.ca

Objectives

A. MEDICAL EXPERT / CLINICAL DECISION-MAKER

Basic Scientific Knowledge:

Understand the role of physics in modern ultrasound. To understand the nature of ultrasound waves and wave properties, modes of transmission. Define necessary terms such as:

- Frequency
- Resolution
- Penetration
- Attenuation
- Echogenicity
- Gain
- Artefact (shadowing, refraction, enhancement)

Understand the role of specific probes; their characteristics, and their uses, such as:

- Phased array probe
- Linear array
- Endocavitary probe

Understand the critical steps of correct image generation and interpretation. This may include the comprehension of:

- Planes of view
- Probe placement
Basic Clinical Knowledge:

Demonstrate knowledge of the following:

- Define the primary emergency applications of emergency ultrasound. To recognize the conditions which require the use of bedside ultrasound for diagnosis. These conditions include, but are not limited to:
  - Abdominal Aortic aneurysm (AAA)
  - Pericardial Effusion
  - Cardiac standstill during cardiac arrest
  - Ectopic Pregnancy
  - Trauma/non-traumatic intrabdominal fluid

- Understand the specific indications, and limitations of bedside ultrasound for the above conditions; Specifically:
  - Cardiac ultrasound:
    - Define your area of interest to generate a subcostal view of the heart when evaluating for cardiac activity and pericardial effusions
    - Define the relevant cardiac anatomy including pericardium, cardiac chambers, septum, valves, and aorta
    - Recognize the causes of cardiac arrest when assessing cardiac activity, and the causes of pericardial effusion.
    - To be able to differentiate between true positive and false positive results
  - Abdominal Aortic aneurysm
    - Define your area of interest in obtaining a transverse view of the abdominal aorta
    - Recognize relevant anatomy, such as the vertebral bodies, the inferior vena cava, the aorta with its major branches
    - Understanding the various locations and different types of AAA
To use the appropriate protocols when evaluating for a AAA

- Abdominal Ultrasound
  - Describe the indications and limitations of bedside ultrasound in blunt and penetrating thoracoabdominal trauma.
  - To be able to evaluate the abdomen at least three sites for the presence of free fluid in traumatic and non-traumatic scenarios.
  - To define the relevant local anatomy including the liver, spleen, kidneys, bladder, uterus, and diaphragm.
  - To understand the sources of false positives and false negatives.
  - To understand the possible clinical pathways depending on your ultrasonographic findings and clinical setting.

- First trimester pregnancy
  - Define your area of interest in obtaining transabdominal and endovaginal images of the female uterus
  - Describe the indications and limitations of focused sonography when evaluating a patient with first trimester pain and bleeding.
  - Be able to identify intrauterine pregnancy, either through the identification of a decidual reaction, gestational sac, AND yolk sac, or through the identification of a fetal pole or fetal cardiac activity
  - To identify free intraperitoneal fluid in the context of an ectopic pregnancy.
  - Understand the role of quantitative B-HCG in the evaluation of a possible ectopic pregnancy
  - To recognize the possible alternatives of an empty uterus

B. COMMUNICATOR

By the end of the rotation, the resident will:

1. Demonstrate the ability to effectively communicate with referring and consultant colleagues regarding the relevant negative and positive sonographic findings.

2. Be able to recognize the limitations of emergency bedside ultrasonography and to request more definitive testing by consultants when required.

3. Demonstrate the ability to communicate effectively with patients and their family regarding the nature of the injury/illness suffered and anticipated management plan, showing them respect and gaining their cooperation and confidence.

4. Be able to explain to the patient the advantages, focused nature, and limitations of an emergency bedside ultrasound examination and to communicate the possible need for further radiographic testing depending on the findings at the bedside.
C. COLLABORATOR

By the end of the rotation, the resident will:

1. Recognize the role of each health care team member with respect to the patient’s care. Show consideration for the knowledge, skills and roles of the various members of the healthcare team.

2. Demonstrate the ability to work well with other health team members. Deal effectively with difficult issues and show the ability to resolve common team conflict problems.

3. Be capable of involving the patient and family in decision-making.

D. MANAGER

By the end of the rotation, the resident will:

1. Demonstrate the capacity to manage multiple patients concurrently, and to handle most common problems independently, while asking consultants for help in more complex situations.

2. Recognize the resources of the tertiary care emergency departments and the use and rationalization of these for the individual patient and the population served.

3. Be able to manage competing interests of consultants from other services with respect to ongoing care of patients.

E. HEALTH ADVOCATE

By the end of the rotation, the resident will:

1. Be the patient’s advocate at all times, particularly when they are unable to do so themselves.

2. Display advocacy for the community at large and for society.

F. SCHOLAR

By the end of the rotation, the resident will:

1. Demonstrate knowledge of current scientific literature with respect to emergency ultrasound applications and use of this knowledge daily patient management.
2. Demonstrate interest in expanding current knowledge base by reading around clinical cases.

3. Demonstrate the ability to critically-appraise research methodology and medical literature with respect to emergency ultrasound.

4. Demonstrate an interest in expanding their knowledge base of future applications of emergency ultrasound.

Once reaching the status of Independent Practitioner, the resident will be able to understand the important responsibility of teaching other health care professionals bedside US in concordance with the requirements of the Canadian Emergency Ultrasound Society

**G. PROFESSIONAL**

By the end of the rotation, the resident will:

1. Demonstrate awareness of the racial, cultural and social factors that influence the delivery of emergency care to patients.

2. Show respect at all times for the patient’s:
   - Race/ethnic/religious background
   - Language
   - Socio-economic level
   - Gender/sexuality
   - Confidentiality

3. Be aware of one’s own strengths and weaknesses, and recognize when to call for back up.

4. Be able to receive and accept constructive feedback.

5. Display ethical behaviour compatible with a physician at all times with respect to:
   - Patients and their families
   - Allied health staff and practitioners
   - Attending Staff, residents and medical students

6. Be a role model for medical students, residents, staff physicians, nurses, and other allied health care personnel.

**Supervisor:** Dr. Joel Turner  
**Administrative Coordinator:** Mrs. Debbie Pollack  
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EMERGENCY MEDICAL SERVICES
(EMS)/PRE-HOSPITAL CARE
update 2012

McGill Emergency residents will have the opportunity to learn about emergency medical services (EMS) through their exposure to EMS in their work in the emergency department (ED) as well as during a four-week rotation in EMS at Urgences-Santé, the pre-hospital care provider for Montreal. During the four-week rotation, interactive presentations as well as practical sessions will be used to educate the resident. By the conclusion of the rotation, the resident will be expected to prepare a short presentation on an EMS topic. (The resident will also have the opportunity to undertake an elective in aviation medicine.)

MEDICAL EXPERT/CLINICAL DECISION MAKER

1. Direct pre-hospital patient care management
   a. Take a concise history and perform a directed physical exam
   b. Develop a differential diagnosis and assess severity of the case
   c. Initiate management in the field
   d. Initiate transport at the appropriate priority level and to the appropriate facility

2. Direct medical control
   a. Provide on-line medical control
   b. On-scene supervision of EMTs

3. Indirect medical control
   a. Participate in the creation of EMT protocols
   b. Review cases for quality assurance.

4. Emergency Medicine Systems:
   a. Explore the history of emergency medical systems
   b. contrast different organizational systems (e.g. urban vs. rural, North American vs. European)

5. Triage
   a. Contrast the different types of telephone triage
   b. Understand the advantages and disadvantages of the advanced medical priority dispatch (Klawson) system

6. Disasters and mass casualty situations
   a. Learn how to perform field triage
   b. Understand the role of the on-scene physician and in the hospital
7. **Aeromedicine**
   a. Understand the basic principles of aeromedicine (flight physiology)
   b. Understand the roles of fixed wing versus rotary transport
   c. Participate in aeromedical transport

8. **ALS and BLS**
   a. Learn the differences between basic and advanced life support care
   b. Understand the controversy that exists between the need for either

9. **Management of Medical Problems**
   a. Differentiate between equipment, techniques and medications used in the pre-hospital setting and in the ED, and understand the evidence behind what is being/should be done

10. **Pediatrics**
    a. Acquire knowledge of the special circumstances surrounding the prehospital care of the pediatric patient, such as unique clinical protocols, legal concerns and areas of research

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**COMMUNICATOR**

1. Establish a therapeutic relationship with patients and their families in the field.
2. Develop the ability to concisely communicate essential information when transferring care of patients in the ED.
3. Understand and demonstrate the importance of cooperation and communication among health professionals involved in the care of individual patients, including EMTs, nurses and physicians.
4. Understand the lines of communication in disaster medicine.

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**COLLABORATOR**

1. Demonstrate the ability to work effectively with other prehospital and in-hospital health care professionals during direct patient care.
2. Identify and describe the role, expertise and limitations of all members of the pre-hospital care team (i.e. first-responder, primary care paramedic, advanced care paramedic, critical care paramedic, physician) required to optimally achieve a goal related to patient care.
3. Participate in an interdisciplinary team meeting, demonstrating the ability to accept, consider and respect the opinions of other team members.
4. Acquire the ability to resolve conflicts between the various members of the prehospital care team.

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**MANAGER**

1. Direct the EMS team during on-scene patient care.
2. Understand the structure, financing, and operation of the local EMS system and its facilities, function effectively within it and be capable of playing an active role in its change.
3. Understand the role of the EMS medical authority in the direction and management of prehospital care delivery.
4. Become sensitive to medico-legal issues in prehospital care and learn to minimize legal risk
5. Learn the role of, and demonstrate familiarity in the use of pre-hospital technology including communication equipment, GPS systems and prehospital information systems

**HEALTH ADVOCATE**

1. Understand the different levels of population: patient, specific population and the general population, and appreciate the distinct issues at each level.
2. Become sensitive to the changing role of the prehospital care provider in the local, provincial and federal levels, and advocate for advancements in their status.

**SCHOLAR**

1. Demonstrate familiarity with the unique characteristics of pre-hospital research and be aware available tools for the advancement of EMS research (e.g. EMSOP, EMS Research Agenda).
2. Prepare a short review of an EMS topic for presentation at the end of the rotation.
3. Apply the principles of evidenced-based medicine to the practice of pre-hospital care and evaluate the interventions currently in use.
4. Demonstrate the fundamentals of teaching pre-hospital care providers, and adapt the level of instruction to the appropriate level of the trainee.
5. Be cognizant of current landmark EMS research.
6. Be able to critically appraise and apply EBM techniques to evaluate this literature.
7. Improve your knowledge base in EMS through the use of selected readings, journals in the field and textbooks (e.g. *Prehospital Systems and Medical Oversight*, Kuehl, 3rd Ed.).

**PROFESSIONAL**

1. Show respect at all times for the patient’s:
   a. Race/ethnicity
   b. Socio-economic status
   c. Religion/belief system
   d. Gender/sexuality
   e. Confidentiality
2. Demonstrate knowledge and insight into ethical and legal issues that arise in the pre-hospital
setting including (but not limited to) advanced directives, refusal of transport etc.

3. Serve as a mentor for EMTs and other prehospital care providers by delivering the highest quality care with integrity, honesty, and compassion.

**Supervisor:** Dr. Eli Segal  
**Administrative Coordinator:** Ms. France Dutilly  
**Telephone:** 514-723-5740
ICU (MEDICAL, SURGICAL, NEURO)

Over the course of their training in Critical Care Medicine at McGill, the resident will have ample exposure to the critically ill patient: Medical and Surgical ICU, Neuro ICU, Pediatric ICU, Trauma Service, CCU, and of course, in the Emergency Department. A graded level of responsibility will be given to the resident as (s)he gains more Critical Care experience.

A progressively greater depth of knowledge will be expected. The resident will do 2 months as a junior resident and 1 month as a senior resident. The junior rotations are done at the MUHC or JGH. These 2 months should provide a varied experience with medical, surgical and trauma ICU patients. The senior rotation will be done at St. Mary’s Hospital, where the resident will be the only resident (or the most senior resident with a junior family medicine resident). Hence, he/she will be running the ICU, doing all the consults in the hospital and ED, gaining a greater appreciation of the indications for intensive care unit admissions and therapy.

By the end of the R2 year, the resident will have completed 2 ICU rotations, 1 PICU, 1 trauma, and 1 CCU rotation. Thus, the resident should be competent in the management of the most critically ill patients. On completion of residency training, the resident should have achieved proficiency in the recognition and initial management of problems commonly encountered in the intensive care unit. For less common problems, the trainee should gain a knowledge base that allows them to formulate a differential diagnosis, initiate a management plan, and request appropriate consultations.

MEDICAL EXPERT

1. Demonstrate and apply a sound fund of basic science knowledge to patient care in the majority of cases.

2. Demonstrate and apply a fund of clinical knowledge in a manner that enables resolution of common clinical situations on a consistent basis. This includes (but is not limited to) the recognition and management of:
   a. Acute respiratory failure (and ventilator orders).
   b. Common rhythm disturbances, including knowledge of the indications, contraindications and side effects of anti-dysrhythmic therapies.
c. Sepsis and other causes of hemodynamic instability. Must be able to classify shock, outline hemodynamic patterns, and understand the indications and contraindications of inotropes and vasopressors.

d. Sepsis.
e. Acute renal failure.
f. Acute intoxications.
g. Acute neurological insults.
h. Electrolyte and acid base disorders (ABG interpretation).
i. Endocrine emergencies.
j. Coagulation disorders.
k. Obtain an appropriate history from the patient, family, or other medical personnel, that is complete, accurate and systematic.
l. Perform a problem-oriented physical examination with the recognition of most findings to allow for proper diagnosis and management.
m. Develop diagnostic plans that are appropriate and reflect current standards. n. Accurately interpret the results of common lab and diagnostic tests.
o. Be able to synthesize historical, physical exam and diagnostic testing information into a problem list and appropriately prioritize problems.
p. Make judgments that are complete and sound. Arrive at appropriate decisions using the available information.
q. Outline a therapeutic plan in conjunction with the ICU fellow or attending physician. Institute appropriate therapy.
r. Develop an ability to recognize acute life-threatening illness and institute life sustaining supportive therapy.
s. Demonstrate adequate knowledge of monitoring techniques for the critically ill patient to allow for appropriate management.
t. Demonstrate competency in performing essential procedures with appropriate skill and manual dexterity for level of training. Carry out techniques correctly and efficiently with appropriate knowledge of indications and risks.

i) RSI and alternative airway techniques (bougie, LMA, cric).

ii) Ventilator settings.
iii) ABG settings
iv) Arterial Lines
v) Central Lines
vi) CVP monitoring principals (leveling, zeroing and measuring).
vii) Swan Ganz monitoring (including determination of central venous and mixed venous blood gas.
viii) Carioversion and defibrillation
ix) Transcutaneous and transvenous pacing
x) Pericardiocentesis
xi) Thoracentesis
xii) Balloon Tamponade (Blakemore tubes).
xiii) Lumbar puncture and opening pressure measurement
xiv) Dialysis catheter placement and be aware of the various dialysis techniques and their indications

COMMUNICATOR

1. Communicates effectively and professionally with allied health professionals.
2. Must communicate calmly and effectively in acute resuscitation situations.
3. Demonstrate an ability to consistently achieve a positive rapport with patients and families, gaining their respect and confidence.
4. Must be able to clearly explain diagnosis and treatment options in an understandable fashion to both patients and their family members.
5. Develop communication skills with patients on a ventilator.
6. Must be able to deliver information and/or bad news to families in a humane manner that is understandable and encourages discussion.
7. Demonstrate an ability to write records/reports that are usually complete, orderly, systematic, generally support management, and allow a physician unfamiliar with the patient to identify the relevant daily issues.
8. In response to a consultation request from another health care provider, the resident must be able to present a well-reasoned, well-documented assessment and recommendations in written and oral form.
**COLLABORATOR**

1. Demonstrate the ability to become an active and vital member of the Intensive Care Unit team.
2. Demonstrate an ability to give and follow appropriate instructions with nurses and allied staff, and to develop rapport, resulting in a constructive working environment.
3. Demonstrate an ability to work well with other services.
4. Deal effectively with issues and achieve good results even in difficult situations without antagonizing others.

**MANAGER**

1. Demonstrate the ability to handle most common problems independently, while asking consultants for help with specific questions in more complex situations.
2. Demonstrate the ability to order investigations and consultations in a logical and cost effective manner.
3. Participate in bed management issues. Understand and manage the flow of patients into the ICU, and timely (yet appropriate) transfer of the patient to the ward.
4. Effectively organize work in such a way that priorities are established and that coordination occurs with the other members of the team ensuring total, acute, and continuing care of patients.
5. Respond in timely fashion to consult requests from the ED and wards, balancing the needs of the critically ill patients in the ICU and elsewhere in the hospital.

**HEALTH ADVOCATE**

1. Educate the families of critically ill patients on the life-style and health issues that have led to the illnesses of their family members.

**SCHOLAR**

Residents should be able to demonstrate their scholarly approach to medical practice in the following areas during participation on patient rounds, teaching sessions, and journal clubs:
1. Self-education skills; demonstrate up-to-date knowledge in major clinically applicable developments. Display effective skills in continuing education. Demonstrate an ability to identify gaps in knowledge and develop a strategy to fill the gaps.

2. Critical Appraisal of the Medical Literature; Demonstrate ability to seek out, locate and judge the strength of the evidence in the literature. Able to pose an appropriate patient-related question, execute a systematic search for evidence, and critically evaluate medical literature in order to optimize clinical decision-making.

3. Scientific Interest; Participates in the scientific activities offered in the program. Contributes actively to discussion and teaching. Able to add to and elevate the level of discussion. Incorporates a spirit of scientific enquiry and use of evidence into clinical decision-making.

4. Teaching Skills; Available, approachable. Effectively shares knowledge. Helps others to develop their potential.

5. Oral Presentation Skills; Able to give a clear, concise, effective oral presentation concerning a clinical or scientific topic with appropriate use of audiovisual aids.

**PROFESSIONAL**

1. Integrity and honesty; demonstrate an honest, straightforward approach that is respectful of others, and deserves the respect of others.

2. Show respect at all times for the patient’s:
   a. Race/ethnicity
   b. Language
   c. Religion/belief system
   d. Gender/sexual orientation
   e. Confidentiality

3. Responsibility and self-discipline; Dependable, reliable, honest and forthright in all information and facts; prompt, appropriate follow-up of patients. Non-clinical responsibilities, (e.g. rounds, teaching, etc.) are similarly dealt with.

4. Bioethics; Sensitive to bioethical issues and demonstrates a reasonable approach to them. Performs in an ethical manner with other health care professionals, patients and families.
5. Self-Assessment; demonstrates appropriate awareness of own limitations; seeks assistance and/or feedback to overcome/ compensate for limitations, and accepts advice graciously.

6. Receptiveness to Feedback: Responds constructively to new suggestions and ideas.

**Supervisor:** Dr. David Hornstein (ICU - MUHC)

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**Supervisor:** Dr. Michel de Marchie (ICU – JGH)

**Administrative Coordinator:** Ms. Antoinetta Maglio ([amaglio@jgh.mcgill.ca](mailto:amaglio@jgh.mcgill.ca))

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**Supervisor:** Dr. Ronald Gottesman (PICU - MCH)

**Administrative Coordinator:** Ms. Lyse Dorion

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INTERNAL MEDICINE: CONSULT SERVICE

As a senior, the resident will have the opportunity to further increase medical knowledge and skills while undertaking a 1 month emergency based Internal Medicine consults. The rotation is based at the Royal Victoria Hospital.

MEDICAL EXPERT

To be able to elicit, present and document a history that is appropriately focused for the ED and/or detailed for admission.

1. To be able to perform an accurate physical exam that is focused and relevant to the clinical presentation.

2. Should be able to generate a relevant differential diagnosis and display an understanding of the pathophysiology, presentation, diagnostic work-up, and treatment of patients presenting with undifferentiated problems from the various systems listed below:
   a. Cardiology
   b. Pulmonary
   c. Gastroenterology
   d. Hematology
   e. Oncology
   f. Renal/nephrology
   g. Infectious disease including tropical medicine and immunodeficiency syndromes
   h. Autoimmune disorders
   i. Rheumatology
   j. Endocrine and metabolic
   k. Neurology
   l. Transplant

3. To be able to develop an on-going care plan and arrange appropriate for appropriate disposition.

4. Demonstrate an understanding of the indications for admission to an internal medicine ward, Short stay unit, geriatric ward, CCU, ICU etc.
6. Demonstrate superior ability in the stabilization and assessment of patients presenting with acute medical disorders.

7. Understand the issues surrounding the transport of critically ill patients within the hospital.

8. Demonstrate technical skills (listed below, but not limited to) and be knowledgeable of the indications, contra-indications, and complications of:
   a. Vascular access (peripheral and central)
   b. Arterial blood gas
   c. ACLS skills (CPR, cardioversion, defibrillation, pacemaker, cardiocentesis)
   d. Abdominal procedures (NG, paracentesis)
   e. Lumbar puncture
   f. Pleurocentesis
   g. Arthrocentesis
   h. Urinalysis
   i. ECG interpretation

**COMMUNICATOR**

1. Demonstrate appropriately concise/detailed and legible charting, with follow-up notes and interpretation/analysis of the lab and radiological investigations.

2. Demonstrate the ability to verbally present an accurate and concise history and physical exam.

3. Demonstrate effective verbal communication with:
   a. Patients and their families
   b. Nurses, Respiratory Therapists, Unit Clerks, Patient Attendants, Social Worker
   c. Attending Physicians, Residents and Medical Students
   d. Consultants by telephone/in person
   e. Home care and discharge planning personnel

4. Demonstrate ability to deliver “bad news” to patients/families in a professional and sympathetic manner.

**COLLABORATOR**
1. Work as a member of the multi-disciplinary medical health care team.
2. Respect the other members of the Internal Medicine Department and seek out their opinions and skills when necessary.
3. Demonstrate flexibility in one’s role within the Medical Ward team or the ED consulting service if the need arises.
4. Be capable of involving the patient and family in decision-making when appropriate.

**MANAGER**

1. Work at a pace that is appropriate for level, maintaining an appropriate patient load per level of training.
2. Effective use of consultants and of follow-up consultant visits (i.e. clinics).
3. Show efficient and effective use of ancillary testing including but not limited to: Blood tests, cultures, diagnostic radiology.
4. Comprehend the importance of and manage the flow of patients within the Emergency Department, from the ED to the ward, and the subsequent appropriate and timely discharge from the ward.
5. Show an understanding how timely disposition from the ward affects ED flow.
6. Incorporate the patient’s family physician or primary care physician into the management plan.
7. Be cognizant of the role of the Department of Medicine within the hospital and as a tertiary/quaternary care referral center.

**HEALTH ADVOCATE**

1. Understand that the patient’s well being is central to all medical care.
2. Be able to educate and counsel both patients and families regarding factors that impact on their health care status.
3. Be the patient’s advocate at all times, particularly when they are unable to do so themselves.

**SCHOLAR**
1. Continuously seeking out new knowledge e.g. texts, journals and incorporate this into daily practice.
2. Be able to use information technology to optimize patient care and self-directed learning.
3. Apply Evidence-Based Medicine to ongoing general medical care.
4. The senior resident must be able to apply landmark studies to patient care.
5. Active participation in the various medical rounds and teaching sessions.

**PROFESSIONAL**

1. Demonstrate awareness of the racial, cultural and societal facets that affect the delivery of medical care.
2. Show respect all times for the patient’s:
   a. Race/ethnicity
   b. Language
   c. Religion/Belief system
   d. Socioeconomic status
   e. Gender/ sexual orientation
   f. Confidentiality
3. Be insightful of one’s own strengths and weaknesses, and recognize when to call for back up.
4. Be able to receive and accept constructive feedback.
5. Display ethical behavior compatible with a physician at all times with respect to:
   a. Patients and their families
   b. Allied health staff
   c. Attending Staff, residents and medical students
6. Be a role model for medical students, residents, nurses.

**Supervisor:** Dr. Tom Maniatis

**Administrative Coordinator:** Ms. Carol Seguin (carol.seguin@muhc.mcgill.ca)

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**MSK/ORTHOPEDICS**

**INTRODUCTION**
This four-week rotation is designed to expose the FRCP Emergency Medicine resident to general musculoskeletal and orthopedic pathology commonly encountered in the field of Emergency Medicine. This experience will be uniquely based in outpatient environments - primarily, but not necessarily limited to, the Emergency Department and Orthopedic Clinic settings. Both adult and pediatric experiences will be included within the same rotation. During this rotation, the resident is expected to consolidate their knowledge and skills in the primary ED management and appropriate referral for follow-up and ongoing care of common MSK/orthopedic problems. Through specific clinic experiences, the resident will amass a more specialized knowledge base and advanced skills that can be applied to their ED patient encounters, as well as to improving their ability to communicate with their consultant colleagues and allied healthcare providers. A suggested reading list, along with core teaching sessions, rounds and resident presentations, will supplement the clinical learning experiences. With regards to direct teaching responsibilities, the resident will be expected to prepare three (3) MSK/orthopedic-related teaching sessions to be given to the residents and medical students rotating through the Montreal General Hospital Emergency Department during their month on service. When possible, the resident will also be expected to prepare an MSK/orthopedic-related case presentation to be presented at the program’s weekly educational rounds.

The rotation supervisor/coordinator will be Dr. Monica Cermignani (Emergency Staff Physician) at the Montreal General Hospital. Teaching and attending staff participation has been offered and endorsed by all implicated players, and approval given by the heads of the various departments involved.

**STRUCTURE**
During this rotation, the resident will participate in direct clinical patient care in the following settings:

2. Emergency Department of the Montreal General Hospital
3. Orthopedic (trauma) clinics at the Montreal Children’s Hospital
4. Orthopedic clinics at the Montreal General Hospital
5. Orthopedic consultation in the Emergency Departments of the Montreal General and Montreal Children’s Hospitals
6. Plastic Surgery clinics at the Montreal General Hospital
7. Casting sessions at the Montreal General Hospital
8. Thus the resident will be exposed to 2 main outpatient settings – that of the Emergency Department and that of the Orthopedic clinic.

During their time in the ED, the resident will be under the direct supervision of the attending ED staff on shift. They will be expected to see all patients in the ambulatory care area of the MGH ED presenting with MSK/orthopedic complaints. They will be responsible for the initial evaluation, ongoing care and disposition of these patients during their visit to the ED. For those patients requiring specialist (orthopedic) consultation in the ED, the resident will be expected to accompany the consultant during their evaluation of the patient and to be involved in any additional investigations, re-evaluations and ultimate disposition planning in concert with the consultant and attending ED staff. The resident will be encouraged to be aware of patients seen in other areas of the ED with MSK/orthopedic problems and to implicate themselves appropriately in their evaluation and management.

During their time in clinic, the resident will be under the direct supervision of the attending orthopedic clinic staff (adult or pediatric). They will be responsible for the initial evaluation of clinic patients, and together with the attending staff, will make decisions regarding their immediate management and ongoing care. While in clinic, the resident will also have the opportunity to be involved in the initial assessment of orthopedic consultations requested by the Emergency Department. These consults will be reviewed and managed in concert with the responsible orthopedic resident and attending staff.

**EVALUATION**

The resident will be responsible for obtaining a completed daily evaluation form from the attending physician for each of the individual clinical experiences attended during the rotation. Daily evaluation forms will be provided to the resident at the beginning of the rotation. The resident is expected to give a blank form to the attending physician at the beginning of the experience (ED
shift or clinic), and to request the completed copy along with feedback at the end of that same experience.

Patients seen by the resident will be recorded on the daily evaluation sheets (by MRN and diagnosis only), in order to give an idea of the number of patients and breadth of pathology seen in each clinical setting, and during the overall rotation. The resident will also be provided with a log book in which he/she is expected to document relevant activities throughout the 4-week rotation, including all procedures performed/witnessed. This log book will also have space to list interesting imaging studies (by MRN and diagnosis), which will ultimately be used to compile a teaching database for the residency program. It is expected that the resident will submit all daily evaluations along with the completed logbook to the rotation coordinator at the end of the rotation.

**OBJECTIVES**

**MEDICAL EXPERT/CLINICAL DECISION-MAKER**

*Basic Scientific Knowledge*

Demonstrate knowledge of the anatomy and physiology of the musculoskeletal system. Demonstrate knowledge of the principles of healing of bone, muscle, tendon and ligament injuries.

*Basic Clinical Knowledge*

Demonstrate knowledge of the following:

1. Mechanism and natural history of traumatic injuries to the musculoskeletal system. These include, but are not limited to:
   a. fractures
   b. dislocations
   c. sprains, strains, muscle tears
   d. tendonitis, bursitis, pophysitis
   e. back pain
   f. radiculopathies
   g. overuse syndromes
2. Accurate description of fractures & dislocations with respect to:
   a. anatomic location
   b. type/classification
   c. comminution
   d. angulation
   e. displacement
   f. open or closed
   g. articular involvement

3. Accurate description of soft tissue and non-fracture injuries with respect to:
   a. anatomic location
   b. severity/grade
   c. degree of limitation of function/range of motion

4. Pathogenesis, pathophysiology and natural history of non-traumatic disorders of the musculoskeletal system. These include, but are not limited to:
   a. infections
   b. inflammatory and rheumatologic conditions
   c. malignancies

5. Clinical presentation of traumatic and non traumatic musculoskeletal conditions.

6. Manifestation of injuries and non-traumatic syndromes in special patient populations. These include, but are not exclusive to:
   a. athletes
   b. children and adolescents
   c. the elderly


8. Pharmacological agents and other modalities used in the treatment of musculoskeletal and rheumatologic disorders.

10. Appropriate consultation and follow-up for acute musculoskeletal conditions.

**History & Physical Examination**

Demonstrate ability to perform a complete orthopedic/musculoskeletal history and physical examination. Examination of the following are emphasized:

- hand
- wrist
- shoulder
- foot and ankle
- knee
- hip
- spine, including peripheral nerve exam

The assessment should be organized in a sequential manner, which permits a clear definition of the problem and a rational approach to differential diagnosis and management.

**Interpretation & Utilization of Information**

Display knowledge of indications, limitations and health risks of the following tests, as well as display appropriate utilization of their results:

- plain radiography
- CT scanning
- MRI imaging
- fluoroscopy
- nuclear medicine
- blood work

Display proficiency in the interpretation of plain radiography of the musculoskeletal system.

**Clinical Judgment & Decision Making**

Demonstrate the ability to do the following:

- Evaluate specific symptoms and signs that occur in disease and injury states of the musculoskeletal system
- Assess the risk of associated injuries in patients with multiple trauma or trauma to
defined anatomical areas
c. Perform the appropriate clinical and imaging assessments that will identify common and important fractures/dislocations
d. Appropriately select and apply temporary immobilization techniques for a given injury or condition
e. Attend to pain and suffering caused by acute musculoskeletal injury

**Technical Skills**
Demonstrate proficiency at the following skills:

a. casting and splinting of non-displaced fractures
b. reduction of common fractures
c. reduction of common dislocations
d. arthrocentesis
e. common joint infiltrations
f. local and regional anaesthesia, including hematoma blocks and nerve blocks, used in the treatment of common musculoskeletal disorders
g. procedural sedation

**COMMUNICATOR**

*Inter-Professional Relationships With Physicians and Other Allied Health Professionals*
Demonstrate the ability to effectively communicate with referring and consultant colleagues regarding the nature (mechanism, description) of injury/illness, performance of necessary interventions and coordination of subsequent care.

Demonstrate the ability to do the following on a regular and ongoing basis:

a. Work effectively with other physicians and allied professionals of the healthcare team
b. Show consideration for the knowledge, skills and roles of the various members of the healthcare team
c. Be respectful of other team members
**Communications With Patients & Families**
Demonstrate the ability to communicate effectively regarding the nature of the injury/illness suffered and anticipated management plan, showing them respect and gaining their cooperation and confidence.

Demonstrate the ability to discuss and explain “bad news” to the patient & family in a sensitive, concise and comprehensible manner.

**Written Communication and Documentation**
Consistently demonstrate the ability to document the history, physical, diagnostic formulation, and management plan in an accurate, complete and organized manner. This includes documentation that may be required in, but is not limited to:

a. initial patient evaluations
b. progress notes
c. discharge summaries
d. consultation reports

Show skill in explaining risks, benefits and obtaining consent for relevant procedures.

**COLLABORATOR**
Demonstrate the ability to:

a. work within the framework of a multi-disciplinary healthcare team.
b. recognize the expertise of each health care team member and their respective role as it relates to the patient’s care.
c. appropriately delegate responsibilities to members of the health care team.

d. resolve common team conflicts
e. involve the patient and family in decision-making.

**MANAGER**
Demonstrate the understanding and utilization of current information technology in managing musculoskeletal injuries and disorders.

Demonstrate the responsible allocation and rationalization of resources to the patient and
population based on the best-available evidence.
Demonstrate the ability to manage competing interests of individual ongoing patient care, new patient assessment and patient flow in the ED setting.
Demonstrate the ability to manage competing interests of individual patient care and consultation requests in the clinic setting.
Demonstrate the capacity to manage multiple patients concurrently.
Understand the role of Orthopedic, Sports Medicine, Physiotherapy, Occupational Therapy and rehabilitation services with respect to the patient, hospital and community as a whole.
Coordinate/direct patients appropriately for ongoing care by Orthopedics, Sports Medicine, Physiotherapy, Occupational Therapy and rehabilitation services.

**HEALTH ADVOCATE**

Be the patient’s advocate at all times, particularly when they are unable to do so themselves.

Display advocacy for the community at large and for society.

Demonstrate the ability to discuss risk and harm reduction strategies, as well as safety precautions to prevent future injury from occurring.

**SCHOLAR**

*Motivation to Read and Learn*

Demonstrate knowledge of current scientific literature and application of this knowledge to case presentation and daily patient management.

Demonstrate interest in expanding current knowledge base by reading around clinical cases.

*Critically Appraises Medical Literature*

Demonstrate the ability to critically-appraise research methodology and medical literature with respect to clinical cases, as well as during organized activities such as journal club.

*Teaching Skills*
Demonstrate initiative to teach other health care professionals and/or patients about specific relevant health care issues.

Discuss clinical topics and/or journal articles with colleagues in the form of presentations or journal clubs.

**PROFESSIONAL**

Demonstrate awareness of the racial, cultural and social factors that influence the delivery of emergency care

Show respect all times for the patient’s:

- Race/ethnic background
- Language
- Socio-economic level
- Religion/Belief system
- Gender/sexuality
- Confidentiality

Be insightful of one’s own strengths and weaknesses, and recognize when to call for back up. Be able to receive and accept constructive feedback.

Display ethical behaviour compatible with a physician at all times with respect to:

- Patients and their families
- Allied health staff
- Attending Staff, residents and medical students

Be a role model for medical students, residents, staff physicians, nurses, and other allied health care personnel.

Maintain a healthy and sustainable balance between personal and professional lives.

**Supervisor:** Dr. Sanjeet Saluja

**Administrative Coordinator:** Ms. Madeleine Becker

**Telephone:** 514-934-1934, ext. 42501
NEUROSCIENCES (NEUROLOGY)

The McGill Emergency Medicine Resident will experience their core Neurosciences on 2 rotations: The Neurology Consult Service and NICU (Neurologic Intensive Care Unit). Both of these rotations are 4 weeks in duration. Further knowledge will be garnered on several other rotations including Adult and Pediatric Emergency, ICU, and Trauma.

MEDICAL EXPERT

1. Display knowledge of neuro-anatomy and (patho)physiology.
2. Develop skill in the performance of both a screening and detailed neurological exam.
3. To be able to cite the criteria and perform the exam for brain death.
4. Demonstrate the ability to recognize and manage the following conditions:
   a. Acute cerebrovascular disorders (ischemic or hemorrhagic)
   b. Status epilepticus/seizure
   c. Acute spinal cord emergencies (compression, trauma, cauda equina)
   d. (Acute) headaches, status migrainosis
   e. Cranial nerve isorders
   f. Demyelinating disorders
   g. Neuromuscular disorders (Myasthenia gravis, Guillain-Barre, ALS)
   h. Pseudotumor cerebri
   i. Normal pressure hydrocephalus
   j. Peripheral neuropathies
   k. Shunt malfunction
   l. Neurological infections (meningitis, encephalitis, abcess, shunt)
   m. Closed head injury/concussion syndromes
   n. Penetrating head injury
   o. Burr holes: indications, how to perform, complications
5. Understand the pathophysiology of raised ICP, the various management techniques and how to perform RSI when there is an elevated ICP.
6. Understand the indications for:
   a. CT(A)
b. MR(A)
c. EEG
d. EMG
e. Doppler
f. Plain radiography

7. Develop skills in performing lumbar puncture and the subsequent interpretation of the results.
8. Develop an approach to interpreting head CTs.

**COMMUNICATOR**

1. To be able to effectively communicate the diagnosis and treatment plan to the patient and/or his/her family, including prognosis, risk modification.
2. When working as a consultant, the resident will effectively communicate the plan both written and verbally to the appropriate health professionals.
3. Demonstrate ability to discuss living wills, advanced directives, and levels of care.
4. Be able to discuss end of life issues (including brain death, organ donation) in a compassionate, concise and understandable way with family members.
5. Show skill in explaining risks, benefits and obtaining consent for relevant procedures.
6. Communicate effectively with the multi-disciplinary team.

**COLLABORATOR**

1. The resident will recognize the role of each health care team member with respect to the patient’s care.
2. The resident will be cognizant of when to contact the organ donation team.
3. Demonstrate ability to resolve common team conflict problems.
4. Demonstrate ability to work in a multi-disciplinary team.
5. Be capable of involving the patient and family in decision-making.

**MANAGER**

1. Demonstrate rational utilization of the various diagnostic imaging tools.
2. Demonstrate rational utilization and understanding the roles of the neurological and neurosurgical consulting services.
3. Demonstrate appropriate outpatient referral.

**HEALTH ADVOCATE**
1. The resident will act as the patient’s advocate at all times.
2. The resident will discuss risks and harm reduction strategies (e.g. BP or sugar control, protective helmets, return to play).
3. Organ donation.

**SCHOLAR**
1. The resident must be aware of the current literature and controversies (e.g. thrombolysis and acute CVAs).
2. The resident must be able to critically appraise the literature.

**PROFESSIONAL**
1. Must display ethical behaviour compatible with a physician at all times when working with:
   a. Patients and their families
   b. Allied health professionals
   c. Attending staff, residents and students
2. Show respect at all times for the patient’s:
   a. Race/ethnicity/socio-economic background
   b. Language c. Religion
   d. Sex/sexuality
   e. Confidentiality
3. The resident must be cognizant of his/her own strengths and weaknesses, and know when to ask for help.
4. Be a role model for medical students, residents, nurses and other colleagues.
5. Be able to receive and accept constructive feedback.
Administrative Coordinator: Ms. Nadia D'Amore (residency.neurology@mcgill.ca)
Telephone: 514-398-2167

Supervisor: Dr. Calvin Melmed (JGH) Administrative Coordinator:
Coordinator: Ms. Terry Hulewicz
OBSTETRICS & GYNECOLOGY

Obstetrics and Gynecology is a 4 week rotation takes place at St. Mary’s Hospital. In addition, the resident will have ample exposure obs/gyn problems at both the RVH and JGH. While rotating at the MGH, the resident will have the opportunity to take call with the sexual assault team.

MEDICAL EXPERT

1. Demonstrate ability to perform an obstetrical and gynaecological history, exam and assessment.
2. Demonstrate the knowledge of the anatomy, physiology of gynaecological and other pelvic structures and the physiologic changes of pregnancy.
3. Demonstrate knowledge of the normal stages of labour and delivery, including their time course.
4. Able to formulate a differential diagnosis, management plan including investigations of the following conditions:
   a. Vaginal bleeding in the pregnant patient (all trimesters).
   b. Pelvic and abdominal pain in the pregnant patient.
   c. Vaginal bleeding in the non-pregnant patient.
   d. Pelvic and abdominal pain in the non-pregnant patient.
   e. Vaginal discharge/pruritis.
5. Display ability to diagnosis, investigate and manage the following emergency gynaecological and obstetrical emergencies:
   a. Abortions
      i. Threatened/Incomplete/Complete.
      ii. Septic Abortions.
      iii. Complications of Therapeutic Abortions.
   b. Placental Emergencies
      i. Placenta Abruption.
      ii. Placenta Previa.
      iii. Vasa Previa.
c. Pregnancy
   i. Ectopic pregnancy.
   ii. Hyperemesis gravidum.
   iii. Molar pregnancy.
   iv. Pregnancy Induced Hypertension (Preeclampsia/eclampsia/HEELP).
   v. Complications of labour.
      1. Preterm labour.
      2. Premature rupture of membranes.
      3. Failure to progress.
      4. Fetal distress.
   vi. Complications of Delivery
      1. Prolapsed cord.
      2. Abnormal presentations (breech, shoulder dystocia, other).
      4. Multiple and still birth. ii.
Neonatal resuscitation.
   iii. Calculation and significance of APGAR scores. iv.
Isoimmunization.
   v. Post partum complications.
      1. Hemorrhage.
      2. Retained products.
      3. Endometritis.
      5. Cardiomyopathy.
      6. Depression.

d. Infection
   i. Pelvic Inflammatory Disease.
   ii. Sexually transmitted diseases.
   iii. Toxic shock syndrome.
e. Ovarian Torsion
f. Sexual assault
g. Trauma: Demonstrate an understanding of the significance and management of minor to major trauma in the pregnant patient including fetal monitoring, US, and indications for emergent delivery.

h. Know the indications and describe the technique for post mortem C-sections.

6. The resident should demonstrate the following skills:
   a. Show ability to perform an uncomplicated delivery
   b. Demonstrate knowledge to perform moderately difficult delivery including but not limited to:
      i. Shoulder dystocia.
      ii. Breech delivery.
   c. Pelvic Ultrasonography
      i. Detection of IUP.
   d. Perinatal and neonatal resuscitation

**COMMUNICATOR**

1. Explore facets of patient e.g. age, gender, ethno-cultural background, social support and emotional wellness and their effect on the patient’s illness or pregnancy.
2. Demonstrate ability to discuss the patient’s care and counsel regarding risk modification with the patient and family.
3. Demonstrate ability to discuss and explain to patients and families “bad news” in a sensitive, empathic and understandable manner.
4. Show skill in explaining risks, benefits and obtaining consent for relevant procedures.
5. Demonstrate ability to discuss living wills, advanced directives and *do not resuscitate* orders.
6. Communicate effectively with the multi-disciplinary team.
7. Demonstrate the ability to enquire about the possibility of abuse in a sensitive manner.

**COLLABORATOR**

1. The resident will recognize the role of each health care team member with respect to the patient’s care.
2. Demonstrate ability to resolve common team conflict problems.
3. Demonstrate ability to work in a multi-disciplinary team.
4. Be capable of involving the patient and family in decision-making.

**MANAGER**

1. Demonstrate evidence-based ability to allocate resources to the patient and population served.
2. Recognize resources of tertiary care gyn/obstetrical care centres and the use and rationalization of these for the individual patient and the population served.
3. Be able to manage competing interests of consults from other services, including the Emergency Department, with ongoing care of admitted patients.
4. Be capable of managing multiple patients concurrently.
5. Comprehend the role of the Obs/gyn service with respect to the hospital and community as a whole.
6. Elucidate and recognise instances of medico-legal risk and identify potential preventive and corrective steps.

**HEALTH ADVOCATE**

1. Demonstrate ability to identify the determinants of health of the individual obs/gyn patient.
2. Be capable of discussing with patients risk and harm reduction strategies.
3. Be the mother’s and baby’s advocate at all times, particularly when they are unable to do so themselves.

**SCHOLAR**

1. Demonstrate knowledge and applicability of specialty relevant important studies.
2. Be consistent in reading around clinical cases and improving obs/gyn knowledge base.

**PROFESSIONAL**

1. Show respect all times for the patient’s:
   a. Race/ethnicity.
   b. Language.
c. Religion/Belief system.
d. Sex/sexuality.
e. Confidentiality.

2. Be insightful of one’s own strengths and weaknesses.
3. Be able to receive and accept constructive criticism.
4. Display ethical behaviour commensurate with a physician at all times with respect to:
   a. Patients and their families.
   b. Allied health staff.
   c. Attending Staff, residents and medical students.
5. Serve as a role model for colleagues and other health care personnel.

**Supervisor:** Dr. S. Laplante/Dr. R. Perrotta (SMH)

**Administrative Coordinator:** Ms. Bernadette Donnelly (bernadette.donnelly@ssss.gouv.qc.ca)

**Telephone:** 514-734-2649
PSYCHIATRY

The McGill EM Psychiatry rotation is a 4 week rotation based in the Psychiatry Emergency of the Royal Victoria Hospital. Under the direct supervision of the emergency based psychiatrist, the resident will be responsible for assessing both the ambulatory psychiatric patients that walk in to psychiatry emergency services, and the patients referred by the Emergency Physician.

MEDICAL EXPERT

The Emergency Medicine Resident must be able to:

1. Demonstrate the ability to conduct an interview with patients with acute and chronic psychiatric disorders.
2. Demonstrate ability to perform a mental status exam in patients with normal and altered mental status.
3. Demonstrate the ability to assess suicide risk and thereafter initiate appropriate management.
4. Must be cognizant of the DSM classification of psychiatric disorders:
   a. Assess and make a differential diagnosis and management plan for patients with major affective (axis I) disorders.
   b. Assess and make a differential diagnosis and management plan for patients with personality and developmental (axis II) disorders.
5. Must understand interaction between psychiatric and medical disorders (axis III):
   a. Understand how to medically clear a patient including the role/utility/indications/limits of various laboratory and other investigative modalities.
   b. Delirium versus dementia.
   c. Dementia versus pseudodementia.
   d. Alcohol and other intoxications as well as withdrawal syndromes.
   e. Altered mental status secondary to a medical condition versus a primary psychiatric disorder.
6. Must learn the principles and demonstrate effective management of the violent patient.
including:

a. Use of restraints, both physical and chemical.
b. Safety of staff.
c. Conflict resolution.
d. Techniques to avoid escalation.

7. Understand the pharmacodynamics, indications, contraindications and side effects of the therapeutic agents (major tranquilizers, sedative hypnotics and anti-depressants) commonly used to treat the various psychiatric disorders.

8. Must be cognizant of the various medico-legal issues of competence, consent, “involuntary hospitalization” including:

   a. “Garde Preventive”.

**COMMUNICATOR**

1. Demonstrate appropriate documentation of the psychiatric history and physical.

2. Communicate effectively with the patient, the patient’s family, and allied health personnel, in an appropriate, sensitive, concise and understandable manner.

3. Communicate effectively back to the consulting physician both verbally and written.

**COLLABORATOR**

1. Understand the roles and work as part of a multi-disciplinary health care team including psychiatrists, nurses, social work, patient attendants, referring physicians.

2. Work with and understand community resources.

3. Working with and involving the patient and family in decision making and treatment plan.

**MANAGER**

1. Must demonstrate the ability to use and allocate psychiatric resources appropriately, including indications for emergency psychiatric consultation.

2. Must be able to manage competing interests between patients, families, psychiatrists,
consulting (Emergency) physicians.

3. Must understand the role of Psychiatry Services within the Emergency Department, the hospital, and the community.

**HEALTH ADVOCATE**

1. Act as the patient’s advocate.
2. Be capable of discussing with patients risk and harm reduction strategies.
3. Intervene on behalf of the patient obtaining appropriate social service involvement.

**SCHOLAR**

1. Demonstrate interest in acquiring psychiatric knowledge by continued reading.
2. Be cognizant of emergency related landmark psychiatric literature.

**PROFESSIONAL**

1. Be mindful of one’s own limitations and know when to call for back-up (by knowing and acknowledging your strengths and weaknesses).
2. Show respect at all times for the patient’s:
   a. Race/ethnicity
   b. Language
   c. Religion/Belief system
   d. Gender/Sexual orientation
   e. Confidentiality
3. Be a leader in dealing with the difficult patient and show skills in conflict management.
4. Display ethical behaviour compatible with a physician at all times with respect to:
   a. Patients and their families
   b. Allied health staff
   c. Attending Staff, residents and medical students
5. Be a role model to fellow physicians, nurses, residents, and medical students.

**Supervisor:** Dr. Karine Igartua/Dr. Kia Faridi

**Administrative Coordinator:** Ms. Nadia Zajac (nadia.zajac@muhc.mcgill.ca)

**Telephone:** 514-934-1934, ext. 42365/35520
RESEARCH

GOALS

Primary Goals

1. The ultimate goal of the research time is to introduce the resident to the basic concepts of research and to stimulate interest in pursuing a career as an emergency physician-researcher. Ideally, residents should produce an original research project. The resident will also have the option to join an on-going research project with specific tasks that he/she must complete.

MINIMUM CRITERIA: The resident will be expected to bring the research project to i) submission for publication or ii) presentation at a conference research forum or iii) poster presentation.

There will be a minimum standard. The minimum criteria will be established by the RRC in conjunction with the resident and his/her research supervisor. This will be dependent on the type of research being done (original versus joining on-going research) and the level of difficulty of the project. As the research progresses, the RRC will have the right to change the minimum criteria.

Secondary Goals

1. To provide the Emergency Medicine residents with an understanding of the principles and practices of clinical research.
2. To critically evaluate scientific literature and encourage future research in emergency medicine.
3. To familiarize residents with principles of scientific writing, grant applications, and potential funding agencies.
4. To produce fundable projects to support research at McGill University Emergency Medicine.
5. To present at scientific meetings.
6. To add to and enhance the field of Emergency Medicine.
7. To expose the resident to research as a career option.
OBJECTIVES

MEDICAL EXPERT/CLINICAL DECISION-MAKER
1. Recognize the interface between clinical practice and the clinical research that informs evidence-based clinical practice.
2. To formulate research questions from the uncertainty that exists in Emergency Department care.

COMMUNICATOR
1. To communicate effectively, both verbally and in writing research proposals.
2. To learn how to write grant proposals, abstracts, and research papers.
3. Demonstrate ability to obtain informed consent.
4. To be able to present research at either rounds and/or major conferences.

COLLABORATOR
1. Work effectively with a research supervisor, biostatistical consultants and other members of a research team to bring a project to fruition.

MANAGER
1. Demonstrate time management skills that will permit timely completion of the scholarly requirements of the research objectives.
2. To manage the financial resources of the research project.

HEALTH ADVOCATE
1. Consider research project from a societal perspective of risk benefit and greater public good.

SCHOLAR
1. The resident will participate in research and thereby
   a. Contribute to development of new knowledge.
   b. Become an expert in the chosen research field.
2. The resident will either:
   a. Develop an independent research project, or
   b. Join a research project/concept that has already been initiated, but has no proposed methodology.

3. The resident will:
   a. Present at the annual Resident Research Day b.

Ideally the resident will:
   i. Present an abstract or poster presentation at a major conference (CAEP, AMUQ, SAEM).
   ii. Bring the research to publication.

**PROFESSIONAL**

1. Recognize the ethical and professional obligations inherent to clinical research.
2. If necessary, interact with an institutional Research and Ethic Review Board to advocate for or defend a research proposal.

**How to Proceed with the Research Project**

1. Research starts with idea generation. Sources for ideas appropriate for study include experienced researchers, both in the field of Emergency Medicine as well as in related specialties, attending physicians, and other residents. The residency research committee (RRC) is also a potential source of research questions. The RRC will have a list of on-going research projects, research staff interested in working with a resident, and a bank of research ideas.

2. All residents will be supported by a research supervisor.

3. Original Research: These studies may be experimental or observational studies or meta-analyses. Case reports are not acceptable. The research proposal must be well-developed, and will likely require multiple revisions.

4. The Emergency Medicine Residency Research Committee (RRC) is a primary
component of the research curriculum. The RRC is accountable to the Program Director to meet the goal and primary objectives as previously stated. The supervisor will monitor Resident’s progress. Both the resident and the supervisor will be accountable to the RRC to meet selected objectives after each research rotation (to be elaborated below). The RRC will establish links with other departments, McGill University and the Department of epidemiology to facilitate resident projects.

5. In order to complete the residency program, the resident must have completed the minimum criteria as established between the resident, research supervisor and the RRC.

PHASES
The following research phases have been developed to provide the resident with a structure for successful completion of the goals and objectives. It is possible that residents accelerate these suggested guidelines.

PHASE I: R1
GOALS
1. To successfully complete two courses offered by McGill Annual Summer Program.
2. By the end of R1, the resident should have come up with a research idea, or linked up with an on-going research project. If the resident has not done so, then the RRC has the right to assign the resident a research project.
3. To gain sufficient background information to present Grand Rounds or a topic specific journal club on a particular subject early in the R2 year.

Epidemiology Course
The resident (R1) will undertake 2 (two) summer courses offered by the McGill University Annual Summer Program in Epidemiology and Biostatistics. These will occur during periods 12 and 13 the first year of the program. For further information phone 398-3973, fax 398-4503 or E-mail summer@epid.lan.mcgill.ca. Please note, this will be combined with a half time ED rotation over these 2 periods.

Research Hypothesis
Residents should develop an area of research interest in the R1 year. The Emergency Medicine Residency Research Committee (RRC) is developing a bank of interested supervisors with accompanying fields of interest and particular projects. Residents should review the databank of projects, and perhaps read through abstracts presented in recent Emergency Conferences with the goal of developing a research idea. Indeed, finding a good research question is often the most difficult part of the Research curriculum.

Residents should then approach the Research Chairpersons, Drs. Eli Segal and Scott Delaney, to help them select their research project. It is a good idea to validate the project before too many hours are spent delving into an impractical project; early consultation will allow greater exploration of ideas and feasibility of the study. The goal is that the resident should have a feasible research project and an appropriate supervisor prior to starting their R2 year.

Residents should initiate OVID or Medline searches during the R1 or R2 years. Help with searches can be obtained from the medical librarians in each hospital or at the Health Sciences Library at McGill. The review of previous research should be regarded as a dynamic process. After a researchable question has been asked, a literature search helps determine what has already been studied, what research designs have been employed, what controversies exist, and where your question fits in. It will allow the resident to critically appraise preceding works, and puts the intended research project in prospective by linking it to previous works. As well, the methods used by previous authors may suggest other ideas.

PHASE II: R2

Hypothesis & Methodology Development

By the end of the R2 year, the resident will have done

1. A thorough review of the literature on their research topic
2. A study hypothesis
3. Research methodology
4. Ethics approval

This information should be submitted to the RRC or presented as the Resident's Grand Rounds on
Wednesday Morning Rounds, (or a topic specific Journal Club). The resident will be expected to discuss his/her research idea and will receive feedback. A written proposal is a necessary working document that will allow the resident to carefully define his/her plan to test the hypothesis stated, and minimizes the risk of wasting time and resources associated with more casual or informal approach. Since the research project does involve the collaboration of others, the proposal helps formulate, structure, and communicate the resident's idea to the others.

Besides their supervisor, Residents are encouraged to consult the Research Chairpersons, and other resource persons in the Department, the Hospital or the University. When seeking expert opinion, study feasibility (i.e. sample size), ethical issues such as, risk to patients, informed consent, and withholding treatment to the control group should be questioned.

**PRELIMINARY Methodology Proposal**

The resident will improve upon and/or reformulate the hypothesis (if necessary) and then develop the research methodology. The format should include the goal of the study, a research plan, inclusion and exclusion criteria for the population to be studied, treatments, statistical considerations, potential risk to subjects, informed consent, and estimated time for completion of the study based on calculations of sample size needed and the number of potential subjects visiting the ED.

Suggested research proposal outline would include:

i) Title

ii) Abstract

iii) Introduction

iv) Review of the pertinent literature

v) Study objective or hypothesis

vi) Significance

vii) Methods:

i. Overview of study design

ii. Patient population

   • inclusion criteria
   • exclusion criteria

iii. Measurements
iv. Interventions  
v. Outcome variables  
vi. Potential confounding variables  
vii. Procedures to be used in the collection of information  
viii. Method of blinding patients, experimenter, and the evaluator  

8. Statistical considerations  
a) Power calculations  
b) Sample size  
c) Statistical analyses  
d) Examples of tables, charts and graphs  

9. Safety  
a) Criteria for early study termination (if any)  
b) Ethical and legal considerations c)  
Adverse event reporting  
d) Patient consent  
e) Responsibilities of the investigator  

10) References  

The supervisor will oversee the preparation of the research proposal. Once the research proposal has been finalized, the project will be submitted to the ethics committee (if required). Early consultation with the ethics committee may help avoid late discovery of ethical issues that could complicate a mature project, thus avoiding needless protocol revisions. After approval from the ethics committee, project implementation may then proceed. 

By the end of the R2 year, a written preliminary research proposal must be submitted to the RRC for review. A written proposal is a necessary working document that will allow the resident (and preceptor) to carefully define their plan to test the hypothesis stated. Revisions to the draft are expected and the resident should not feel defeated or discouraged, but view the comments
constructively.

PHASE III: R3/R4
Once the research proposal has been accepted by the EMRRC, the project will be submitted to the ethics committee (if required). After approval from the ethics committee, project implementation may then proceed.

1. **Granting Application**
The resident will be guided on how to tailor their research proposal to gain acceptance by granting agencies. Applications to agencies such as national emergency associations, the FRSQ and MRC, pharmaceutical companies and research funding from the university and the hospital will be encouraged.

2. **Project Implementation**
Recruitment of the medical staff and support personnel for data collection will be necessary to complete a study without bias, such that there is no selective entrance and processing of patients. The resident will need to develop an educational package for introduction of his/her study to ensure adequate recruitment and proper initiation of the study. It may be advisable to commence with a pilot study to rectify haunting errors in methodology. It would be extremely unusual for a study to be abandoned if it passed through the above stages, and if no problems are encountered the pilot patients can be entered into the main study.

3. **Data Collection & Analysis & Drafting the Research Paper**
   **Analysis of Data**
This stage may be tedious, but should not be a “fishing expedition”, if the hypothesis has been properly formulated. Excellent computer software such as SAS, Systat, Statview, Superanova all will assist the resident to analyze the data in a responsible and thoughtful manner.

   **Draft the Research Paper**
Preparing the draft and manuscript for publication is the final objective the resident should reach. If the resident's abstract or articles are accepted for national
meeting, they will be given the opportunity to travel to present their work.

## SUMMARY

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<td>Select field of interest &amp;</td>
<td>Resident translates an idea into</td>
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<td>meet with supervisor, RRC</td>
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<td>Hypothesis development</td>
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<td>Proposal</td>
<td>Write introduction &amp; methodology</td>
<td>with the objective of improving upon original</td>
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<td>Preliminary Draft</td>
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<td>Final draft</td>
<td>Improve the methodology</td>
<td>Resubmit final proposal to RRC</td>
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<td>Ethics committee</td>
<td>Submit protocol to ethics</td>
<td>Approval of protocol; revision of protocol if</td>
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<td>Phase III</td>
<td>R3/R4</td>
<td>Granting &amp; Project implementation</td>
<td>Learn how to procure funding and prepare implementation of protocol</td>
<td>Applications to granting agencies</td>
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<td>Data collection &amp; analysis</td>
<td>Collect and analyze data.</td>
<td>Complete data collection.</td>
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<td>Results and conclusions</td>
<td>Complete research project.</td>
<td>Submit for presentation and publication.</td>
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**Ongoing Research:** Should the resident undertake research in an ongoing research project, then the time line for progression will need to be established between the RRC, the research supervisor, and the resident. The research should be completed by the end of the R4 year.

**Research Time:** The resident will have an equivalent of 5 periods (20 weeks) of research over the entire program. No research time will appear on the resident’s annual schedule. The resident will have to “apply” for time just as they would for vacation/conference/study leave. Research time can only be taken from Emergency rotations. The procedure for obtaining research time is:

1. Submit time request to the RRC (with a copy to the program director) a minimum of 45 days prior to the rotation. This will give the RRC to review the request, and once approved, will allow the 30 day minimum time required for schedule requests.
2. The resident must state how much time they want in terms of weeks (1, 2, 3 or 4).
3. The resident must indicate what their goals are for that time period.
4. Once approved, the RRC will inform the resident and research supervisor. In addition the RRC will inform both the program director and program coordinator/secretary (who will keep a grid of all the research time used by the residents).
5. The resident will then inform (with a copy of the RRC approval) the person
responsible for emergency schedules of the time allowed for that period, and whether they want it off as an entire block, specific days, or just a proportional decrease in number of shifts.

Please note, residents are still expected a) to do their share of nights and weekends and b) attend rounds and journal club.

6) Accountability: Once completed the resident must present to the RRC the work that they have accomplished.
RESEARCH EVALUATION

Residency Research Committee (RRC) Resident
Feedback Form

Date: __________________________
Resident: ______________________ Year: ____________
Project Title: ________________________________ –

1. Is the Review of Literature satisfactory? Yes No

2. Is the research question appropriately formulated? Focused? Yes No

3. Is the study design scientifically valid? Yes No

Overview of study design
Patient population
a) inclusion criteria
b) exclusion criteria

Measurements Intervention
Outcome variables
Potential confounding variables
Planned procedure for collection of information
Blinding and bias considerations

4. Does the study consider the appropriate statistical considerations? Yes No
(power calculations, sample size, statistical analyses, etc.)

5. Does the study have the appropriate ethical / legal considerations? Yes No
(adverse event reporting, patient consent, responsibilities of the investigator, etc.)

6. Is the project feasible (time, resources)? Yes No

7. Are there potential obstacles or questions that should be considered?

General comments?

Overall, the project is: Approved Incomplete Should be reconsidered
# Resident Research Project Tracking Sheet

**Legend:** U=Unsatisfactory; B=Borderline; S=Satisfactory; SP=Superior

Research Evaluator: Date: Resident: Date:

## Project Title:

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<td>Review of Literature presented (ie. Grand Rounds, JC, RRC)</td>
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<td>Research question formulated</td>
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<td>Methodology re-submitted</td>
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<td>Data Analysis Performed</td>
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<td>Project Presented at Resident Research Day</td>
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<td>Abstract/Poster Prepared and Accepted</td>
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<td>Paper Accepted for Publication Journal:</td>
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**Supervisor:** Dr. Eli Segal/Dr. Scott Delaney

**Administrative Coordinator:** Ms. Debbie Pollack

**Telephone:** 514-340-8222, ext. 3898
SHORT STAY MEDICINE (SSU)

A new domain of the Emergency Physician is that of “short stay” medicine. This involves taking care of patients with single system medical/surgical problems who will require hospitalization usually less than 48 hours duration. The basic goals of this rotation are for the resident to learn which patients are appropriate for a brief hospital admission, to do proper consultations in the ED, to develop in-depth knowledge (including the evidence behind) the investigation, treatment and disposition of acute medical/surgical diseases which require only brief hospital admissions. NB. For the time being, this rotation is under trial and will replace 1 of the internal medicine ward rotations.

MEDICAL EXPERT

1. Demonstrate an expertise in determining who would be and would not be an appropriate “short stay” candidate.

2. Demonstrate an expertise in Emergency Department consultation on behalf of the short stay unit.

3. Demonstrate an expertise in obtaining a proper history and physical exam.

4. Demonstrate an expertise at developing a differential diagnosis, investigation and management plan.

5. Be knowledgeable of the indications, use and interpretation (where appropriate) of:
   a. Laboratory testing
   b. ECGs
   c. Diagnostic radiology tests/procedures (X-rays, CT, US, MRI, nuclear medicine)

6. Understand the pathophysiology, presentation, evaluation and management of systemic diseases of the patients admitted to the unit. Because of the inherent variability in clinical cases coming through the ED, a resident cannot be guaranteed that he/she will see all the clinically relevant pathologies. Consequently it is the responsibility of the resident to read beyond the cases they are involved with.

7. Demonstrate technical expertise:
   a. Vascular access (peripheral and central)
   b. Wound Management
   c. MSK procedures (arthrocentesis)
   d. Abdominal procedures (NG insertion, abdominal paracentesis)
e. Arterial Blood gas
f. Lumbar puncture

**COMMUNICATOR**

1. Demonstrate an expertise in documenting:
   a. Emergency consultation
   b. Admission history and physicals
   c. Follow-up notes
   d. Discharge summary.
   e. Prescriptions.
2. Be capable of communicating effectively in a multidisciplinary environment with:
   a. Patients and their families
   b. Emergency staff
   c. Attending physicians, residents, medical students
   d. Nurses, unit clerks, orderlies, respiratory technicians, social workers.
   e. Consultants (by phone or in person)
3. Demonstrate ability to communicate “bad news” in a professional manner.

**COLLABORATOR**

1. Understand the role of a “short stay” unit with the continuum of care in the institution.
2. Demonstrate an ability to work effective in a multi-disciplinary team, recognizing the role of each of the health care team members.
3. Be able to appropriately involve the patient and family in the decision making process.
4. Be able to effectively consult physicians and health care professionals
5. Respect and highlight the role of the patient” primary care physician, CLSC, social worker for ongoing health care on discharge.

**MANAGER**

1. Demonstrate an ability to effectively allocate and use resources (lab, radiology, consultation).
2. Be able to manage competing interests between patient care needs, ward duties, consultants, other services/departments.

3. Be capable of managing multiple patients concurrently.

4. Demonstrate an ability to (independently) manage flow of patients, from the initial consultation, admission, treatment to the point of appropriate and timely disposition.

5. Practically demonstrate an understanding of the critical role of discharge planning and arranging appropriate follow-up.

**ADVOCATE**

1. Demonstrate the ability to identify determinants of health of the patient.

2. Be capable of discussing preventive medicine or harm reduction strategies that influence the patient’s health and well-being.

3. Be an advocate for the patient.

**SCHOLAR**

1. Continuously seeking out new knowledge e.g. texts, journals and incorporate this into daily practice.

2. Be cognizant of and appropriately apply any relevant or landmark studies.

3. Apply evidence-based medicine to ongoing care.

4. Demonstrate an ability to use information technology to direct self-learning as well as patient care.

**PROFESSIONAL**

1. Show respect at all times for the patient’s:
   a. Race/Ethnic background
   b. Language
   c. Religion/belief system
   d. Gender/sexuality
   e. Confidentiality

2. Be insightful of one’s own strengths and weaknesses (and when to call for back up)

3. Be able to receive and accept constructive feedback.

4. Display ethical behaviour compatible with a physician at all times with:
   a. Patients and their families
b. Allied health staff

c. Attending staff, residents, students

5. Be a role model for colleagues and other health care professionals.

**Supervisor:** Dr. Alex Guttmann

**Administrative Coordinator:** Debbie Pollack ([emacademics.jgh@mail.mcgill.ca](mailto:emacademics.jgh@mail.mcgill.ca))

**Telephone:** 514-340-8222, ext. 3898
SPORTS MEDICINE

Structure

During this 4 week rotation the resident will participate in direct clinical patient care in several settings which include primarily the:

- McGill Sports Medicine Clinic
- Primary Care Orthopedics Clinics at the Montreal General Hospital

During their time in clinic, the resident will be under the direct supervision of the attending clinic staff. They will be responsible for the initial evaluation of clinic patients, and together with the attending staff, will make decisions regarding their immediate management and ongoing care. Additional learning opportunities exist in the context of sideline coverage of varsity level, or other, sporting events that are covered by clinic staff.

Objectives

A. Medical Expert / Clinical Decision-maker

Basic Scientific Knowledge:

Demonstrate knowledge of the anatomy and physiology of the various systems involved as they pertain to sport and exercise, including the cardiovascular, gastrointestinal, musculoskeletal and neurologic systems.

Demonstrate knowledge of the mechanisms of acute and overuse injuries and other physiologic and pathologic conditions unique to sport and exercise.

Basic Clinical Knowledge:

Demonstrate knowledge of the following:

- Specific conditions which may preclude or limit involvement in sport and exercise. These conditions may not be addressed in other rotations and include, but are not limited to:
- Hypertrophic cardiomyopathy
- Marfan’s syndrome
- Exercise induced asthma
- Female Athlete Triad

- Mechanism and natural history of traumatic and overuse injuries to the musculoskeletal system. These include, but are not limited to:
  - fractures and dislocations
  - sprains, strains, muscle tears
  - tendonitis, bursitis, apophysitis
  - back pain and radiculopathies (including brachial plexus injuries)
  - stress injuries and other overuse syndromes

- Accurate description of soft tissue and non-fracture injuries with respect to:
  - anatomic location
  - severity/grade
  - degree of limitation of function/range of motion

- Use and abuse of different pharmaceutical agents including
  - ergogenic aids (anabolic steroids, erythropoietin)
  - stimulants
  - creatine and protein powder/bars
  - anti-inflammatory medications

- The pathophysiology, healing and assessment tools involved in sport-related head injury and concussion.
- Appropriate use of consultation for different sport related injuries or conditions. This should include some learning about the expertise of other fields, including:
  - Physiotherapy
  - Athletic therapy
  - Osteopathy
  - Sports psychology
• Common bracing and orthotic devices used to aid recovery and/or prevent injury.

**History & Physical Examination:**
Demonstrate ability to perform a directed history and physical examination related to sport and exercise. As well as assessing for a fracture or dislocation, examination of the following are emphasized:

- **Shoulder**
  - Impingement Syndrome and Rotator Cuff Injuries
  - Shoulder Instability
  - Brachial Plexus Injuries
  - Acromioclavicular injuries

- **Elbow and forearm**
  - Epicondylitis
  - Condylar injuries

- **Wrist and hand**
  - Tendonitis
  - DRUJ and TFCC injuries
  - Carpal tunnel syndrome
  - Ligament injuries of fingers (including ulnar collateral injury of thumb)

- **Spine**
  - Facet joint irritation
  - Foraminal stenosis
  - Cervical and lumbar disc herniation with dermatome/myotome assessment
  - Spondylolysis and spondylolisthesis

- **Hip**
  - Bursitis
  - Labrum injury
  - Adductor strain

- **Knee**
  - Ligament Injuries
- Meniscal Injuries
- Anterior knee pain and Overuse

* Lower leg
  - Medial tibial stress syndrome
  - Muscle strains
  - Achilles' tendon injuries

* Foot and Ankle
  - Ligament injuries
  - Osteochondral injuries
  - Neuromas
  - Stress fractures

* Abdomen
  - Rectus injuries
  - External oblique muscle tear (sport hernia)

* Head
  - Concussion evaluation (using McGill ACE tool & BESS testing)

The assessment of injuries in an acute “on-field” setting should also be addressed. The assessment of an athlete wearing equipment may involve:

- the removal of a helmet and/or “log rolling” an injured athlete while maintaining cervical precautions
- assessment of the cervical spine and brachial plexus in athletes wearing cervical collars and shoulder pads

Interpretation & Utilization of Information:
Display knowledge of indications, limitations and health risks of the following tests, as well as display appropriate utilization of their results:

- blood work
- pulmonary function tests
- plain radiography
- ultrasound (including echochardiography)
- CT scanning
- MRI imaging
• nuclear medicine (bone scan, SPECT scan)
• nerve conduction studies and electromyography

Clinical Judgement & Decision Making:

Demonstrate the ability to do the following:
• Evaluate the safety and ability to commence or resume sport and exercise when assessing a pre-existing or traumatic condition
• Utilize appropriate clinical and imaging adjuncts that will help identify common and important injuries or conditions.
• Appropriately treat pain and inflammation caused by an injury or underlying condition.
• Utilize appropriate ancillary services in rehabilitation and recovery
• Counsel patients on the expected stages of recovery and return to sport and exercise.

Technical Skills:

Demonstrate proficiency at the following skills:
• arthrocentesis
• common joint infiltrations

B. Communicator

Inter-professional relationships with physicians and other allied health professionals:
Demonstrate the ability to effectively communicate with referring and consultant colleagues regarding the nature of sport-related injuries and conditions, performance of necessary interventions and coordination of subsequent care and rehabilitation.

Demonstrate the ability to do the following on a regular and ongoing basis:
• Work effectively with other physicians and allied professionals of the healthcare team (including those members involved in both the acute care and rehabilitation/recovery of patients with sport-related injuries or conditions).
• Show consideration for the knowledge, skills and roles of the various members of the healthcare team
• Be respectful of other team members

Communications with patients & families:

Demonstrate the ability to communicate effectively regarding the nature of the injury/illness suffered and anticipated management plan, showing them respect and gaining their cooperation and confidence.

Demonstrate the ability to discuss and explain the expected stages of recovery and return to sport and exercise to the patient & family in a sensitive, concise and comprehensible manner.

Written communication and documentation:

Consistently demonstrate the ability to document the history, physical, diagnostic formulation, and management plan in an accurate, complete and organized manner. This includes documentation that may be required in, but is not limited to:
• initial patient evaluations
• progress notes
• consultation reports

Show skill in explaining risks, benefits and obtaining consent for relevant procedures.

C. Collaborator

Demonstrate the ability to:
• work within the framework of a multi-disciplinary healthcare team.
• recognize the expertise of each health care team member and their respective role as it relates to the patient’s care.
• appropriately delegate responsibilities to members of the health care team.
• resolve common team conflicts
• involve the patient and family in decision-making.
D. Manager

Demonstrate the understanding and utilization of current information technology in managing injuries and conditions related to sport and exercise.

Demonstrate the responsible allocation and rationalization of resources to the patient and population based on the best-available evidence.

Demonstrate the ability to manage competing interests of individual patient care and consultation requests in the clinic setting.

Understand the role of Orthopedic, Physiotherapy, Occupational Therapy and other rehabilitation practitioners and services with respect to the patient, clinic, hospital and community as a whole.

Coordinate/direct patients appropriately for ongoing care by Orthopedic, Sports Medicine, Physiotherapy, Occupational Therapy and other rehabilitation practitioners and services.

E. Health Advocate

Be the patient’s advocate at all times, particularly when they are unable to do so themselves.

Display advocacy for the community at large and for society.

Demonstrate the ability to discuss risk and harm reduction strategies, as well as safety precautions to prevent future injury from occurring.

F. Scholar

Motivation to read and learn:
Demonstrate knowledge of current scientific literature and application of this knowledge to case presentation and daily patient management.

Demonstrate interest in expanding current knowledge base by reading around clinical cases.

**Critically appraises medical literature:**
Demonstrate the ability to critically-appraise research methodology and medical literature with respect to clinical cases.

**Teaching skills:**
Demonstrate initiative to teach other health care professionals and/or patients about specific relevant health care issues.

Discuss clinical topics and/or journal articles with colleagues in the form of presentations or rounds.

**G. Professional**

Demonstrate awareness of the racial, cultural and social factors that influence the delivery of care to patients with sport-related injuries or conditions.

Show respect all times for the patient’s:
- Race/ethnic background
- Language
- Socio-economic level
- Religion/Belief system
- Gender/sexuality
- Confidentiality

Be insightful of one’s own strengths and weaknesses, and recognize when to call for back up.

Be able to receive and accept constructive feedback.
Display ethical behaviour compatible with a physician at all times with respect to:

• Patients and their families
• Allied health staff and practitioners
• Attending Staff, residents and medical students

Be a role model for medical students, residents, staff physicians, nurses, and other allied health care personnel.

Maintain a healthy and sustainable balance between personal and professional lives.

**Supervisor:** Dr. Scott Delaney
TOXICOLOGY

GENERAL OBJECTIVES

During the course of their training in Emergency Medicine at McGill, residents have to acquire an understanding of Toxicology as well as be able to apply this knowledge in clinical practice.

Residents will be exposed to the area of Clinical Toxicology during their Emergency Medicine rotations where they will encounter patients presenting with deliberate self-poisoning, accidental intoxications, intoxications resulting from deliberate recreational use of substances, occupational hazards or environment injuries such as bites and stings from venomous creatures. They will also be exposed to Poison Center base toxicology during their one month rotation at a Poison Control Center in their senior years.

It is expected that at the end of their training, residents will have acquired the knowledge to recognize signs and symptoms of intoxication which is the effect of a drug beyond the scope of what is considered its therapeutic effect. They should be able to initiate diagnostic measures and treatment as well as identify situations where further or additional expertise is required and collaborate effectively with other consultants.

Emphasis will be placed on the recognition, appropriate management of common intoxications encountered in the emergency department and their modalities of treatment. As well, the resident should demonstrate knowledge of the differential diagnostic exercise when approaching the unknown overdose with use of laboratory results, electrocardiogram and toxidromes.

MEDICAL EXPERT AND CLINICAL DECISION-MAKER

Residents should be able to:

1. Obtain a history that is accurate, pertinent and concise for the nature of the problem.
2. Perform physical examination that is sufficient to initiate a diagnosis or management plan.
3. Discriminate types of poisoning with the knowledge of the different toxidromes.
4. Identify the need for gastrointestinal decontamination and the benefits and risks of:
   a. Gastric lavage b. Emesis
c. Single and multiple dose activated charcoal
d. Cathartics
e. Whole Bowel irrigation

5. Demonstrate the ability to interpret accurately the results of common diagnostics tests.

6. Demonstrate knowledge in the mechanism of toxicity, usual toxic dose, stabilization and treatment modalities of the following with the following scale

   a. Extensive and detailed knowledge of this subject matter is obligatory
   b. Ability to explain the principles involved in this subject matter is expected but detailed knowledge is not required
   c. Recognition of the importance of this subject is expected by broad knowledge of the principles involved.

   i. Analgesics
      - Acetaminophene (1)
      - NSAID’s (1)
      - Aspirin (1)
      - Opiods including methadone (1)

   ii. Autonomic agents
      - Anticholinergic (1)
      - Antihistamines (1)
      - Serotoninergics (1)
      - Benzodiazepines (1)
      - Over the counter non benzodiazepines sedatives (2)
      - Sympathomimetics (1)

   iii. Chemicals and substance of abuse
      - Alcohol (1)
      - Cannabinoids (1)
      - Cocaine, amphetamines, psychostimulants (1)
      - CNS depressants (1)
      - Nicotine and tobacco (1)
      - Opioids (1)
      - Psychedelics (2)

   iv. CNS drugs and muscle relaxants
      - Toxic alcohols, methanol, ethylene glycol, isopropyl alcohol (2)
- Anesthetics (2)
- Anticonvulsants (2)
- Cyclic antidepressants (1)
- GHB (2)
- Muscles relaxants (2)
- Neuromuscular blocking agents (1)
- Parkinson drugs (3)
- Antipsychotics, (phenothiazines and butyrophenones) (1)
- SSRI’s and SNRI (1)
- Lithium (2)
- MAOI (2)
- Hallucinogens (1)
- Sedatives, hypnotics and anxiolytics (1)

v. Cardiovascular
- Antiarrhythmics (2)
- Anticoagulants (2)
- Antihypertensives (2)
- Antiplatelets (2)
- Thrombolytics and antifibrinolytics (2)
- Inotropes (2)
- Nitrates and nitrites (2)

vi. Environmental (3)
- Biological incidents
- Chemical incidents
- Plants
- Ingestions
- Contact dermatitis
  vii. Gastrointestinal agents (3)
- Antacids
- Antidiarrheals
- Laxatives
- Toxic gases
- Carbon monoxide (1)
- Chlorine (3)
- Carbon dioxide (3)
- Cyanide (1)
- Smoke inhalation (1)
- Products of combustion (1)

ix. Hydrogen fluoride (3)

x. Vitamins, minerals and endocrine agents (3)
- Oral hypoglycemicants (2)
- Insulin (2)
- Newer diabetic drugs (3)
- Potassium salts (2)

7. Demonstrate knowledge of mechanisms of action and indications for the following antidotes:
   a. Analeptics (2)
   b. Chelation agents (3)
   c. Benzodiazepine antagonists (1)
   d. Activated charcoal (1)
   e. Cyanide treatment (1)
   
   f. Glucagons (1)
   g. Calcium (1)
   h. Methylene blue (2)
   i. Opiods antagonists (1)
   j. Oxygen including hyperbaric (2)
   k. Atropine (1)
   l. Protamine (2)
   m. Thiamine (1)
   n. Vitamin K (1)
   o. Folinic acid (3)
COMMUNICATOR
Residents should be able to demonstrate effective communication skills by their ability to:

1. Work harmoniously within the team.
2. Being able to formulate a clear plan of action and convey information to other colleagues.
3. Deliver information to patient and families in a sensitive manner using the appropriate vocabulary for their understanding of the situation.
4. Link effectively with the provincial Poison Center and summarize the evidence to allow for better consultation and follow-up on the cases.
5. Produce legible and pertinent written documentation enabling another professional to access the information pertaining to the case.

COLLABORATOR
Residents should be able to identify and act as leader of the multidisciplinary team required for the management of poisoned patients in the Emergency Department. More specifically, residents should be able to contact and request assistance of other allied health professionals when dealing with:

1. Poison control and toxicology consultant.
2. ICU physicians.
3. Psychiatry.
4. Social services, and community support organizations.

MANAGER
Residents should understand and be able to apply in their practice:

1. Principles of HAZMAT.
3. Providing effective consultation when a referral from an outside hospital is made and be able to utilize resources judiciously in accepting a transfer for an intoxicated patient.

HEALTH ADVOCATE
Residents should be able to recognize and advise patients and their families regarding the general epidemiology and prevention of poisonings and more specifically:
1. Inappropriate use of medications.
2. Dangerous interactions between medications.
3. Long term or chronic side effect of medications.
4. Risks of polypharmacy and excessive over the counter medications use.
5. Health issues pertaining to drug and illicit substance abuse.
6. Social issues relating to the behavior of deliberate self harm and poisoning.

SCHOLAR
Residents should be able to demonstrate an intellectual approach to medical practice in the following areas during participation on patient rounds, teaching sessions, journal clubs and interdisciplinary meetings.

1. Continuing Medical Education
   a. Show interest in self-education skills by demonstrating knowledge in the evolving concepts in the management of poisoned patients and new pharmacological developments.

2. Critical Appraisal of the Medical Literature
   a. Demonstrate the ability to research the medical literature, and then identify and critically appraise the best available evidence for any patient related question.
   b. Identify limitations in current toxicological research

3. Scientific Interest
   a. Show interest in other scientific areas closely related to clinical toxicology such as biochemistry, basic pharmacology, agricultural and occupational toxicology by recognizing potential implication of these fields into clinical practice
   b. Demonstrate ability in identifying areas in toxicology where gaps in knowledge or expertise exists by retrieving the essentials of the literature, summarizing the evidence to date and develop research ideas to fill these gaps while being able to demonstrate the clinical relevance of finding answers to the question at hand.

4. Teaching skills
   a. Residents should be able to explain the mechanisms of poisoning and share knowledge with others in a manner that helps others to develop their own skills.
   b. Residents should be available to answer questions or discuss common toxicological problems.
**PROFESSIONAL**

Residents should be familiar with medical, legal, psychiatric and social aspects of toxicology. They should approach situations with the highest level of integrity and honesty. Resident should more specifically demonstrate professionalism in the following issues:

1. Obtaining consent for therapeutic modality or research study inclusion by the patient or the next of kin.
2. Respect patients’ rights to confidentiality and neutrality in the face of authorities involvement whilst fulfilling social and legal obligations as per the medical ethics code and the local regulations.
3. Recognize the limitation of medical practice in the face of threat or assault and decide when appropriate to involve legal authorities.
4. Recognize the impact of delivering care to a patient with impaired judgment due to intoxication, and their capacity to make appropriate decisions.
5. Be aware of your own strengths and weaknesses and when to ask for help. Seek appropriate advice from consultants to achieve the best therapeutic or management plan for these patients.

**Supervisor:** Dr. Sophie Gosselin

**Administrative Coordinator:** Ms. Gillian Frontin (gillian.frontin@muhc.mcgill.ca)

**Telephone:** 514-934-1934, ext. 34277
TRAUMA

MEDICAL EXPERT

Basic Scientific Knowledge

1. Discuss the principles of anatomy and physiology specifically relating to traumatic disorders, in particular:
   a. the various zones of the neck
   b. the posterior chest
   c. the posterior abdomen and flanks

2. Compare blunt and penetrating mechanisms of injury, further differentiating gun shot wounds and stab wounds.

3. Describe the indications and limitations, mechanism of action, interactions and complications of pharmacologic agents used in the context of trauma:
   a. Analgesic agents
   b. sedatives and induction agents
   c. paralytic agents
   d. antibiotics
   e. vasopressor agents
   f. corticosteroids

4. Knowledge of the principles of fluid therapy in a multiply injured patient.

5. Learn a systems approach to trauma management at local and provincial levels.

6. Learn the principles of pre-hospital trauma care

Basic Clinical Knowledge

1. Describe the presentation, pathophysiology, natural history and therapy of various injuries/syndromes related to trauma of body systems in the adult, paediatric and geriatric population. More specifically, knowledge about:
   a. Immediately life-threatening injuries
   b. Potentially life-threatening injuries
   c. Limb-threatening injuries
d. Closed head injuries
e. Raised ICP
f. Facial trauma
g. Blunt and penetrating neck trauma
   i. zone I, II, III injuries
   ii. airway injuries
   iii. esophageal injuries
h. Blunt and penetrating chest trauma
   i. tracheobronchial injuries
   ii. pneumothorax
   iii. hemothorax
   iv. aortic injuries
   v. lung contusion
   vi. diaphragmatic injuries
i. Blunt and penetrating abdominal trauma
j. Posterior chest and abdominal injuries
k. Pelvic trauma, including uro-genital trauma
l. Spinal cord trauma and syndromes
m. Extremity trauma, including peripheral vascular injuries, partial or complete amputations, fractures, tendons injuries, lacerations
n. Compartment syndrome

2. Describe special considerations in the evaluation and management of the pregnant, pediatric and geriatric trauma patient.

3. Demonstrate the principles of trauma resuscitation, stabilization, and disposition.

4. Describe principles of burn management.

5. Describe principles of inhalation injuries.

6. Assess and develop the appropriate differential diagnoses of clinical presentations in the trauma patient, describing the various potential lesions associated with specific mechanisms of injury.

7. Acquire knowledge of indications and limitations of the following tests with respect to the trauma patient: plain radiography, CT scanning, echography, angiography, endoscopy, blood work.

History & Physical Examination
1. Competently complete a clinical assessment of a trauma patient in an organized and timely fashion.
2. Demonstrate knowledge of common signs of major traumatic injuries.
3. Demonstrate knowledge of the Glasgow Coma Scale.

**Interpretation and Utilization of Information**
1. Assess and develop the appropriate differential diagnoses of specific clinical presentations in the adult, paediatric and geriatric population (e.g. abdominal pain, UGI bleed, LGI bleed etc).
2. Compare/contrast the use of diagnostic peritoneal lavage, ultrasound and CT scan in the evaluation of abdominal trauma.
3. Compare/contrast the use of CT scanning, echocardiography and angiography for thoracic aortic injuries.

**Clinical Judgement & Decision Making**
1. Identify indications for immediate laparotomy and thoracotomy.
2. Set the priorities, and initiate the required resuscitation, stabilization, investigation and disposition of the traumatized patient.
3. Identify the needs for consultation/admission/transfer of such patients presenting to the Emergency Department.
4. Initiate the appropriate management of acute traumatic conditions in the adult, paediatric and geriatric patient according to injuries identified.

**Technical Skills Required in the Specialty**
1. List the indications, techniques and complications of manipulative procedural skills:
   a. endotracheal intubation with C-spine recuations
   b. cricothyroidotomy
   c. needle decompression of chest
   d. chest tube insertion
   e. resuscitative thoracotomy
   f. cardiorrhaphy (suturing the heart)
   g. diagnostic peritoneal lavage
   h. F.A.S.T. exam
   i. venous cutdown
j. insertion of large bore peripheral lines
k. insertion of central venous lines (IJ, subclavian and femoral)
l. naso and orogastric tube insertion
m. suturing of basic and complex wounds
n. reduction of major joint dislocations
o. pelvis immobilization
p. Foley catheter insertion
q. proper splinting and reduction of extremity fractures
r. local wound exploration in penetrating trauma

2. Perform the required manipulative/procedural skills.

3. Ability to interpret specific radiological tests in a trauma patient:
   i. plain films of the cervical, thoracic, lumbar spine; chest; pelvis, extremity
   ii. focused ultrasonography of the abdomen/pericardium
   iii. CT of the head for the presence of the epidural and subdural hematoma, cerebral contusion, subarachnoid hemorrhage,
   iv. perform and interpret a retrograde urethrogram

**COMMUNICATOR**

*Interprofessional Relationships With Physicians and With Other Allied Health Professionals*

1. Communicate effectively with the multi-disciplinary team.

*Communications With Patients*

1. Demonstrate skill and behaviour towards alleviating patient anxiety, appropriate for patient age and gender.
2. Demonstrate ability to discuss the patient’s care and counsel regarding risk modification with the patient and family.
3. Show skill in explaining risks, benefits and obtaining consent for relevant procedures and surgeries.

*Communications With Families*

1. Demonstrate ability to discuss and explain to families “bad news” in a sensitive, concise and
understandable manner.

2. Demonstrate ability to discuss living wills, advanced directives and *do not resuscitate* orders.

**Written Communication and Documentation**

1. Ability to document concisely and precisely pertinent findings on history and examination as relevant to the trauma patient.

**COLLABORATOR**

*Interacts and Consults Effectively With All Health Professionals by Recognizing and Acknowledging Their Roles and Expertise*

1. The resident will recognize the role of each health care team member with respect to the patient’s care.
2. Demonstrate ability to resolve common team conflict problems.
3. Demonstrate ability to work in a multi-disciplinary team, work as part of a trauma team.
4. Consults appropriate services for the definitive care of the patient.

**Delegates Effectively**

1. Demonstrates ability to delegate various parts of the evaluation and procedures during a trauma resuscitation.

**MANAGER**

*Uses Health Care Resources Cost-Effectively*

1. Recognize resources of tertiary care trauma centres and the use and rationalization of these for the individual patient and the population served.
2. Demonstrate knowledge of trauma systems and the function it serves to the hospital and the region.
3. Comprehend the rationale, organization and resources required to create trauma centers and systems.

**Organization of Work & Time Management**

1. Ability to establish priorities in a single complex trauma patient under stressful conditions.
2. Be capable of managing multiple ill patients concurrently.

**HEALTH ADVOCATE**

*Advocates for the Patient*

1. Be capable of discussing with patients risk and harm reduction strategies.
2. Be the patient’s advocate at all times, particularly when they are unable to do so themselves.

**Advocates for the Community**
1. Learn principles of disaster management.
2. Be able to discuss and promote injury prevention.
3. Be aware of organ procurement procedures.

**SCHOLAR**

**Motivation to Read and Learn**
1. Be consistent in reading around clinical cases and improving trauma knowledge base.

**Critically Appraises Medical Literature**
1. Demonstrate knowledge and applicability of landmark (specialty relevant) studies in trauma care.

**Teaching Skills**
1. Demonstrate ability to supervise students and more junior residents in the evaluation of the traumatised patient and performance of procedures.

**PROFESSIONAL**
1. Show respect at all times for the patient’s:
   a. Race/Ethnic background
   b. Language
   c. Religion/belief system
   d. Gender/sexuality
   e. Confidentiality
2. Be insightful of one’s own strengths and weaknesses (and when to call for back up).
3. Be able to receive and accept constructive feedback.
4. Display ethical behaviour compatible with a physician at all times with:
   a. Patients and their families
   b. Allied health staff
   c. Attending staff, residents, students.
5. Be a role model for colleagues and other health care professionals.

*Understands Principles of Ethics; Applies to Clinical Situations*

**Supervisor:** Dr. Kosar Khwaja  
**Administrative Coordinator:** Ms. Tina Posperis  
**Telephone:** 514-934-1934, ext. 44334
IV. ELECTIVES

Residents should be using their elective time to complement core rotations concentrating on areas of weakness or interest, or to develop a field of expertise. All electives must be approved by the Program Director.

Residents will be expected to establish specific objectives for their electives before starting the rotation. These should be discussed with and submitted to the Rotation Coordinator and the Program Director. In this way we can all ensure that your elective rotation will be productive and tailored to achieve your objectives. This must be completely arranged at least two months prior to the beginning of the rotation.

In addition, for any out of town electives, residents all encouraged to communicate with the Program Director well in advance. Residents must ensure adequate time to register with the (1) local University and/or College of Physicians, (2) CMPA, and (3) the local medical licensing agency. As above, residents must (4) clearly identify the rotation supervisor who has a copy of the (5) objectives you and your Program Director have discussed. The rotation supervisor will be asked to submit to the Program a formal evaluation of your rotation. All this must be completely arranged at least two months prior to the beginning of the rotation.

WRITTEN CONFIRMATION OF THE ABOVE FIVE IS A PREREQUISITE FOR APPROVAL

A block of a few months can be used as a "Fellowship" type of rotation to develop a specific area of expertise. Any resident wishing to do this will be expected to organize this block rotation with the Program Director well in advance.

The residents will find an Elective Binder in the Secretary's office. Comments from residents are welcome additions to this binder. This list is by no means exhaustive; be creative and try to get the maximum out of your elective time.
V. COMMITTEES & ROLES

COMMITTEES:

1. Residency Program Committee (RPC)
2. Residency Research Committee (RRC)
3. Promotions Committee
4. Selection Committees
5. Ad Hoc Committees
1. RESIDENCY PROGRAM COMMITTEE (RPC)

As per the General Standards of accreditation, section B.1.2, the Residency Program Committee assists the Program Director in the planning, organization and supervision of the Program. The general responsibilities of the RPC include (but not limited to) the following:

1. Establishing, organizing and reviewing educational components and resources of program (clinical facilities, teaching facilities etc., to maximize the learning experience).
2. Development and operation of program so that it meets standards of accreditation, as per the Royal College of Physicians and Surgeons document "General Standards of Accreditation".
3. Setting educational goals and periodically reviewing them. The Goals and Objectives shall comply with the Royal College of Physicians and Surgeons (RCPS) document titled "Specific Requirements and Guidelines for Accreditation of Residency Programs in Emergency Medicine.
4. Ensure that trainees and the Faculty get copy of educational goals.
5. Establish mechanism to provide career planning and counseling for residents.

Membership

1. Program Director (Chair).
2. Program Site Coordinators (RVH, MGH, JGH, MUHC).
3. Resident representation from each of the 5 years.
4. Chief residents.

Ex-officio members include:

1. Associate Dean of Postgraduate Education.
2. Program Director (CFPC-EM).
3. Adult Emergency Department Directors of the major teaching hospitals (RVH, MGH, JGH, MCH).

Frequency of Meetings

The RPC meets on the 4th Wednesday of each rotation.

Minutes
Minutes of the meeting are:

1. Kept by the Program Coordinator.
2. Edited by the Program Director.
3. Approved by 2 members of the RPC.
4. Distributed to all residents and staff.

2. RESIDENCY RESEARCH COMMITTEE (RRC)

The role of the RRC is:

1. To guide the resident through their 5 periods of research, ensuring that the resident has an appropriate research topic, research supervisor/preceptor, and that the resident is progressing at an appropriate pace.
2. To ensure that the resident produces an original research proposal. To guide and encourage the resident to bring the project to the point of a either a poster or abstract presentation at a major conference, and/or publication.
3. To ensure that residents apply the techniques of EBM and critical appraisal (learned at JC) to their research project.
4. To evaluate the progress of the research project (as outlined in the Research Goals and Objectives) on a bi-annual basis.
5. To provide the program director with written feed back/evaluation of the progress research project.
6. To encourage residents to pursue research as part of their career path.

It should be noted that the RRC is not the actual research project supervisor/preceptor.

Membership

1. The two Research Chairpersons.
2. The Program Director.

The Emergency Medicine Residency Research Committee (RRC) is accountable to the Program Director to meet the above-mentioned Goals and Objectives. Residents’ progress will be monitored by their preceptor and both are accountable to the RRC to ensure selected objectives have been met after each research
rotation. The RRC will establish liaison with other Departments, McGill University, and the Department of Epidemiology to facilitate resident projects.

3. PROMOTIONS COMMITTEE

The Emergency Medicine program has established the Promotions Committee in accordance with section B 3.3 and 3.4 of the Royal College’s General Standards of Accreditation. The committee follows the guidelines outlined by both the Royal College and the post graduate office at McGill. Within the postgraduate medicine’s website there is a document entitled “Evaluation System.” This document can be accessed at: www.medicine.mcgill.ca/postgrad/welcometopostgrad_evaluationpromotions.html

Within this document are two links; one to the “Evaluation and Promotion” guidelines, and the other is a description of the evaluation criteria. The resident is strongly encouraged to review these documents. They are available in both English and French.

Members

1. Andreas Krull (Chair).
2. Two (2) Emergency Physicians (not the Site Coordinators).

Responsibilities

1. Review of 6 month and year end ITERS.
2. Meet with the resident twice per annum to review evaluations and progress.
3. Review the FITER submitted to the Royal College.
4. Maintain and respect confidentiality.
5. Review the entire record of a resident who has received a BORDERLINE or UNSATISFACTORY global evaluation during any period.
6. The overall performance of any resident can be reviewed by the Committee, at the discretion of the Program Director. This may occur even in the absence of BORDERLINE or UNSATISFACTORY evaluations.
7. Inform the Associate Dean for Postgraduate Education (in writing) of any resident that is in academic or non-academic difficulty.
8. Maintain an appeal mechanism in accordance with McGill’s guidelines.
9. Establish a remedial education program for any resident placed on “probation”.
4. SELECTION COMMITTEE

The role of this Committee is to select candidates for admission to this Program. There are two Committees, one for CaRMS and one for Clinical Fellows.

Membership

1. Program Director (Chair).
2. Three (3) Site Coordinators (RVH, MGH, JGH).
3. Chief Residents.
4. Two (2) Clinical Fellows.

This gives a total of 6 or 7 people in each Committee. The Selection Committee has the mandate to review applications, select applicants to interview, interview applicants and participate in the subsequent rank order of the applicants.

5. AD HOC COMMITTEES

As need arises, Ad hoc Committees will be established. Their terms of reference (mandate, chair, membership) will be established at the outset. In the past, there has been a Rounds Review Committee.
VI. ROLES

1. Emergency Site Coordinators.
2. Mentor.
3. Chief Resident.
4. Academic/Interactive Coordinators.

1. EMERGENCY SITE COORDINATOR

*Site Coordinator Responsibilities and Duties include:*

1. Liaison between Program Director and Rotation Coordinators in respective institution.
2. Assists Program Director with the coordination of academic activities within the institution.
3. Assists the RPC in setting up global goals and objectives for rotations.
4. Acts as ED Rotation Coordinator in the respective institution; i.e. coordinates individual resident’s schedule and requests; coordinates residents’ supervision and evaluation, provides timely verbal evaluation at the end of the rotation.
5. Assigns to the resident the staff who will be evaluated for that period/rotation.
6. Assists Program Director and residents to address difficulties with specific rotations (i.e. non-emergency rotations) in the given institution.
7. Handles logistical issues concerning site-specific rotations.
8. Is an active member of the RPC.
9. Together with the ED Director, acts as liaison to the Emergency Department attending staff.
2. MENTOR

Each resident will be assigned a mentor at the beginning of his/her residency. Barring, special circumstances, the mentor will maintain this role until the completion of the mentee’s residency.

The responsibilities of the mentor include (but not limited to) the following:

1. Meet with his/her mentee at the beginning of the first year and help him/her feel welcome and part of the Program.
2. Meet at least once a year, thereafter, and in conjunction with the Program Director, act as a resource person.
3. Together with the Program Director help resident develop fields of interest or subspecialization early in his/her residency.
4. Assist resident to recognize his/her individual strengths and weaknesses and support activities to enrich the resident’s experience.
5. Attend the different presentations of the mentee(s) (Case Presentation, Grand Rounds, Journal Club and Journal Watch) that are mandatory to the Program, and be available to discuss different aspects of their presentations ahead of time.
6. Give feedback on the various presentations using a summary of the evaluations completed by the audience.
7. Be available to discuss the 6-month evaluation after it has been reviewed by the Promotions Committee. The Program Director maintains the right to discuss evaluations with the resident alone or at the request of the resident. In the case of a borderline or unsatisfactory evaluation, assist to outline corrective measures in an effort to address weaknesses.
8. The mentor is NOT the research preceptor. Specific help can be obtained through the Resident Research Committee.
9. The mentor is NOT the Area of Interest Project Supervisor.
10. The mentor will hopefully develop a special kinship towards his/her mentee(s).
11. The mentor should be a role model and conduct him/herself professionally and maturely.
3. CHIEF RESIDENT

There are 2 chief resident positions with shared responsibilities, which will be divided equally by the chief residents at the start of their mandate.

Elections

1. The Chief Resident shall be selected by all the residents currently enrolled in the McGill University Royal College Emergency Medicine Training Program by secret ballot elections. Proxy votes will not be accepted, however residents who are out of town may cast their vote by email to the current Chief Resident.
2. Elections for RPC resident representatives shall be held week 3 of period 1. There is a representative from each year (R1 through R5). Term is for one year.
3. Each Chief Residency term lasts one year and runs from July 1st to June 30th of the following year. Elections should take place by period 11 of the previous year.

Responsibilities

1) General

1. Assist the Program Director and RPC in maintaining the Standard of Accreditation established by the Royal College.
2. Act as an advocate for the residents at all levels within the McGill system. (Examples include interdepartmental scheduling problems, interpersonal conflicts, and ‘troubleshooting the ER experience for the off-service residents).
3. Organize, attend and ‘host’ all academic rounds – ensure availability of necessary A/V equipment.
4. Organize “Special Events”.
5. Keep record of resident attendance at weekly rounds and at monthly Journal Clubs.
6. Manage the resident budget, which includes Petty Cash Fund.
7. Coordinate elections of new incoming Chief residents, such that they will assume their new responsibilities by July 1st. The Chief resident should also orient the incoming Chief(s) to their new responsibilities.
8. Liaising, encouraging and scheduling 3 Adult ED site Rounds.

2) Committees

1. Residency Program Committee: One vote for each Chief Resident. Where appropriate, the Chief residents may assist the Program Director in preparation of the meeting’s agenda.
2. CaRMS Selection Committee: Each Chief Resident would act separately during interview and selection procedures.
3. **Ad hoc Committees.**

Scheduling and Rounds

1. Schedule lecturers for Wednesday morning Rounds, and release the schedule by the second week of the prior month. It is the responsibility of the Chief Resident to ensure that the program’s educational objectives are being met during Wednesday Rounds.
2. Ensure that the schedule for Wednesday morning Rounds posted on the e-mail Listserv.
3. Ensure curriculum guidelines are being covered during weekly rounds, and cycle lectures every two years.
4. Maintain a database of lectures, to both further future scheduling and minimize topic overlap.
5. The Chief Resident is responsible for creating the scheduling template for the end of the year. This is a skeleton annual schedule to ensure that all residents give their appropriate number of presentations.

1. Perform his/her academic and administrative duties as Chief Resident with professionalism; thus acting as a Role Model for the other Residents.
2. To be accessible to assist in the management of resident crises or scheduling.
3. Schedule and arrange the end-of-year party, including obtaining Senior Resident Gifts, and the Teacher of the Year Award.

Compensation

About $300/month (as determined by the contract between the FMRQ and the MSSS). In addition, the resident will do 0.5 shift/week less during an Emergency rotation (i.e. dedicated time compensation to allow the Chief Residents to fulfill their responsibilities (RVH, MGH, JGH, MCH).
4. ACADEMIC/INTERACTIVE COORDINATORS

There will be 2 Academic/Interactive Coordinators, one for the Junior residents and one for the Senior residents. Their responsibilities include:

1. Organizing the Interactive sessions, ensuring that either Tintinalli (Juniors) or Rosen (Seniors) are covered in a 2-year period.
2. Organizing the staff to lead these sessions.
3. Developing and marking an annual or biannual exams.
4. Submitting exam results to the Program Director.
5. Program Policies

1. Vacation.
2. Number of ED shifts.
4. Intimidation and Harassment.

1. **Vacation**

Residents have a total of 4 weeks of vacation per year. Vacation time can be taken any time during the academic year with the following restrictions:

1. Residents must not miss more than 1/4 of a period. McGill has a policy that no more than 25% of a rotation can be missed or the rotation will be considered ‘incomplete.’ Consequently, once a vacation has been taken, this leaves no room for study leave, conference, personal days during that rotation.
2. Residents can take 2 weeks vacations consecutively if they:
   a. Take the last week of one period, and the first week of following period, or
   b. Request a two-week vacation during a two-month block rotation.
3. Residents must inform the Rotation Supervisor with a sixty (60)-days notice. (Please use the "Change of Schedule Request" form and submit it immediately to the Program Coordinator for submission to Unit Coordinator and EM Program Director).
4. Article 25.01 of the Residents contract, states that the "rotation supervisor has the right to refuse a vacation request should this have an effect on the medical care provided by that service."
5. Vacation will not be granted during the trauma rotation in Baltimore, as we are guests in their institution and subject to their regulations.

**Clinical Fellows** have two options:

1. Take 1-2 week vacations as described above, or
2. Take a 4-week vacation that fall entirely within 1 rotation. Consequently, 1 rotation per year will have to be eliminated (R1 Geriatrics or Plastics, R2 Sports Medicine, R3 Area of Interest, R4 Elective, R5...
Emergency Medicine).

Request for Change of Schedule Request Form are found in the Evaluation Section of this manual.

2. **Number of ED Shifts**

1. Based on the premise that it is essential to see volume while the resident is in training.
2. Based on 20 shifts per month (i.e. work week of 5 days x 4 weeks).
3. Based on 8-9 hours per day.
4. Less 4 x .5 days for Wednesday AM teaching.
5. Less any special days e.g. Casting at MGH.
6. Less Stat days. Stat days must be requested! (NB. Stat days vs. collecting overtime).

**Vacations:**

1. McGill policy is that a rotation is considered complete only if 75% of the number of shifts are done.

**ED/Research**

1. Two (2) weeks research, 2 weeks ED.
2. Number of shifts will be multiplied by 0.5.
3. All odd numbers will be rounded up to the closest number.

**ED/Research/Vacation**

1. 75% of the ED must be completed as per McGill, and Rotation Supervisor.
2. Odd numbers will be rounded up to the closest number.

**Policy:**

**Full rotation:**

1. R1-R3: 18 x 8-9 hrs. . . . less stat days, less special training (casting).
2. R4: 18 (or 16 x 8-9 hrs, if replaced with extra clinical duty e.g. teaching, admin.)
3. R5: 14 x 8-9 hrs.

**Vacation:**
1. R1-R3: 18 x .75 = 14 (rounded up).
2. R4: 18 x .75 = 14 (or 16 x .75 = 12 if replaced with teaching etc.).
3. R5: 14 x .75 = 11 (rounded up).

ED/Research:
1. R1-R3: 9 x 8-9hrs.
2. R4: 9 (or 8 x 8-9hrs. if replaced with extra clinical duty)
3. R5: 7 x 8-9 hrs.

ED/Research/Vacation:
1. 7 shifts for all R1-R5.

3. Non-Negotiables
The emergency resident shall:
1. Show up to all Wednesday morning academic Rounds.
2. Show up to Rounds on time.
3. Show up to all Journal Clubs.
4. Show up to all Journal Club on time and prepared.
5. Show up to all Interactive sessions, prepared.
6. Submit to the Program Coordinator all staff evaluations and rotation evaluations by the first Wednesday of the subsequent period.

McGill Emergency Medicine has a long established practice of having Wednesday AM academic half day. All the off service rotations know this. Nonetheless, the resident is responsible to make rotation schedule requests to ensure that they are available to attend. For reasons other than vacation, out of city rotations, conference or study leave, a sick day will be deducted from the bank of sick/personal days.

4. Pharmaceutical and Industry Policy
1. The McGill Emergency Medicine Residency has a need to collect funds to help sponsor emergency academia and education of the residents. Consequently, the McGill Emergency Residency Education fund has been created. It is to be used for academic purposes that benefit the program as a whole (e.g. sponsoring speakers, educational equipment). It is not to be used for personal benefit (books,
trips etc.) nor is it to be used for food.

2. (Pharmaceutical) companies may make unlimited donations (frequency and amount, with a suggested minimum of $750) to the Emergency Medicine Residency educational fund.

3. **No obligations or conditions can be set by the pharmaceutical companies** in exchange for the donations (however, the names of donors will be listed amongst the companies making donations).

4. In return, the companies will be allowed to attend up to 4 Journal Clubs per Year. However, there will be only one company present per Journal Club. The company representative will set up their display outside the Journal Club room. They will not be allowed to give a formal presentation to those attending the Journal Club. Residents and staff are free to politely interact with the company representative outside of the Journal Club room.

5. Contributions will all go into a single fund, and the amount contributed will remain undisclosed to both the residents and the other pharmaceutical companies.

6. The Chief Residents will continue to manage the fund, but expenditures greater than $100.00 will require consensus and approval by both Chiefs and the Program Director.

7. There will be one selected Emergency Resident who will be responsible for contacting the companies, soliciting, scheduling and collecting the donations.
VII. SOCIETIES & CONFERENCES

EMERGENCY MEDICINE SOCIETY MEMBERSHIP & JOURNALS

CAEP - Canadian Association of Emergency Physicians

AMUQ - Association des Médecins d’Urgence du Québec

All McGill Residents should join both Associations. CAEP and AMUQ represent our interests at the National and Provincial levels. There is a joined membership available through AMUQ. It entitles you to receive free the Canadian Journal of Emergency Medicine (CJEM) as well as cheaper registration fees at CAEP and AMUQ conferences. (CAEP 1-800-463-1158 www.caep.ca; and AMUQ 1-418-658-7679 or amuq@amuq.qc.ca). Every Emergency resident should also be a member of "AMSMU" - Association des Médecins Spécialistes en Médecine d’Urgence (also through AMUQ, amuq@amuq.qc.ca).

ACEP and SAEM

Membership to "ACEP" - American College of Emergency Physicians (www.acep.org) and "SAEM" - Society for Academic Emergency Medicine (www.saem.org) are encouraged if not just for the two free monthly journals that are given to their members. (The Annals of Emergency Medicine with ACEP and Academic Emergency Medicine with SAEM). Both offer discounts to their members for conferences and other publications.

Other

Visit the "URGENET" site www.urgenet.qc.ca. Initiated by Dr. Alain Vadeboncoeur, Emergency Physician, this site has become the cornerstone of Emergency Medicine in Quebec with links to many organizations, a chat line and the GTI document entitled Les Urgences au Québec.

Conferences

You are entitled to ten days of conference leave per year. Currently, the Emergency Departments at the RVH, MGH and JGH offer to CaRMS residents $1000/year, stipend that can be used towards conferences. You cannot defer them to the next academic year so use them or lose them. Conferences are either supported $500 or $1000 depending on whether they are «minor» or «major». Major conferences are Royal College,
SAEM, ACEP, AAEM and CAEP. Minor conferences would be subject to approval by the Program Director. Residents who have not attended at least one major conference by their third year will not receive any more funding until they attend a major conference. Note that if you present at a conference, whether an abstract, poster presentation, etc., you are entitled to additional supplement of $1000.

VIII. VACATION & VACATION POLICY

Request for Change of Schedule Request Form: Available at the Program Coordinator’s office. Vacation time can be taken any time during the academic year with the following restrictions:

1. Residents must not miss more than 1/4 of a period, or it will be considered incomplete and it will have to be repeated.
2. Residents can take 2 weeks vacations consecutively if they:
3. take the last week of one period, and the first week of following period, or
4. request a two-week vacation during a two-month block rotation.
5. Residents must inform the rotation supervisor with a sixty (60)-days notice. (Please use the "Change of Schedule Request" form and submit it immediately to the Program Coordinator for submission to Unit Coordinator and EM Program Director)
6. Residents are encouraged not to take vacation time during Orientation (1st week of July) or when Senior residents are writing exams (beginning of June).
7. Article 25.01 of the Residents’ Contract, states that the "rotation supervisor has the right to refuse a vacation request should this have an effect on the medical care provided by that service."
IX. TELEPHONE NUMBERS & ADDRESSES

Royal College & CMQ Emergency Medicine Residency Program
Royal Victoria Hospital
Room A4.62
687 Pine Avenue West, Montreal, Quebec H3A 1A1

RVH Locating: 514 934-1934 ext. 53333

TELEPHONE NUMBERS AND ADDRESSES

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