2008 Program Review- Faculty

Category/Question
List the strengths of the residency program.
2) The program encourages residents to be progressive in the management of patient and encourages patients in the new modalities coming into Emergency Medicine.
2) Great residents
2) The residency program has many strengths but by far the leading reason is the staff/faculty. Dr. Ankel's dedication and commitment to the program is the number one reason our residency program is rated so high. Secondly the support by Dr. Asplin and the continual support by our esteemed staff (Such as Drs. Knopp, Holger, Harris, Quaday,Dahms, Hegarty) make this program outstanding.
2) The PD, the support staff, the residents
2) Clinical training, resident involvement in decisions/committees, conference and clinical education, quality of the residents, quality of the staff, quality of the residency administration staff (Lori/Pat), support of department/chair.
2) Education, approachable faculty, great residents
2) Leadership, patient, faculty, residents, nurses, support services, transparency, educational focus, ethical
2) Progressive, innovative, vigilent of educational opportunities
2) Broad staff base. Frequent assessments of the program itself to make sure it is meeting our goals and vision. Cutting edge.
2) Patient volume and variety, Acuity of patients. Toxicology
2) Heterogenious faculty and resident groups
2) faculty involvement faculty diversity strong leadership despite recent turnover Lori and Pat!
2) Elasticity, rigor, experience.
2) residency support-Lori and Pat, Felix and assistants are interested and available.
2) Excellent exposure to critical care/critical patients. Excellent airway exposure. Excellent Ultrasound teaching.
2) Solid leadership, Felix very committed to great reident education.
2) Great leadership from Felix, Lori and Pat. Motivated residents who take pride in their program.
2) the faculty, the facility, mix of patient population, ability to do procedures
2) Graduated responsibility. Residents staff directly with attendings. Sense of camaraderie. Emphasis on well-being. Extensive critical care experience. Relatively diverse group of faculty. Good relationship with most consult services, trauma surgery in particular. Adequate numbers of procedures. High acuity of patients.
List the weaknesses of the residency program.
3) I think sometimes there is more emphasis put on seeing patients and not enough time allowed for academic pursuits.
3) Time to allow outside pursuits (ie ATR). Pediatric exposure and Regions support of peds.
3) Lack of pediatrics is an issue, however residents are getting pediatric training at other hospitals.
3) Need more focus on research and other more traditional academic pursuits.
3) Ultrasound MACHINES (not teaching/interest)--need a west end machine and need all machines to have batteries to avoid long boot-up issues.
3) The Admin piece. I wish we had more didactics around basics like chest pain eval, abd pain eval and less textbook oriented topics. I would be willing to work with this (KQ). I also wish we had mandatory followup of discharged patients.
3) Research. Pediatric resuscitations. Too much psych. Poor relationship with Hospitalists happens too much
3) too many evaluations

3) On the whole, we struggle to find the right balance between patient care, education and other faculty requirements (research, documentation, etc.).	
3) I think that some staff have limited interest in teaching and onsite feedback. We need more conferences with certain specialties- colorectal to talk about hemorrhoids, etc; GU to talk about kidneys stones, torsion, epididymitis, etc. More objective ratings on feedback cards-too many excellent avid having to give feedback	
3) Dichotomous vectors of HP/throughput/outreach and academics. Outreach is less of a distraction than it has been in the past which is good. The lack of clinical research is disappointing and needs to be re-visited.	
3) peds trauma	
3) admin exposure	
3) diversity	
3) we are chronically understaffed with midlevel providers, so that the residents have extremely stressful shifts each time they work. so many of them feel overwhelmed with the number of patients they are carrying and the onerous documentation burden. too many psychiatric patients too much expectation to move patients	
3) Ultrasound program. Under-staffing which decreases time for clinical teaching. Pediatric visits to primary site relatively low but compensated by peds EM experience at Children's hospitals.	
Lists ways to improve or address areas of weakness in the program.	
4) It's difficult; I think maybe longer shifts and less shifts may be one way of increasing time off of the floor.	
4) Change the resident scholarly project into a true research project.	
4) Buy a new US for the west end of the ED and get a battery for the other US machines.	
4) work to get peds back at Regions	
4) more time, more admin assistance from the department. More defined but less onerous research/project process for residents (and their advisors).	
4) see above	
4) We have a more motivated, younger RN staff who may be more supportive of clinical research than the staff of 5 years ago.	
4) leadership of admin exposure, engagement of Drs Asplin, Chun, Quaday	
4) continue to assess and re-assess program, resident and staff satisfaction.	
4) add more midlevel providers, especially at night, so residents can think about their patients First year residents should pick up the pace after January, so they aren't so overwhelmed with the transition to 2d year	**Rating Scale** 1-3 Poor 4-6 Adequate 7-9 Outstanding
4) Increased support/time for ultrasound training of faculty. Increase staffing.	
	Average
Accessibility and responsiveness of program coordinator and program assistant (Lori & Pat)	**8.2**
22) They seem to have a finger on what is going on with the residents personally and academically.	
22) 2nd and 3rd mothers since I was a resident here. You thought the upheaval of assistant/associate residency directors was tough. When decide to retire - watch out!	
22) They run the day-to-day program--they are organized, helpful, and are utterly indespensible.	
22) Lori and Pat are the best!	
22) indespensible!	
Opportunities for resident responsibility for patient care	**7.9**
11) Good level of autonomy.	
Overall clinical competence of EM-3 residents.	**7.8**

10) All ready to go out there and practice alone. 10) they are all great	
Quality and responsiveness of social work staff in the ED.	**7.8**
20) we are spoiled rotten! 20) I'm not sure what we would do without the SWs helping out. 20) They are unbelievable. They never complain, even when volume is overwhelming. Deserve more credit for the work that they do.	
Overall direction and leadership of residency provided by director and assistant directors (Ankel, Dahms, Hegarty, Morgan, Taft)	**7.6**
23) The addition of some of the new staff has improved the overall leadership of the resident group. 23) Hard working group. Only thought is to be more open/receptive to feedback at times--sometimes feedback is given and there is an immediate negative response by the PD. I think if feedback is requested we should at least listen and then reply later with a response to the feedback. Also, I'd limit some of the new feedback we're giving to residents via email and do more verbal communication--email communication can be hard to interpret emotion/feelings at times and I think for resident well being a face to face talk will 9/10 times be more beneficial. 23) For the number of people we have in the residency leadership, it seems more should be accomplished- publications, chapters, presentations, etc. The residency has always been excellent with fewer people at the helm. I would think the additional people would enable more production. 23) Excellent leadership by Ankel, great engagement of asst Pds 23) Solid. 23) Ankle works tremendously hard on the residency program and keeps it together, although he can be hard to talk to with concerns about specific residents or scheduling shifts. He seems very set in his ideas and resistant to change.	
Patient volume and quality of medical, surgical, pediatric, gynecological and behavioral emergency cases seen in the ED	**7.6**
5) Pediatrics at Regions is weak. 5) Have more of the psych pts be taken care of by PA's 5) could use more peds, but I don't really want them here until the hospital's more prepared for them. I don't think more comments about the BH situation are all that helpful. We know it's a problem - just need to manage it. 5) Too much psyche. Too little peds. 5) This is a very mixed question. I feel see a good mix of med, surg, and probably too many of some Gyn cases (1st trimester bleeds). Too many behavioral health patients, although the PAs protect the residents from the extended stay patient cares. If you're looking only at Regions, not enough sick kids. 5) too many psychiatric patients--they do not contribute to learning at all too many drug seekers	
Opportunities for progressive resident responsibility in patient care	**7.6**
12) Transition to 2nd year is a quantum leap, pretty stressful but a god developmental step. . 12) first year residents need to be pushed to see more patients after Jan 1. (snip) Great opportunities for early intubations and procedures and running codes.	
Quality and team attitude of Physician Assistant staff in the ED. 19) They work together well and not infrequently the residents will ask PA's for information and also the PA's look to the residents as a source of information.	**7.5**
19) lots of variability now. Some I trust implicitly, some I watch like a hawk. I appreciate their willingness to take care of our BH pts - they do a very good job with this difficult and not-very-satisfying pt population. I know that's not what they went into this job for.	

19) LOVE the PAs! There is some variability among them (some see more patients, some have more positive attitudes. 19) They do not get enough credit for the things that they do. 19) PAs are great--we need to do a better job of keeping/retaining the best PAs as our department does rely on them in our current staffing model. 19) most are great	
Your impression of the SICU rotation and overall performance by EM residents on SICU.	**7.4**
36) improved with more responsibility and b/u	
Rate the overall quality of the residency program.	**7.4**
1) Strong training, good leaders. An ideal training site with a diverse population. Staff overall are committed to education. 1) outstanding	
Your impression of the EM-3 support of the residency a group. Do the residents promote the residency to others and work to improve the residency?	**7.4**
43) Outstanding end of training attitude, much better then last year's third year class	
A availability and accessibility of activities promoting general resident well being (scheduling and leave policies, access to advisors, access to resident support services).	**7.2**
38) good support and except for SICU hours are ok 38) A resident and family-friendly residency.	
Your impression of the MICU rotation and overall performance by EM resident on MICU.	**7.2**
Competence and responsiveness of Clerk staff in the ED	**7.2**
18) individual dependent 18) almost all are great	
Availability and accessibility to resources for academic development (memberships to specialty societies, attendance at national conferences,inservice and oral board preparation, mentorship opportunities).	**7.2**
Your impression of the EM-1 support of the residency as a group. Do the residents promote the residency to others and work to improve the residency?	**7.1**
41) A phenomenal group. Wish we could have interns like this every year! 41) A little much of the "system is doing this to us" from a few. Most actively search out opportunities to maximize their education	
Overall clinical competence of EM-1 residents	**7.1**
8) very good class on the whole 8) Our intern class is awesome! Year-to-year we recruit a strong intern class. 8) some are better than others (snip)-- some may not be ready for July, when the expectations sky-rocket.	
Quality of resident involvement in teaching of EM residents, rotators and medical students	**7.1**
29) they get lots of opportunities to teach. Do we as faculty give them enough support and teaching as to how to teach? 29) Ample opportunities.	
Overall clinical competence of EM-2 residents	**7.1**
9) Solid. 9) most are great--with a few exceptions	
Departmental direction and leadership by department head and associate department head (Asplin & Chung)	**7.1**
24) Great job--only thought is to have a clear sense of where education fits into our ED overall and use that in decision-making. I think education is valued but sometimes feel that the HP/Regions suggestions/decisions clearly trump education. 24) difficult job mediating between lots of conflicting interests and personalities	

24) Asplin is doing a great job in a difficult position, but is intimidating to talk to with concerns. He should be more approachable to the general Senior staff doctors. I am less clear as to Chung's role, but he needs to support the ED staff doctors more (snip), e.g., relationships with hospitalists. (snip)	
Overall performance of HCMC residents and success of Regions-HCMC "swap"	**7.0**
31) The perception is that it is beneficial to both groups although I am not personally aware of the resident feedback from both groups. 31) HCMC residents have been a joy to work with not sure how the residents feel overall on the other end but I have heard good things. 31) A great experience. 31) I think that this is a great relationship and eye opening about differences in the programs (I think favorably in terms of our residents). 31) some are quite good, others seem procedurally behind our residents	
Opportunities for involvement in recruitment and selection of future residents.	**6.9**
Your impression of the Toxicology rotation and overall performance by EM residents on Tox.	**6.9**
Quality/responsiveness of specialty back-up to the ED	**6.9**
7) Has deteriorated some since the mvt of the specialty clinics off campus. 7) I would like to see more Staff presence in ED of specialty back-up when their residents are the first (and usually only) evaluator. 7) Consultant response is based on thier commitment to their inpatient population. Consulting residents tend to over-order studies (by phone) without evaluating patient first. 7) in the grand scheme of things (across the US), we're doing fine. 7) surgery is slow sometimes 7) Ortho and TACS consults sometimes take hours. Otherwise OK. 7) Most excellent, decrease of unprofessional behavior by hospitalists appreciated 7) podiatry is great, as is hand. neurosurgery is not. too much push-back from certain hospitalists on admissions (this is not the case with United hospitalists at all---it's a pleasure to send a patient there)	
Overall quality of format and content of ED conferences - critical case, core content, journal club, QI, small groups.	**6.8**
27) I'd vote for more small group/simulation conference days to get away from the old powerpoint lecture sessions. I love the new 90min critical case. 27) small groups are nice addition - it would be nice to see more faculty involved in this. Also, I've noticed my few core content lectures are coming around more frequently - are we having more scheduling issues than usual? 27) need better faculty attendance at journal club, QI. Need more specialist participation. Need all residents to read the journal articles and oarticipate journal club 27) Good variety with the changes Matt has made. 27) Excellent leadership by Morgan	
Your impression of the EM-2 support of the residency as a group. Do the residents promote the residency to others and work to improve the residency?	**6.8**
42) A solid group. 42) Most really contribute to the residency	
Faculty support for residency activities.	**6.7**
25) Variable. 25) Not enough research support. The money available for this is very adequate. 25) lots of folks didn't come to graduation dinner 25) Could use more faculty attendence at conference, especially by operations people	
Competence and responsiveness of ancillary care providers, x-ray, lab, respiratory, blood bank, transportation.	**6.7**

21) Lab compared to Hudson seems slow and to have more hemolysis issues. 21) Respiratory is excellent 21) occasional annoyances with hemolyzed samples, otherwise no issues. 21) Lab is often slow. 21) inconsistent responsiveness of lab 21) labs can be slow to come back	
Quality of US program in the ED quality of ultrasound education and teaching. Opportunities for residents to perform ultrasound examinations in the ED.	**6.7**
28) Need more input, support and dedication of US by staff other than core US staff. 28) See above re: need for new machine for WEST and a battery for machine #2 (check our number of machines vs HCMC and you'll see why they do more US). 28) getting better. Faculty getting more comfortable. I'm not convinced we need to harp on US so much. In how many jobs will we be expected to do transvag, RUQ US, etc. I'm not out to replace the ultrasonographer. 28) Need more US for critical case-then residents will understand its importance/relevance 28) Decent, and improving. 28) Excellent leadership by Zwank 28) Residents often so busy, it's difficult to use the ultrasound for non-emergent things to get more experience and practice. Largely due to resident responsibility for large patient volume but also because ultrasounds are very cumbersome and one has to be booted up every time it is moved.	
Quality and responsiveness of ED Nursing staff	**6.7**
16) Excellent floor nurses, less hostility by nurse management towards residency recently. This is appreciated 16) most are great and helpful	
Competence and responsiveness of ERT staff in the ED	**6.6**
17) Some work very hard while others do not, perfering to chit-chat. 17) This is where we are most understaffed. They are the least expensive piece to staff and the hardest to find. I don't know why we don't add more. It is frequently quicker to get something yourself as a staff or resident MD than it is to find a ERT. 17) ERTs are good, numbers at times seem low. 17) variable	
Overall performance of EM resident on Plastics/Hand rotation.	**6.6**
33) EM staff often end up supervising consults in the ED since Hand staff aren't present. 33) appears adequate	
Accessibility and maintenance of equipment in ED exam rooms.	**6.5**
14) Not always stocked since we have been in construction 14) Frequently diagnostid equipment does not work and on weekends not restocked. 14) occasionally run into bad bulbs for otoscopes, but ERT's responsive to my asking for help. 14) otoscopes not working or available enough 14) Overall OK. 14) Ultrasound machines--need one new one for WEST and need a battery for machine #2. Ideal world getting a video fiberoptic intubating scope (ala Karl Storz) would be great for patient care and education of the residents.	
Overall performance of EM resident on Orthopedics rotation.	**6.3**
32) Continues to appear to be a thorn in our side. Low quality teaching and some abuse by Ortho staff and residents. 32) could be more involvement on the part of the orthpedic staff.	
Overall direction/assistance/support provided by IME.	**6.2**
26) Not very visible.	

Resident performance in handling EMS radio calls.	**6.1**
13) resident appearance at radio seems a little more variable lately (but we're at year change so I'd bet there's some confusion). 13) Some residents respond well, others not. 13) Adequate but could be improved with more training in triage 13) Residents do ok--I'm not sure what percent they do vs. staff, but it would be nice to have them respond to more of the radio calls.	
Your impression of the OB rotation and overall performance by EM resident on OB.	**5.8**
34) need more deliveries 34) I'm told by the residents that there are very few deliveries because of the number of the people involved and vying for deliveries. 34) Need to do OB elsewhere or guarentee they'll get their deliveries here.	
Resident coverage for patient volume	**5.7**
6) could use more residents, or more paramedical personnel such as PA-C's 6) One resident on the B/west side at night is not enough for some nights--especially when there is one staff/one resident then for the early hours of the night and all rooms are full. ?need to expand residency given new ED expansion. 6) we don't need more residents. We need to move patient upstairs quicker. Probably need more PAs 6) Seems OK, thanks to the PAs for extra midlevel staffing. 6) Overnights can be very thin. At times seem dangerous. 6) residents are often overwhelmed and EPIC documentation is onerous for them they need scribes (or a less cumbersome system) some of the more conscientious residents are here long after their shifts end documenting (somewhat better after the 10 hour shifts were implemented) 6) Needs to be increased mid-level staffing (whether resident or PA) in order to increase time for teaching.	
Accessibility and condition of ED conference rooms	**5.5**
15) Too small. Auditorium is large enough, but outdated. 15) Tough with construction but working ok. It was nice to have our own conference space in the past. *A dedicated sim/education room should be included in our new office/ED space when we move for staff, resident and RN/tech/other ED education via simulation. 15) can't wait until the construction is over! Tell me they'll be some cool educational space coming, please. Amphitheater is getting run down. 15) There needs to be dedicated conference space with a wider availability. 15) The amphitheater is fine...but all the alternative arrangemets we're making during construction are confusing. The AV setups are different, and sometimes the rooms are too small. 15) It would be nice to have state of the art conference room, does not seem to be a priority for hospital 15) Good when able to use amphitheatre for conferences but poor when not able.	
Opportunities for involvement in ED research. Faculty encouragement, departmental support and sufficient time during residency to participate in research.	**4.9**
30) opportunities are there. However, there isn't a lot of HP support unless it falls into what HP is into (health systems stuff). EMD support is there. But the process beyond that is rather painful (IRB). Sufficient time - no way - for faculty or research. 30) Serios work needs to be done here. Start with the IRB which is notorious for being obstructive and then get some faculty who know how to navigate the process (there are a few but not enough with enough time). 30) Not a focus at Regions, although there are opportunities.	

30) Fair. We need a dedicated section of our department to assist with research to really get things rolling. Currently there are a lot of people listed as the 'research people' for our deparment that are overloaded/overwhelmed with their current duties/projects and can't mentor staff/resident projects.	
Please provide any additional comments about the program that you feel would be helpful.	
44) outstanding residency, a privilege to work at Regions 44) We have a great program which is strong. Need to continue to finds ways to improve and to tweak rotations. Need to have a greater national presence with lectures and national conferences. More clinical research. 44) EPIC is a huge burden to the residents (and the faculty)--documentation requirements are ridiculous, and added to that is CPOE, discharge instructions, etc. They need scribes, or some other help with documentation so they can do their real job, which is seeing and taking care of patients.	