PHILIPPINE BOARD OF EMERGENCY MEDICINE

STANDARDS AND REQUIREMENTS FOR THE ACCREDITATION OF RESIDENCY TRAINING PROGRAMS IN EMERGENCY MEDICINE

I. OBJECTIVES

1. To develop professionally competent physicians in emergency medicine and acute care.
2. To develop and promote the attitudes and values of the specialty.
3. To promote and stimulate research in emergency medicine and acute care.
4. To equip physicians, aspiring to be specialists in the field, the knowledge and skills needed in the practice of emergency medicine.
5. To appropriately teach the essentials of the specialty.
6. To provide an adequate clinical environment and give sufficient hands-on experience to be able to apply the principles of emergency care.
7. To ensure supervision of training residents by competent faculty to help them achieve the target performance and acquire the terminal competencies expected of an emergency physician in providing the highest quality of care in their future practice.

II. MECHANICS OF ACCREDITATION

Steps:

1. The Chairperson of the PCEM-accredited Emergency Department shall apply for an accreditation visit in writing, together with the fee of SIX THOUSAND PESOS (P6,000).
2. The PBEM shall notify the applicant of the approximate time of the visit.
3. The Chairperson of the ED shall be given a written assessment of the PBEM, including any deficiency /ies his program may have.
4. The PBEM shall issue a plaque of accreditation to indicate approval for the 3-year residency program until the specified date of re-accreditation.

III. TRAINING INSTITUTIONS

Both PCEMAC-accredited and PSECP-accredited hospital ERs may be approved for residency training in Emergency Medicine by the Philippine Board of Emergency Medicine through the recommendation of its Accreditation Committee for three(3) years depending upon the findings of the accreditation team. The privilege or approval may be revoked by the Philippine College of Emergency Medicine anytime through the recommendation of the Accreditation Committee for failure to maintain the standards set up by the PCEM for Emergency Medicine Training Programs and/or Emergency Departments.

A. SPONSORING INSTITUTION

A sponsoring hospital with a Department or Section of Emergency Medicine willing to assume full responsibility

a for the duration of the entire training program and
b. for residents to complete the needed requirements which provides a comprehensive emergency medical care that is accredited by the PCEM.

B. PARTICIPATING INSTITUTION

A surrogate hospital or institution Emergency Medicine residents are assigned to in cases when the Primary Hospital is unable to provide all the requirements needed to fulfill the EM education.

A. Requirements:

1. There must be a valid reason for the assignation.
2. With set objectives and activities integral to the completion of the program.
3. Must be justified.
4. Must offer significant resources, educational opportunities or clinical experience unavailable in the primary training hospital.
5. Must be well-coordinated
6. Geographically feasible
7. Must guarantee continuity of medical experience

B. Assignment to should have the consent and agreement of both parties.
This agreement should put into writing all the duties, responsibilities, and obligations of the participating hospital and should include:

a. The supervising faculty for the duration of the resident's rotation, who will assume full responsibility for both the clinical training and education.
Said faculty will also be responsible in evaluating the EM resident at the end of the posting.
b. The objectives of the whole rotation should specify the activities.
c. The length and content of the entire rotation.
d. The policies and guidelines that will apply to the resident.

When multiple institutions are needed to fulfill the EM program, commitment of each institution to the training of the resident is mandatory. Clear demarcation of roles, objectives and responsibilities of each institution in the training program should be explicitly stated to avoid duplication and ambiguity in function.

C. MEDICAL SCHOOL AFFILIATION
Medical school affiliation is recommended but not necessary. If present, a memorandum of agreement must be forged between the medical school and the program as to the duties and responsibilities of each other. Proper and sufficient number of faculty appointment must be in place in the medical school.

D. FACILITIES AND RESOURCES NEEDED FOR THE TRAINING
The primary training hospital for the EM program must provide the following:

1. An Emergency Department capable of providing
    i. emergent and
    ii. urgent
    care duly accredited by the Department of Health
2. Administrative services
3. Laboratory and diagnostic imaging services available to the staff of the Emergency Department
4. Structural and physical support for the clinical and program requirements. These include
    a. Office space for the faculty, residents, and medical students, if applicable.
    b. Adequate spaces for didactics, meetings, and conferences
    c. Medical libraries and databases accessible to EM faculty, residents, and staff.
    d. Adequate security services for the staff and patients of the Emergency Department.
    e. Financial capabilities to sustain the program.

E. CLINICAL SERVICES
The primary or sponsoring institution should

1. Be a General Hospital of at least 100 beds with departments or sections of
    Surgery
    Obstetrics
    Pediatrics
    Medicine

ENT and Ophthalmology

2. Be capable of giving 24-hour clinical services. It must provide expected demands in
    a. Nursing care
    b. Diagnostic Support Units i.e. Clinical Laboratory, Radiology Department
    c. Prolonged life support units i.e. Intensive Care Units, Operating Rooms
    d. Peripheral services like clerical and transportation at any given time.

The Hospital should assure that all the clinical specialties are available for emergency department consultation and admission. If not possible, a written protocol accessible to the ED staff must be available at all times for the provision of the services elsewhere.

3. Medical Records System

IV. TRAINING STAFF OF THE EMERGENCY DEPARTMENT

The following medical personnel are required of an accredited Emergency Medicine program under the PBEM:

A. Program Director/ Training Officer

A single director for the program must be appointed, who will be responsible for the implementation of the Emergency Medicine program.

He must have the following qualifications:

a. A medical doctor of a qualified specialty expertise to implement the program with good professional standing.
   A certified PBEM fellow or EM specialist is desirable, recommended and is a requisite.
b. He should be an active staff of the primary training hospital and a member of the core training faculty for EM
c. He should have good administrative capabilities and must demonstrate leadership qualities able to supervise and mobilize fellow faculty consultants and residents.
d. He should show commitment to the program.

The program director will have the following responsibilities

1. He should actively oversee the actual implementation of the program, including organizing educational activities for the ED staff
2. Make sure primary objectives of the program are met both by the faculty and the trainees.
3. Select the residents for appointment to the program, leaving to his discretion the number and quality in accordance with departmental guidelines and requirements.
4. Evaluate the clinical and overall performance of the faculty and residents.
5. Administrative duties of the department
6. Smooth daily operations and functions of the Emergency Department
7. Appoint faculty to key positions needed for the program including Clinical Training officer, assistant director, research director, clinical services coordinator, etc.

B. Faculty

A minimum of three (3) board certified Emergency Medicine consultant among the faculty is recommended for the entire duration of the training. When the total number of residents in a program exceeds 30, the faculty-resident ratio may be altered with clear and valid justification.

The physician must support the goals and objectives of the program and is willing to actively participate in the curriculum development and implementation. Each faculty should average 20 clinical hours per week or 1120 service hours per year.

Delineation of function and job of each faculty, and appointment there of, is in the discretion of the program director.

The physician faculty must possess the following qualifications:

1. Should be an active staff of any of the participating institutions and in good professional standing
2. Must possess the required specialty expertise and competence to teach and supervise the trainees. A fellow of PBECP or a certified EM specialist is highly recommended.
3. Must devote sufficient time to the educational program which includes didactics, clinical teaching, research activities and direct supervision of residents.

C. Other Program Personnel

Additional program personnel to fulfill administrative, clerical and technical needs must be provided to support the program and must be provided by the participating hospitals.

V. RESIDENT APPOINTMENT

A. Eligibility

1. Any graduate of a recognized medical school in the Philippines who has finished a one year rotating internship in an approved hospital and is licensed to practice in the Philippines may be eligible for admission to the program.
2. In addition to the prescribed requirements by the Philippine College of Emergency Medicine, the hospital/ institution may set other requirements that will suit their own standards.
3. The minimum duration of the residency training program shall be three (3) years.
4. Certification for the period of a successfully completed residency shall be granted by the approved hospital.

B. Number

The number of residents will be decided on by the program director and faculty.This will depend on the available resources for the training such as:

a. quality and volume of patients
b. educational materials
c. faculty to resident ratio
d. hospital funding
e. quality of faculty supervision.

VI. PROGRAM CURRICULUM

Goal: To train Emergency physicians with the knowledge, skills, and attitudes in handling general emergency patients.

A. Program Design

Each year level should set end-goal competencies which the resident should achieve, to continue with the program. These aim to increase the responsibilities and duties of the resident as he gets higher up in the seniority ladder.

Formulation of the design will be done by the director and faculty, in accordance with the primary training hospital's policies and guidelines.

The PBEM reserves the right to approve said curriculum upon application for accreditation.

The program design should be reviewed regularly to assure goals and objectives are rightfully achieved

B. Specialty Curriculum

1. PATIENT POPULATION

There must be an adequate number of patients of all ages and sexes covering a wide variety of

clinical situations to provide sufficient clinical exposure to meet the needs of the emergency medicine training. The annual ED attendance should be at least 18,000, but limitations due to geographical settings may be considered to justify failure to meet the number.

2. SCOPE
   a. Must provide a course outline of the Emergency Department organization and administration.
   b. The curriculum must ensure that the residents get adequate clinical exposure, experience and develop competence in handling the wide spectrum of emergency cases and scenarios. Supervisory and advisory hours by the senior doctors will be based on guidelines agreed upon by the core faculty members and director.
   c. It must ensure competence in providing effective cardiopulmonary and cerebral resuscitation (basic, advanced, and prolonged life support).
   d. Aside from his training in the emergency department , the resident should be adequately trained in the evaluation and management of critically-ill and injured in the intensive and specialized care units of the hospital.
   e. Adequate exposure and training should be given to residents in the planning and implementation of disaster programs and emergency service networks.
   f. Scope must include didactics, to achieve the core competencies of the training program. These knowledge and skill-based competencies as listed in the *2005 Model of the Clinical Practice of Emergency Medicine* published in the October 2006 Academic Emergency Medicine issue, include, but is not limited to signs, symptoms and presentations of
      - abdominal and gastrointestinal disorders
      - endocrine, metabolic and nutritional disorders
      - environmental disorders
      - head, ear, eye, nose, throat disorders
      - hematologic disorders
      - immune system disorders
      - musculo-skeletal disorders(non-traumatic)
      - nervous system disorders
      - obstetrics and gynecology
      - thoracic-respiratory disorders
      - toxicologic disorders
      - traumatic disorders
   g. The curriculum must include measurable competency goals for each level of training, a description of how it will be achieved, assessed and remediated when necessary. Measurable objectives must also be developed for non-EM and other specialty rotations with appropriate assessment tools
   h. The curriculum must provide a venue for residents to formulate or participate in research projects to promote scholarly interactions and academic progress.
   i. The curriculum must initiate continuous performance quality improvement program for the department, which should include tools for the improvement of standard of care and identifying problem areas in the department. Residents are required to actively participate in these programs.

C. ACCREDITATION COUNCIL FOR GRADUATE MEDICAL EDUCATION (ACGME) CORE COMPETENCIES

The ACGME formulated 6 general core competencies to assure physicians are appropriately trained in knowledge and skills of their specialties; and these are expected of a new practicing physician:

C.1. Patient Care

Residents must provide patient care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health.

Residents are expected to

a. Gather accurate and essential information in a timely manner or under variable time constraints
b. Generate an appropriate differential diagnosis
c. Implement an effective patient management plan especially with limited data, in the field or hospital
d. Competently perform the diagnostic and therapeutic procedures and emergency stabilization to all real or potential threats to life or limb
e. Prioritize and stabilize multiple patients and perform other responsibilities simultaneously
f. Work with health care professionals to provide patient-focused care

C.2. Medical Knowledge

Residents must demonstrate knowledge about established and evolving biomedical, clinical and cognate sciences and the application of this knowledge to patient care. It is expected that residents

a. Identify life-threatening conditions, the most likely diagnosis, synthesize acquired patient data, and identify how and when to access current medical literature
b. Properly sequence critical actions for patient care and generate a differential diagnosis for an undifferentiated patient
c. Complete disposition of patients using available resources

C.3. Practice-Based Learning

Residents must be able to investigate and evaluate their patient care practices, appraise and assimmilate scientific evidence and improve their care practices.

Among other things, residents are expected to:

a. Analyze and assess their practice experience and perform practice-based improvement
b. Locate, appraise, and utilize scientific evidence related to their patient's health problems
c. Apply knowledge of study design and statistical methods to critically appraise the medical literature.
d. Utilize information technology to enhance their education and improve patient care
e. Facilitate the learning of students and other health care professionals

C.4. Interpersonal Communication Skills

Residents must be able to demonstrate interpersonal and communication skills that result in effective information exchange and teaming with patients, their families and professional associates. Residents are expected to

a. Develop an effective therapeutic relationship with patients and their families with respect to diversity and cultural, ethnic, spiritual, economic and age-specific differences.
b. Demonstrate effective participation in and leadership of health care team.
c. Develop effective written communication skills.
d. Demonstrate the ability to handle situations unique to the practice of emergency medicine.
e. Effectively communicate with out-of-hospital personnel as well as non-medical personnel.

C.5. Professionalism

Residents must demonstrate a commitment to carrying out professional responsibilities, adherence to ethical principles and sensitivity to a diverse patient population.

Residents are expected to demonstrate a set of model behaviours that include but are not limited to

a. Treating patients/family/staff/paraprofessional personnel with respect
b. Protect staff/family/patient's interest/confidentiality
c. Demonstrate sensitivity to patient's pain, emotional state and gender/ethnicity issues and be able to cope with and handle behavioral problems that may arise from such
d. Be able to discuss death honestly, sensitively, patiently and compassionately
e. Unconditional positive regard for the patient, family, staff and consultants
f. Accept responsibility/ accountability
g. Openness and responsiveness to the comments of other team members, patients, families and peers

C.6. System-Based Practice

Residents must demonstrate an awareness of responsiveness to the larger content and system resources to provide care that is of optimal value.

Residents are expected to:

a. Understand, access, appropriately utilize and evaluate the effectiveness of the resources, providers and systems necessary to provide optimal emergency care.
b. Understand different medical practice models and delivery systems and how to best utilize them to care for the individual patient.
c. Practice cost-effective health care and resource allocation that does not compromise quality of care.
d. Advocate for and facilitate patients' advancement through the health care system.

D. PLANNED EDUCATIONAL EXPERIENCE

The curriculum must include an average of at least 5 hours per week of planned educational experience developed by the EM residency program. These will entail:

a. case presentations
b. morbidity and mortality reviews
c. journal reports
d. administrative seminars
e. and research methods

It may also include:

- problem-based or
- evidence-based learning
- laboratories
- and computer-based instructions

Members of teaching faculty are expected to attend, facilitate and participate in theses training activities. No less than 50% of these should take place under the supervision of an EM faculty.

1. MONITORED PROCEDURES

a. Each resident is expected to perform a minimum number of emergency procedures (please refer to Annex A)
b. Procedures done will be recorded in a PBEM-issued logbook and duly countersigned by his Training Officer, a PCEM Fellow or a specialty consultant of the department or institution in which the procedure was done by a rotating resident. It is the responsibility of the resident to keep this logbook updated and ready for presentation prior to every qualifying examination. It shall include the following information:

- Patient's chart number
- Name of patient

- Age of patient
- Date performed
- Disposition
- Signature of superior

2. RESEARCH PAPER

Each resident is required to submit at least one research output or activity for every year of his training.

Case studies or reviews are limited to first year residents only.

A resident may not submit the same kind of research twice (i.e. if retrospective study for 2nd year, must submit a prospective study for 3rd year).

Each resident must present a completed research paper by the end of the training program.

First Year: Case Study/ Report
Second Year: Retrospective or Prospective Study or Research Protocol

Third Year: Retrospective or Prospective Study or
Completion of previously presented research protocol.

Research papers must be submitted to the PBEM as prerequisite to taking the board exam. The authors shall allow reproduction of same research papers in the official publication of PCEM. The PBEM shall, in turn, select which ones will qualify for presentation for the annual research paper contest.

3. DEPARTMENTAL ACTIVITIES

a. Journal Club

Accredited hospitals shall conduct the following journal dissection and discussion:
One (1) per quarter presided by the training officer and
One (1) per year sponsored by PAREM

b. Lectures and Exams

Lectures are to be conducted by the residents to strengthen their academic knowledge and understanding of the principles of emergency medicine.

The number or frequency of lectures will be at the discretion of the training officer with a monthly quiz.

c. Monthly Audit

This shall serve a two-fold purpose:
a. A peer review of the management of unusual or critical cases
b. Review of the adequacy of the documentation of all patient charts

E. REQUIRED ROTATIONS

E.1. Residents must have at least 60% or 7months per year of adult emergency setting rotation. By the end of each year each resident must have sufficient opportunities to perform resuscitative procedures including invasive interventions and manage different clinical conditions needing emergent care.

Care of critically-ill or -injured by the residents should be significant. These include patients admitted to monitored settings, operative care, or the morgue following treatment at the ED; and should comprise at least 3% or 1,200 of the ED patients per year whichever is greater.

E.2. Pediatric experience, defined as the care of patients less than 19 years of age, ideally should be at least 16% of all ED encounters or 8 weeks of exposure to Pediatrics divided between ICU

and wards or ER. A deficit in the pediatric patients can be balance by assigning a dedicated rotation for infants and children, which can include care of critically-ill patients.

E.3. Critical Care Rotation is a must; for it constitutes an integral part of residents' training. It is needed to develop decision-making skills in managing critically-ill patients. Residents must complete 8 weeks of adult CCU rotation. This critical care experience can be augmented or achieved with out-of-primary hospital postings.

E.4. Residents must also have pre-hospital experience as part of their out-of-hospital rotation. This should include participation in paramedic activities, emergency transportation pre-hospital care and disaster planning/drills

E.5. Non-EM or other specialty rotations for the resident may include anaesthesia, psychiatry, ENT, and Ophthalmology, and must comprise at least 20% or 2 months in a year. Only Anesthesiology and Psychiatry are considered as Elective rotations and, as such, require a minimum of 2 weeks rotation.

E.6. A minimum rotation of 4 weeks in each of Toxicology and Obstetrics & Gynecology are required.
A minimum of 8 weeks rotation in Trauma is required.
A minimum rotation of 4 weeks in each of Orthopedics and Radiology are required.
The residents on rotation will be fully seconded to the service they are rotating in. However, they may be assigned by the service to do their duty at the ER if necessary.

DEPARTMENT	DURATION
Adult Critical or Intensive Care	8 weeks
Trauma	Minimum of 8 weeks
Orthopedics	Minimum of 4 weeks
Pediatrics (divided between ICU, ward, ER)	Minimum of 8 weeks
OB-Gyne	Minimum of 4 weeks
Ophthalmology	Minimum of 2 weeks
ENT	Minimum of 2 weeks
Radiology	Minimum of 4 weeks
Toxicology	Minimum of 4 weeks
Pre-Hospital	Minimum of 4 weeks
Psychiatry or Anesthesiology	Minimum of 2 weeks
TOTAL	

E.7. Residents are not allowed to do moonlighting jobs in whatever means while in training.

VII. SUPERVISION OF RESIDENTS

All patient care must be adequately supervised by qualified faculty. Supervision can be direct or in any form of telecommunication services. All residents must be supervised by a more qualified or senior medical doctor at all times in the emergency department. Their level of supervision must be commensurate to their level of training. A consultant mentor should be designated for every resident to monitor their clinical performance and general welfare.

Other specialty services can supervise EM residents provided they are the qualified faculty in their fields. The exact number of hours a faculty or consultant will render to supervise a resident will be set upon by the core faculty members and director.

VIII. EVALUATION

An effective and timely evaluation of the residents, faculty, services, and the program itself should be in place to achieve goals and to effect change as needed.

A. Resident Evaluation

1. These evaluations must objectively assess residents' achievement of core competencies which include competence in patient care, medical knowledge, practice-based learning and improvement, interpersonal and communicational skills, professionalism, and system-based practice. Assessment tools should be regular and communicated back to the residents. These may be in the form of semi-annual examinations at least, whether written or oral; faculty, peer, and other professional staff feedback evaluation.

2. Residents must have a formal evaluation of competency, medical knowledge, procedural skills, and interpersonal skills annually. They should satisfactorily achieve set goals and pass set marks in order to progress to the next year of training. Thereafter, residents will advance to positions of higher responsibility, clinically and administratively. Ways of remediation must be in place when needed.

3. Final Evaluation

Each resident should have a final evaluation provided by the department upon completion of the training program. This evaluation must include a review of the resident's performance, and should verify that the resident has fulfilled all requirements to be able to practice competently and independently; thus becoming eligible to sit for the diplomate specialty exam given by the PBEM. The final evaluation must be a permanent part of the resident's record in the department and should be accessible anytime to the resident and other authorized personnel.

B. FACULTY EVALUATION

An annual evaluation of the faculty reviewing their teaching abilities, commitment to the training program, clinical knowledge, administrative skills, and participation in the educational experience is required for continuous accreditation of the program by the PBEM.

Each faculty must have a formal evaluation from the director and residents kept in the department's records for posterity.

An unfavorable evaluation of a faculty will merit a written confidential report or evaluation from the PBEM to maintain check and balance, but no sanctions may be given to private institutions.

C. PROGRAM EVALUATION

The effectiveness of a program must be evaluated at least annually by qualified medical staff which should include the program director and one other faculty and/ or senior resident. Objective tools of measuring whether goals and objectives are achieved should be used to effect any changes or improvements needed.

The following must be considered during the process of evaluation:

- Provision of patient care
- Written comments and feedbacks from the medical personnel of the department
- Residents' performance evaluation and
- Outcome of graduates in the certification board exam.

A plan of action should be prepared if the results are unsatisfactory and deficient.

In cases when a 50% of a training program’s graduates (barring re-takers) fail the Board Exam in a year, the accreditation team will take the following measures:

For the initial year: Warning or reprimand letter

For the second year: Program will be given a Probation status and will be re-evaluated

For the third year: Suspension of accreditation

IX. OTHERS

Notice of Changes in the Program

The program director is responsible to notify the PBEM within 30 days, in writing, of any major changes in the program that may significantly affect the training experience of the residents. These may include, but are not limited to, the following:

- changes in the leadership or key positions in the department
- changes in the curriculum
- changes in the administrative hierarchy in the department or the institution
- failure to meet the required faculty to resident ratio
- a drop in the number of residents undergoing training for 2 consecutive years

Failure to notify the PBEM can be used as a ground for revocation of accreditation.

X. EXAMINATIONS

A. In-Service Exams

1. Written
2. To be taken by ALL residents in PBEM-accredited emergency medicine training programs
3. Conducted every July
4. Serves to:
   a. Standardize the quality of residency training programs
   b. Assess the performance and knowledge of the examinee in relation to his peers and in general
5. A resident's average for all three exams must make the 70% (adjustable) mark in order to be able to take the Board Exam.
   A resident may take and need only to pass a 4th exam if he does not make the average passing mark. If still unsuccessful, he may take it again an unlimited number of times annually till he passes, to qualify for the Board Exam.
   If he decides to take the exam after a lag of 2 or more years, he must submit a certificate attesting to continued clinical practice for the time interval.

B. Board Exams: Written Qualifying

1. To be taken by graduates of PBEM-accredited emergency medicine training programs desiring to become Diplomates of the PBEM.
2. Scheduled every (first) Saturday of March, barring Holy Week.
3. Requirements:
   - Must have completed a 3-year residency in emergency medicine in an accredited training program
   - Complied with the requirements for research
   - Acquired the necessary skills and has performed the obligatory procedures as attested to in the resident's logbook
   - Fulfilled all other requirements stipulated by the host hospital

This shall be validated by the presentation of pertinent documents and upon the written recommendation of his training officer.

4. PBEM Chairperson will assign topics to each of the examiners and training officers of accredited hospitals, who, in turn shall submit 10 questions in multiple choice format.
5. Composed of 200 items with the passing mark being 70%.

C. Board Exams: Practical

1. Ideally conducted in training hospitals with actual patients/cases.
2. In cases where there are no actual patients, actual tracings, radiographs, pictures and the like may be used.
3. Consists of X# of stations, with each candidate given Y# of minutes to analyze the given questions before moving to the next one.
4. Will be conducted the same day (afternoon) as the Written Exam, on the 1st Saturday (or 2nd Saturday, if examinees are plenty) of March, barring Holy Week.
5. Passing mark is 70% (adjustable).

D. Board Exams: Oral

1. To be eligible to proceed with the oral exam, candidates must pass both the written and practical exams.
2. Exams are scheduled the remaining Saturdays of March, barring Holy Week, by lots drawn by members of the board.
   Examinees who fared lower will be scheduled earlier.
3. Panel will consist of all seven (7) members, unless takers number more than 20. In which case, the panel will be divided in two, to facilitate ease and to distribute load.
4. Respective Training Officers are expected to refrain from asking questions during the exam but their inputs and grading will be counted.
5. Grading will utilize the Oral Exam Guidelines for Examiners.
6. Should an examinee fail the Oral Part of the Board Exam, he will be given an incomplete grade. He may re-take the Oral Exam again the following year, infinitely, annually, till he passes, at no extra cost.

FEES:

Accreditation Fee (paid by training hospital)----------P6000 for 3 years
In-Service Exam(paid by training hospital department)--------P500 per examinee
Board Exam (paid by applicant)----------P1500

PHILIPPINE BOARD OF EMERGENCY MEDICINE

TERMINAL COMPETENCIES FOR RESIDENTS

Objectives	Required Terminal competencies/ Processes utilized	Evaluation Tools	Passing Level/ Required Minimum Number of Cases
Clinical procedures and skills	**1. Airway management skills** i. Open and maintain airway in emergency setting (insertion of OPA and NPA) ii. Endotracheal Intubation iii. Alternative airway techniques in Emergency setting e.g. LMA Nasotracheal Intubation Cricothyrotomy iv. Difficult airway management v. Rapid sequence intubation **2. Breathing and Ventilation Skills** i. Assessment of breathing and ventilation ii. Oxygen supplemental therapy iii. Bag-valve ventilation iv. Interpretation of blood gas analysis v. Thoracentesis vi. Needle Decompression and Chest Tube insertion connected to under-water drainage and assessment of function vii. Non-invasive ventilation techniques viii. Invasive ventilation techniques **3. Circulatory Support and Cardiac Skills/Procedures** i. Administration of fluids , including blood products and substitutes ii. Defibrillation and pacing, Including cardioversion iii. Emergency pericardiocentesis iv. Central vascular access a. Femoral b. Jugular c. Subclavian d. Umbilical e. Intraosseous f. Arterial v. Peripheral vascular access/ cutdown **4. Command of Resuscitation (BLS, ACLS)** i. Institution of CPR procedures in a timely and effective manner according to current ILCOR	1. Procedure or Case Logs	1. i. 5 ii. 30 iii. 1 iv. 1 v. 5 2. i-iv. 10 v. 2 vi. 3 vii. 1 viii. 1 3. i. 5 ii. 5 iii. 1 iv. a. 2 b. 2 c. 2 d. 2 e. 10 f. 1 v. 10 4. i. 30

	guidelines ii. Proper Advanced Cardiac Life Support skills a. Adult b. Pediatric **5. Diagnostic Procedures and Skills** i. Interpretation of ECG ii. Appropriate request and interpretation of laboratory investigations iii. Appropriate request and interpretation of diagnostic imaging (e.g. x-rays, ultrasound, CT/MRI) iv. Performance of Focused Sonographic Assessment (e.g. FAST) **6. Analgesia and Sedation skills** i. Provide procedural sedation and analgesia including conscious sedation ii. Use of appropriate local and topical anesthesia and regional nerve blocks **7. Gastrointestinal Procedures** i. Gastric Lavage ii. Peritoneal Lavage iii. Abdominal Paracentesis **8. Genito-urinary Procedures** i. Insertion of indwelling urethral catheter ii. Suprapubic cystostomy **9. Head and Neck** i. Control of Epistaxis a. Anterior nasal packing b. Posterior packing/ balloon placement ii. Control of bleeding gums/teeth iii. Removal of foreign body a. Ear b. Nose c. Pharynx iv. Reduction of temporo-mandibular joint dysfunction 10. **Neurological Skills and Procedures** i. Lumbar Puncture ii. Fundoscopy iii. Interpretation of neuro-imaging 11. **Obstetrical and Gynecological Skills and Procedures**		ii. 30 5. i. - iii. 10 iv. 5 6. 30 7. i. 10 ii. –iii. 2 8. i. 30 ii. 2 9. i. a. 5 b. 5 ii. 5 iii. a – c 10 iv. 2 10. i. 1 ii. 5 iii. 10

	i. Emergency vaginal delivery ii. Vaginal examination using a speculum **12. Ophthalmology Skills & Procedures** i. Irrigation of eyes as management of chemical burns/foreign body ii. Slit-lamp examination **13. Orthopedic Techniques and Skills** i. Immobilization of fractures/dislocations ii. Manipulation and closed reduction of joint dislocations a. Shoulder b. Elbow c. Skin traction of femur iii. Splinting (e.g. plasters, braces, slings, tapes, and other bandages) iv. Log roll and spine immobilization v. Management of compartment syndrome vi. Fasciotomy, escharotomy vii. Completion of phalangeal amputation viii. Removal of (finger) rings **14. Trauma Procedures and Wound Management** i. Wound irrigation and wound closure with aseptic technique ii. Abscess incision and drainage iii. Treatment of laceration and soft tissue injuries iv. Debridement and dressing of burns **15. Transportation of the Critically-Ill Patient** i. Specific aspects of monitoring treatment during transportation ii. Preparation of EMS vehicle **16. Universal Infection Precautions** **17. Surgical** i. Manual reduction of inguinal hernias ii. Ungiectomy iii. Removal of foreign bodies (e.g. fish hook, embedded needles, fingernail splinters)		11. i. 5 ii. 3 12. i. 5 ii. 5 13. i. 10 ii. a. 5 b. 5 c. 5 iii. 5 iv. 5 v. 3 vi. 1 vii. 1 viii. 3 14. i. 20 ii. 10 iii. 20 iv. 10 15. i. 3 ii. 3 16. 20 17. i. 5 ii. 3 iii. 5

OBJECTIVES	REQUIRED TERMINAL COMPETENCIES/ PROCESSES UTILIZED	EVALUATION TOOLS	PASSING LEVEL/ REQUIRED MINIMUM NUMBER OF CASES
Clinical Procedures and Administrative/ Managerial Skills	1. Managerial and Administrative Skills i. Improve on the managerial skills as the leader of the ER medical team. ii. To assist the DEM consultant staff in the administrative management of the Year Level 1 and 2 residents. iii. Teach and appropriately supervise medical students and junior residents. iv. Acts as leader in spearheading department-sponsored activities. v. Demonstrate mastery of all other core procedures. 1. Demonstrate an understanding of the role of the Emergency Department in the larger context of health care delivery. i. Plan and participate in mass casualty disaster drill and management ii. Demonstrate an understanding of the core curriculum.	1. Procedure or case logs 2. Performance evaluation rating	1. Passing mark as assessed by consultant examiner. 2. Passing level: 70%