UNMC Critical Care Medicine White
Rotation Goals and Objectives
Pulmonary/Critical Care Medicine Fellowship Program
University of Nebraska Medical Center
Revised: February 2012

Rotation Goals
To manage the scope of critical care patients in a Medical-Surgical Intensive Care Unit
To become an effective Intensivist

I) Education Objectives

A) Patient Care
1) Fellows must be able to provide patient care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health.
   (a) Fellows must demonstrate competence in the practice of health promotion, disease prevention, diagnosis, care, and treatment of patients of each gender, from adolescence to old age, during health and all stages of illness;
      (i) Demonstrate caring and respectful behaviors when interacting with patients
      (ii) Gather essential and accurate information to evaluate patients with a variety of critical illnesses
         a. Obtain a comprehensive and accurate history of present illness for a variety of presentations of critical illness.
         b. In a comatose patient, the fellow should demonstrate the resourcefulness to utilize a number of information sources including patient’s family, friends and other health care providers.
         c. Identify historical facts that suggest an immediate threat to survival and be able to prioritize those needing immediate attention
         d. Demonstrate physical examination skills appropriate to the presentation
      (iii) Counsel and educate patients and their families
      (iv) Use information technology to support patient care decisions and patient education
      (v) Demonstrate an ability to work with a variety of health care professionals to provide patient-focused care
      (vi) Demonstrate effective communication through the informed consent process for minor procedures
2) Fellows must demonstrate competence in the prevention, evaluation and management of:
   (a) acute lung injury, including radiation, inhalation, and trauma;
   (b) acute metabolic disturbances, including over dosages and intoxication syndromes;
   (c) anaphylaxis and acute allergic reactions in the critical care unit;
   (d) cardiovascular diseases in the critical care unit;
   (e) circulatory failure;
   (f) detection and prevention of iatrogenic and nosocomial problems in critical care medicine;
   (g) diffuse interstitial lung disease;
   (h) disorders of the pleura and the mediastinum;
   (i) end of life issues and palliative care;
(j) hypertensive emergencies;
(k) iatrogenic respiratory diseases, including drug-induced disease;
(l) immunosuppressed conditions in the critical care unit;
(m) metabolic, nutritional and endocrine effects in critical illness,
(n) hematologic and coagulation disorders associated with critical illness;
(o) multi-organ system failure;
(p) obstructive lung diseases, including asthma, bronchitis, emphysema, and bronchiectasis;
(q) occupational and environmental lung diseases;
(r) perioperative critically-ill patients, including hemodynamic and ventilatory support;
(s) psychosocial and emotional effects of critical illness on patients and their families;
(t) pulmonary embolism and pulmonary embolic disease;
(u) pulmonary manifestations of systemic diseases, including collagen vascular disease and diseases that are primary in other organs;
(v) pulmonary vascular disease, including primary and secondary pulmonary hypertension and the vasculitis and pulmonary hemorrhage syndromes;
(w) renal disorders in the critical care unit, including electrolyte and acid-base disturbance and acute renal failure;
(x) respiratory failure, including the acute respiratory distress syndrome, acute and chronic respiratory failure in obstructive lung diseases, and neuromuscular respiratory drive disorders;
(y) sepsis and sepsis syndrome;
(z) severe organ dysfunction resulting in critical illness to include disorders of the gastrointestinal, neurologic, endocrine,
(aa) hematologic, musculoskeletal, and immune systems as well as infections and malignancies;
(bb) shock syndromes;
(cc) Sleep-disordered breathing; and,
(dd) the use of paralytic agents and sedative and analgesic drugs in the critical care unit.

3) Fellows must demonstrate competence in interpreting data derived from various bedside devices commonly employed to monitor patients, and data from laboratory studies related to sputum, bronchopulmonary secretions, pleural fluid;

4) Fellows must demonstrate competence in:
(a) airway management;
   (i) Establishment of airway
   (ii) Maintenance of an open airway in a non-intubated, unconscious patient
   (iii) Ventilation by bag and mask
   (iv) Oral and/or nasotracheal intubation
(b) the use of a variety of positive pressure ventilatory modes, including:
   (i) initiation and maintenance of ventilatory support;
   (ii) respiratory care techniques; and
   (iii) withdrawal of mechanical ventilatory support
(c) the use of reservoir masks and continuous positive airway pressure masks for delivery of supplemental oxygen, humidifiers, nebulizers, and incentive spirometry;
(d) flexible fiber-optic bronchoscopy procedures, including those where endobronchial and transbronchial biopsies, and transbronchial needle
aspiration are performed (each fellow must perform a minimum of 100 such procedures);
(e) diagnostic and therapeutic procedures, including paracentesis, lumbar puncture, thoracentesis, endotracheal intubation, and related procedures;
(f) use of chest tubes and drainage systems;
(g) insertion of arterial, central venous, and pulmonary artery balloon flotation catheters;
(h) Calibration, operation and interpretation of data from bedside hemodynamic monitoring systems;
(i) insertion of operation of bedside hemodynamic monitoring systems;
(j) emergency cardioversion;
(k) interpretation of intracranial pressure monitoring and transcranial Doppler data;
(l) nutritional support;
(m) use of ultrasound techniques to perform thoracentesis and place intravascular and intracavitary tubes and catheters; and,
(n) use of transcutaneous pacemakers.

5) Make informed decisions about diagnostic and therapeutic interventions based on patient information and preferences, up-to-date scientific evidence and clinical judgment specifically required for the diagnosis and treatment of critical illness
(a) Interpret an electrocardiogram and other appropriate laboratory tests that demand immediate attention.
(b) Integrate the interpretation of radiographic tests related to pulmonary diseases including chest roentgenograms, computed axial tomography (CT) scans, ventilation/perfusion studies and CT angiograms to provide a therapeutic plan for the patient.

6) Utilize ultrasonography at the bedside to optimize diagnosis and patient safety
(a) Ultrasonography is an adjunct to physical exam and should be used when possible to increase diagnostic acumen
(b) Ultrasonography at the bedside should be used in real time to guide invasive procedures such as placement of central venous catheters, arterial catheters, thoracentesis and paracentesis

7) Develop and carry out patient management plans in association with the supervising physician
(a) Apply the skills listed above to provide or confirm a clear and concise resident admission note and assist the resident in the assessment and in developing a therapeutic plan.

8) Evaluation methods for this competency:
(a) Attending evaluation
(b) Associate ratings from residents, students and ICU nurses
(c) Mini-CEX (to be arranged with attending)

B) Medical Knowledge
1) Demonstrate an investigatory and analytic thinking approach to clinical situations by applying an evidence-based medicine principles
2) Demonstrate a fundamental knowledge of the care of critical care medicine patients
3) Fellows must demonstrate knowledge of established and evolving biomedical, clinical, epidemiological and social behavioral sciences, as well as the application of this knowledge to patient care. Fellows:
(a) must demonstrate knowledge of the scientific method of problem solving, and evidence-based decision making
(b) must demonstrate knowledge of indications, contraindications, limitations, complications, techniques, and interpretation of results of those diagnostic and therapeutic procedures integral to the discipline, including the appropriate indication for and use of screening tests/procedures, and
(c) must demonstrate knowledge in the indications, contraindications and complications of placement of percutaneous tracheostomies
(d) must demonstrate knowledge of:
   (i) imaging techniques commonly employed in the evaluation of patients with pulmonary disease or critical illness, including the use of ultrasound;
   (ii) pericardiocentesis;
   (iii) percutaneous needle biopsies
   (iv) renal replacement therapy;
   (v) pulmonary function tests to assess respiratory mechanics and gas exchange, including spirometry, flow volume studies, lung volumes, diffusing capacity, arterial blood gas analysis, exercise studies, and interpretation of the results of bronchoprovocation testing using methacholine or histamine;
   (vi) pharmacokinetics, pharmacodynamics, and drug metabolism and excretion in critical illness;
   (vii) principles and techniques of administration and management of a MICU;
   (viii) ethical, economic, and legal aspects of critical illness;
   (ix) recognition and management of the critically-ill from disasters, including those caused by chemical and biological agents; and,
   (x) the psychosocial and emotional effects of critical illness on patients and their families.

4) Evaluation methods for this competency
   (a) Attending evaluation
   (b) Chart-stimulated recall sessions

C) Practice-based Learning and Improvement
   1) Fellow must demonstrate the ability to investigate and evaluate their care of patients, to appraise and assimilate scientific evidence, and to continuously improve patient care based on constant self-evaluation and life-long learning
   2) Fellow must demonstrate the ability to investigate and evaluate their care of patients, to appraise and assimilate scientific evidence, and to continuously improve patient care based on constant self-evaluation and life-long learning
   3) Fellows are expected to develop skills and habits to be able to meet the following goals.
      (a) identify strengths, deficiencies, and limits in one's knowledge and expertise;
      (b) Set learning and improvement goals;
      (c) identify and perform appropriate learning activities;
      (d) systematically analyze practice, using quality improvement methods, and implement changes with the goal of practice improvement;
      (e) incorporate formative evaluation feedback into daily practice;
      (f) locate, appraise, and assimilate evidence from scientific studies related to their patients' health problems;
      (g) use information technology to optimize learning;
      (h) participate in the education of patients, families, students, fellows and other health professionals; and,
(i) obtain procedure-specific informed consent by competently educating patients about rationale, technique, and complications of procedures

4) Evaluation methods for this competency
(a) Attending evaluation
(b) Chart stimulated recall session
(c) Performance on presentation at case conference during the month

D) Interpersonal and Communication Skills
1) Create and sustain a therapeutic and ethically sound relationship with patients
2) Demonstrate effective listening skills
3) Elicit and provide information using effective nonverbal, explanatory, questioning and writing skills
4) Fellows must demonstrate interpersonal and communication skills that result in the effective exchange of information and collaboration with patients, their families, and health professionals.
5) Fellows are expected to:
(a) communicate effectively with patients, families, and the public, as appropriate, across a broad range of socioeconomic and cultural backgrounds;
(b) communicate effectively with physicians, other health professionals, and health related agencies;
(c) work effectively as a member or leader of a health care team or other professional group;
(d) act in a consultative role to other physicians and health professionals; and,
(e) maintain comprehensive, timely, and legible medical records, if applicable.

6) Evaluation methods for this competency
(a) Attending evaluation
(b) Evaluations from ICU nurses, non physician providers and members of the multidisciplinary team
(c) Mini-CEX

E) Professionalism
1) Fellows must demonstrate a commitment to carrying out professional responsibilities and an adherence to ethical principles
2) Fellows are expected to:
(a) compassion, integrity, and respect for others;
(b) responsiveness to patient needs that supersedes self-interest;
(c) respect for patient privacy and autonomy;
(d) accountability to patients, society and the profession;
(e) sensitivity and responsiveness to a diverse patient population, including but not limited to diversity in gender, age, culture, race, religion, disabilities, and sexual orientation;
(f) high standards of ethical behavior, including maintaining appropriate professional boundaries and relationships with other physicians and other health care team members, and avoiding conflicts of interest; and,
(g) a commitment to lifelong learning, and an attitude of caring derived from humanistic and professional values.
3) Demonstrate a commitment to ethical principles pertaining to provision or withholding of clinical care, confidentiality of patient information, informed consent and business practices
4) Evaluation methods for this competency
F) Systems-based Practice

1) Fellows must demonstrate an awareness of and responsiveness to the larger context and system of health care, as well as the ability to call effectively on other resources in the system to provide optimal health care.

2) Understand how their patient care and other professional practices affect other health care professionals, the health care organization, and the larger society.

3) Advocate for quality patient care and assist patients in dealing with system complexities.

4) Fellows are expected to:
   - (a) work effectively in various health care delivery settings and systems relevant to their clinical specialty;
   - (b) coordinate patient care within the health care system relevant to their clinical specialty;
   - (c) incorporate considerations of cost awareness and risk-benefit analysis in patient and/or population based care as appropriate;
   - (d) advocate for quality patient care and optimal patient care systems;
   - (e) participate in identifying system errors and implementing potential systems solutions;
   - (f) acquire the skills to organize, administer, and direct a critical care unit; and,
   - (g) acquire the skills to organize, administer and direct a respiratory therapy section.

5) Evaluation methods for this competency
   - (a) Attending evaluation
   - (b) Evaluations from ICU nurses, non physician providers and members of the multidisciplinary team

II) Teaching Methods

A) Clinical experience

1) Evaluate and manage all patients assigned to CCM Red in the ICU
   - (a) The CCM Red team will take care of all patients admitted to the Nebraska Medical Center Adult Intensive Care Units during the days they are on-call and any patients transferred to their care. In addition, The CCM Red team will care for all Cardiovascular Surgery, Cardiology and Vascular Surgery patients admitted to the ICU. The CCM White team will care for all patients admitted to the ICU during the days they are on-call and any patients transferred to their care. The CCM White team will care for all Neurosurgery and Neurology patients admitted to the ICU. The resident on-call will see all admissions after normal duty hours and review these with the fellow on call. The fellow on call will be responsible for checking out the patient in the morning to the fellow on the receiving service, CCM Red or CCM White.

2) Write or confirm a daily progress note on all critical care patients on the CCM service.

3) Perform those ICU procedures expected of an intensivist, e.g.; chest tube placement, central line and arterial line placement, and intubation for mechanical ventilation.
(a) All invasive procedures require documentation in the medical record of procedural preparations including the consent process, confirmation that appropriate preparations have been made (including a Time Out), findings and complications.

(b) Perform all bronchoscopic procedures on patients on the CCM service.

B) Clinical Teaching
1) Supervise presentation of clinical findings to the CCM attending daily on rounds
2) Review ICU patient management daily

C) Performance Feedback
1) Fellow and CCM attending physician will review these goals and objectives at the beginning of the rotation
2) CCM attending physician will provide ad hoc feedback on a regular basis
3) Fellow and CCM attending physician will meet and provide written and verbal feedback at the completion of the rotation.

D) Didactic Sessions
1) Attend all daily noon conferences of the PCCM fellowship program.
2) The fellow will provide at least one didactic session to students and residents on the service covering a critical care medicine topic.

E) Self-Learning
1) The fellow is expected to read the primary literature to gather evidence in regards to current CCM problems
2) The fellow is expected to complete any readings assigned by the CCM attending physician
   (a) Read the appropriate material from a Critical Care Medicine source covering airway management, central line placement, hemodynamic monitoring and sedation and paralysis.

III) Responsibilities
A) Fellow
1) First Year
   (a) The first year fellows are responsible for taking call on this service throughout the year according to the call schedule
   (b) Responsibilities include all on-call responsibilities for the service including supervision of the resident on-call.
   (c) Obtain informed consent for all fellow-level procedures, eg bronchoscopy, chest tube thoracostomy, etc. and arrange for any ancillary support for the procedure.
      (i) All fellow-level procedures require direct supervision by faculty

2) Second Year
   (a) Each second year fellow will be scheduled on this rotation once during the first three months of their second year.
   (b) The second year fellows are responsible for taking call on this service throughout the year according to the call schedule
   (c) Responsibilities include all on-call responsibilities for the service including supervision of the resident on-call.
   (d) Performance should reflect completion of the first year of fellowship
Competencies listed for first year fellows should be solid.

3) Third Year

(a) The third year fellow has greater ICU experience and is therefore expected to take on greater responsibility commensurate with that experience.

(i) The third year fellow should demonstrate leadership of the multidisciplinary ICU team, taking the initiative in solving system problems and anticipating necessary interventions to expedite patient care.

(ii) The third year fellow should take on a greater role in directing work rounds and contributing to teaching rounds with the attending.

(b) Supervise the evaluation and management including mechanical ventilation of each patient on the CCM service daily and confirm appropriate documentation.

(i) Review daily all the primary findings for each new admission such as the physical exam, laboratory, consultations and x-ray studies with the Residents and/or Students. This process should be completed prior to Attending rounds. As the designee of the CCM Attending, the fellow will be expected to initiate discussion and decisions regarding patient care during this time, with emphasis on new or unstable patients, or those for whom an early decision is required for patient care.

(ii) The fellow is responsible for supervision of care, and emphasis should be placed upon direct supervision when diagnosis, treatment or patient stability is unclear.

(i) Fellows are expected to personally evaluate all new admissions or transfers to their team.

(ii) Ensure that a critical care note is written each day prior to rounds on all patients on the CCM team. Use the pre-formatted progress note designed for this.

(iii) Alert the CCM Attending about any changes in patients who are critically ill, for all deaths and for any potential problems with staff or with interactions with patients and their families.

(iv) Review all of the patients who are on the service with the nurses, and house officers. This can be accomplished by reviewing the daily goal sheet with the nurses and resident responsible for the individual patient.

(v) The fellow should have in depth knowledge regarding the daily assessment and plan for each patient and should discuss these plans with the patients’ nurse, resident and student prior to Attending rounds. The third year fellow should be able to anticipate what the Attending would do and is expected to formulate a reasonable plan and review it with the Attending if necessary prior to implementation.

(vi) The fellow must expedite intervention if necessary and help the residents and students think through the reasoning behind the plan.

(vii) Assure continuity of care during resident absences. This will include resident obligations such as clinic, in-service exams or illness. When necessary the fellow must assume or reassign the responsibility for the care of the resident’s patients in consultation with the attending.

(viii) Facilitate CCM Attending Rounds. The fellow should work with the Attending to provide high quality teaching in a small group format. The fellow will organize, facilitate and co-direct the presentation and
discussion of patients with the CCM Attending. The format for these rounds may vary, depending upon the team size, number and type of patients, and experience of the fellow and CCM Attending.

(ix) Communicate with patients and families about diagnoses and prognoses on an ongoing basis.

(x) Alert the attending physician about patients who qualify for ongoing research protocols and participate in ongoing trials when possible.

(c) Demonstrate competency in all medical and invasive procedures performed on this rotation

(d) Be available when on-call, within five minutes, to respond to ICU staff (residents, nurses and/or respiratory care practitioners) regarding care for CCM patients

(i) Fellows will take at home call according to the schedule.

(ii) The fellow will not be required to come in for all admissions, however, they must be called by the resident about all new admissions and on any unstable patients and will have to decide whether they need to come in based on the stability of the patient and the experience of the resident on call for the ICU.

(iii) The only exceptions to these availability rules are illness, outpatient clinic obligations, or other arrangements previously made with the CCM Attending

(e) Attend Multidisciplinary Rounds each weekday in AICU and in 800/850 or arrange an appropriate proxy

(f) Supervise all resident procedures done on the CCM service

(i) Perform or directly supervise all invasive procedures and make sure that a time out is taken and documented. These include but are not limited to intubation, arterial line placement, central line catheter placement, chest tube placement and pulmonary artery catheter placement. If for some reason the fellow is not able to perform these duties, they must alert the Attending so that the Attending can come to supervise or arrange a surrogate. All bronchoscopies, chest tube placements and pulmonary artery catheter placements must be performed with the faculty in attendance at the bedside. The fellow must dictate a note for all procedures they perform. When a pulmonary artery catheter is placed, the fellow is responsible for dictating a procedure note that includes all pertinent pulmonary artery catheter data from the procedure. All notes and forms must be timed and dated. The fellow needs to document all procedures performed or supervised in their procedure log on New Innovations.

(g) Obtain informed consent for all fellow-level procedures, eg bronchoscopy, chest tube thoracostomy, etc. and arrange for any ancillary support for the procedure.

(i) Percutaneous tracheostomies must be scheduled with the pulmonary function staff and a PCCM attending who has privileges in the procedure. As a courtesy, the ENT resident should be notified about the procedure at least 24 hours prior. The fellow should ensure that all necessary supplies are available in the patient’s room at the scheduled time of the procedure.

(h) Provide didactic session(s) to students and residents on the CCM service

(i) Give 1 lecture for the monthly residents’ Critical Care lecture series.

(ii) Schedule one didactic session for students only, once per week. Inform the attending when this meeting is to be held.
Attend all Pulmonary and Critical Care Fellowship conferences.

All efforts must be made to attend these educational conferences. With the exception of a true medical emergency, rounds should be orchestrated to allow for conference attendance. The fellow will be dismissed from Attending rounds at 11:45am.

The fellow is responsible for patient movement onto and off of the service.

The fellow on-call should receive all requests for transfer to the CCM team

- The fellow may not refuse transfers to the team; if the fellow has questions about appropriateness of or stability for transfer the attending physician should be called to discuss this with the referring physician

- The fellow should assign patients to the residents to maintain intra-team balance and to triage specific service patients to the appropriate CCM team

The fellow is responsible for making sure that an appropriate handoff is made for patients transferring off of the service

- The fellow is responsible for knowing which patients are priority transfers if an ICU bed is needed in times of high census

- The fellow must confirm that the resident caring for a patient transferring off of the service has called the receiving team and provided an adequate checkout
  a. The fellow will need to make the checkout call if the resident needs to leave due to work hour limitations; this responsibility cannot be delegated to another resident.
  b. If there is a priority transfer after regular duty hours, the fellow on-call must be notified by the resident on-call.

Conduct check-out rounds with the fellow and resident on-call each weekday and report off to the CCM attending physician

Complete an evaluation of the CCM attending physician and one of the rotation

B) Critical Care Medicine Attending

1) Review these goals and objectives with the fellow at the start of the rotation along with any other expectations

2) Provide direct or indirect supervision as appropriate for procedures performed by the fellow

3) Provide instruction in the evaluation and management of CCM patients

4) Be available to cover for the fellow when he/she is unavailable to supervise the residents on the service.

5) The attending should be available for indirect supervision within 30 minutes of notification and should be able to come to the bedside for direct supervision or arrange coverage for that supervision within a reasonable time if requested by the fellow or if the acuity of the patient’s illness requires their presence.

6) Each new admission to the service should be seen by the attending within 24 hours and preferably within 16 hours of admission.

7) Complete a written evaluation and provide verbal feedback at the completion of the rotation

C) Service

1) On Call Responsibility
(a) Be available, in house, from 8:00 am to 5:00 PM except for officially sanctioned events
   (i) It is recommended that the fellow arrive in the ICU earlier than that to evaluate the patients and attend to problems.
   (ii) For unstable or decompensating patients it is imperative that the resident, fellow and attending be readily available to come to the bedside so that the highest quality of care can be delivered.

(b) Take after hours call as assigned by the Program Director. Call may be altered by mutual agreement with the CCM attending physician

(c) The On-Call fellow will receive a check-out report on each patient on the service from the fellow going off-call and will give an updated check-out report to the fellow coming on-call the following morning.

(d) Fellows covering the weekends will be expected to see all new consults that will require urgent intervention, even if initially seen and evaluated by the resident.

(e) New patients to the service that are seen after-hours should be seen promptly by the resident who will, after making a quick assessment, call the fellow.
   (i) The CCM resident will see all new admissions and consults to the service and call the fellow
   (ii) New admissions or urgent consults to the Pulmonary Consult service after hours will be seen by the resident on call or will need to be seen by the fellow if there is no resident on-call

(f) Supervise the evaluation and management including mechanical ventilation of each patient admitted to the CCM service.
   (i) The fellow is responsible for supervision of care, and emphasis should be placed upon direct supervision when diagnosis, treatment or patient stability is unclear.
   (ii) Alert the CCM Attending about any changes in patients who are critically ill, for all deaths and for any potential problems with staff or with interactions with patients and their families.
   (iii) The fellow must expedite intervention if necessary and help the residents and students think through the reasoning behind the plan.
   (iv) Communicate with patients and families about diagnoses and prognoses on an ongoing basis.

(g) Be available when on-call, within five minutes, to respond to ICU staff (residents, nurses and/or respiratory care practitioners) regarding care for CCM patients
   (i) Fellows will take at home call according to the schedule.
   (ii) The fellow will not be required to come in for all admissions, however, they must be called by the resident about all new admissions and on any unstable patients and will have to decide whether they need to come in based on the stability of the patient and the experience of the resident on call for the ICU.
   (iii) If there is a disagreement regarding patient care, between the resident on-call and the fellow on-call, the fellow must assess the patient personally and inform the attending on-call. The attending may be required to assess the patient personally to arbitrate the disagreement.
(iv) The only exceptions to these availability rules are illness, outpatient clinic obligations, or other arrangements previously made with the CCM Attending.

(h) The fellow is responsible for patient movement onto and off of the service.
   (i) The fellow on-call should receive all requests for transfer to the CCM team.
      (i) The fellow may not refuse transfers to the team; if the fellow has questions about appropriateness of or stability for transfer the attending physician should be called to discuss this with the referring physician.
      (ii) The fellow should assign patients to the residents to maintain intra-team balance and to triage specific service patients to the appropriate CCM team.
   (ii) The fellow is responsible for making sure that an appropriate handoff is made for patients transferring off of the service.
      (i) The fellow is responsible for knowing which patients are priority transfers if an ICU bed is needed in times of high census.
      (ii) The fellow must confirm that the resident caring for a patient transferring off of the service has called the receiving team and provided an adequate checkout.
         a. The fellow will need to make the checkout call if the resident needs to leave due to work hour limitations; this responsibility cannot be delegated to another resident.
         b. If there is a priority transfer after regular duty hours, the fellow on-call must be notified by the resident on-call.

2) Vacation
   (a) No extended vacation time may be taken during this rotation. The fellow may request up to 4 days off but must arrange coverage. This coverage will require approval by the CCM attending, the supervisor of the fellow providing the coverage and the Program Director.
   (b) Emergency leave may be requested after discussion with the Program Director or surrogate (CCM attending physician).

IV) Method of Evaluation

A) Formative

1) The Critical Care Medicine Attending should give feedback throughout the rotation and a formal verbal evaluation should be given at the mid-point and at the end of the rotation.
2) The CCM attending physician must prepare a written evaluation of the fellow at the conclusion of the attending’s rotation.
   (a) This evaluation will assess the six general competencies as outlined by the ACGME and on the form provided.
   (b) The fellow should review the assessment personally. This is best done in the presence of the CCM attending physician.
3) At the conclusion of the fellow’s service period, he/she should complete an evaluation form assessing the quality of the rotation.
4) The Fellow should complete evaluation(s) of the teaching undertaken by the attending physician(s).
V) Readings
   A) Readings are from the ATS Reading List found at:
      (a) http://www.thoracic.org/sections/career-development/fellows-and-
          fellowships/ats-reading-list-intro.html