

# DEPARTMENT OF MEDICINE

## Internal Medicine Residency Housestaff Manual

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Medical College  
of Georgia

ACADEMIC YEAR 2015-2016

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## **INTRODUCTION**

### **MISSION**

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To provide the highest quality of education and training for physicians in the field of Internal Medicine through the emphasis of the Core Competencies as described by the Accreditation Council for Graduate Medical Education (ACGME): Patient Care, Medical Knowledge, Professionalism, Systems - Based Practice, Practice - Based Learning and Improvement, and Interpersonal and Communication skills.

### **EDUCATIONAL GOALS**

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By the completion of training, a graduate of this program will have all requisite competencies of a general internist, and will be able to provide outstanding care for his or her patients over the next 40-50 years. Key to this is to develop in the graduate self-sustaining and disciplined skills, attitudes, and behaviors to acquire and use new knowledge under whatever form of medical care is practiced. Internists and subspecialists will be problem solvers, change agents, and seekers of improved health for patients, populations, and nations. By its nature, internal medicine is both broad and deep in focus, and includes biophysical aspects of normal and abnormal human physiology from the molecular to multi-organ systems. It is no less concerned with psychosocial, economic, ethical and humanistic/spiritual aspects of the health and function of the individual patient from the asymptomatic adolescent to the end-of-life issues of the dying patient. It is the intent of this program to produce excellent internists and future subspecialists practicing with such breadth and depth of competency to be recognized by their peers and patients as truly excellent in the 6 Core Competencies of Practice, as outlined by the ACGME.

### **PATIENT CARE**

Residents are expected to provide patient care that is compassionate, appropriate and effective for the promotion of health, prevention of illness, treatment of disease and palliation of symptoms. Patient care competency consists of appropriate and high quality diagnosis (history, physical examination, lab/radiology, procedures), therapy (pharmacology, procedures, patient education, discharge planning, followup), prognosis, and documentation (quality of clinical notes).

### **MEDICAL KNOWLEDGE**

Residents are expected to demonstrate knowledge of established and evolving biomedical, clinical, and psychosocial sciences, and demonstrate the application of their knowledge to the provision of patient care and to the education of others.

## **PRACTICE BASED LEARNING/IMPROVEMENT**

Residents are expected to constantly evaluate their own performance, incorporate feedback and external evaluation into their behavior to effect self-improvement, use appropriate knowledge and outcome-information sources to manage their patients, track improvements inefficiency and cost of care, and maximize quality of life of patients.

## **INTERPERSONAL AND COMMUNICATION SKILLS**

Residents are expected to establish a highly effective and personalized therapeutic relationship with patients and families through developing and maintaining excellent listening, narrative, and nonverbal skill. They are expected to provide patients and families culturally and personally appropriate counseling and education; and to educate colleagues and the public effectively on health and disease related matters.

## **PROFESSIONALISM**

Residents are expected to demonstrate values that are exemplary of altruism, accountability, excellence, duty, honor, integrity, and respect for others. They are expected to be fully honest, accept responsibility, acknowledge failures, and seek continual improvement for the betterment of patients and colleagues.

## **SYSTEMS-BASED LEARNING**

Residents are expected to demonstrate an understanding of the contexts and systems in which health care is provided, and demonstrate the ability to apply this knowledge to improve and optimize health care.

## **MEDICINE QUALITY AIM**

At the same time, residents are expected to demonstrate attitudes, skills, and behaviors consistent with the following Institute of Medicine Quality Aims:

- **Safety:** Avoiding injuries to patients from the care that is intended to help them.
- **Timely:** Reducing waits and potentially harmful delays for both those who receive and who give care.

- **Effective:** Providing services based on scientific knowledge to all who could benefit and refraining from providing services to those not likely to benefit (avoiding underuse and overuse, respectively)
- **Efficient:** Avoiding waste, including waste of equipment, supplies, ideas and energy
- **Equitable:** Providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location and socio-economic status.
- **Patient centered:** Providing care that is respectful of and responsive to individual patient preferences, needs and values and ensuring that patient values guide all clinical decisions.

Every clinical rotation will incorporate the 6 competencies and 6 IOM Quality Aims contextually for the specific patients seen on that rotation. Residents are evaluated on their learning and subsequent performance of the attitudes, skills, and behaviors comprising these general competencies as specifically seen on the rotations conducted.

## RESPONSIBILITY

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The responsibility for the attainment of the mission, goals, and objectives of this program belongs solely to the Program Director. He/she is assisted by Associate Program Directors, who are designated Key Faculty Members of this Program, working through the Clinical Competency Committee.

The Program Director delegates to the faculty responsibilities and activities of education and mentorship for the daily implementation of this program and holds them responsible for their performance through feedback, recommendations and counsel to the Chairman, Department of Medicine.

## METHODS USED TO ACHIEVE PROGRAM MISSION, GOALS, AND OBJECTIVES

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In all the methods used and enumerated below, feedback by program directors and faculty is critical to development and growth of the resident. Just as important is resident self-awareness and self-improvement. Both are absolutely fundamental to the development of life-long habits of excellence in patient care, leadership, and scholarship. Self-awareness and feedback are continuous, spontaneous, and pertinent to the behavior and outcomes observed. Faculty will be encouraged by the program directors to be outstanding role models for residents.



# EDUCATION

## GENERAL INPATIENT ROTATIONS

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Rotation: **General Inpatient Services (GRU and VA)**

### EDUCATIONAL PURPOSE

To provide supervised patient care and educational opportunities to develop the following competencies of internal medicine: humanistic practice, professionalism, medical ethics, lifelong learning, clinical method, continuity of care, medical interview, physical diagnosis, clinical pharmacology, nutrition, palliative care, and discharge planning. The resident by the end of the rotation should have improved and advanced his level of competency in the principles of management of the most common medical conditions necessitating hospitalization on general medical wards. The goals and objectives for all the clinical rotations can be found on the website:

<http://www.gru.edu/mcg/residents/internalmed/documents/2014internalmedicinecurriculum1.pdf>

### GOAL

By the end of the rotation, the educational participants will have progressed in their understanding of physiology and execution of clinical management of inpatients seen in this rotation.

**Patient characteristics:** Most patients will be very ill, with near end-stage disease, poor prognosis, and multiple interacting pathologies. They will also have severe psychological, social, economic and spiritual complexities resulting from and contributing to their disease. Most patients and their families will be suffering. They will comprise adults from age 18 upwards, representative of the Augusta population in make-up, from predominantly poor to middle-class socio-economic background, of all races and both genders. Predominant religious preference and cultural background will be southern Black evangelical Christian. Family and social support will range from extensive to absent. Patients will include those transferred from state correctional and domiciliary facilities, as well as nursing homes, intensive care units, and rehabilitation facilities, emergency rooms, clinics, and outside hospitals.

**Types of clinical encounters:** In patient evaluation, management and discharge planning.

**Types of procedures:** Lumbar puncture, bladder catheterization, thoracentesis, paracentesis, joint aspiration, central venous catheter, arterial blood gas, peak flow measurement, PPD skin testing, NG tube, O2 monitoring, cognitive assessment

**Types of services provided:** Acute inpatient care, palliative care, discharge planning

## **ROLE OF THE WARD ATTENDING**

Ward attending will teach students during ward teaching rounds as appropriate to their level, give feedback on knowledge, participation in patient care, and demonstrated qualities of professionalism, communication skill, practice-based learning, and systems-based practice. Teaching attending will review and grade 4 patient write-ups during the rotation, and provide students-only bedside teaching for 2 hours weekly.

1. PGY-1, 2, and 3 residents, along with the ward attending will participate in a facilitated grading session at the end of each MSM-3 student rotation.

## **Evaluations**

Method of evaluation of resident competence and quality of care: Expected standards of competence and quality: Residents are expected to demonstrate attitudes, skills, and behaviors consistent with the competency level appropriate for level of PGY training for the following

- a. ACGME Competencies
  - i. Patient care: physician patient interaction (physical and written) that is compassionate, appropriate and effective for the treatment of health problems and promotion of health, based on standards of evidence in the medical literature.
  - ii. Medical knowledge: understanding and facility about established and evolving biomedical, clinical and cognate sciences (e.g. epidemiological and social-behavioral) and the application of this knowledge to patient care.
  - iii. Practice-based learning and improvement that involves investigation and evaluation of their own patient care, appraisal and assimilation of scientific evidence and improvement in patient care.
  - iv. Interpersonal and communication skills: that result in effective information exchange and teaming with patients, their families and other health professionals

- v. Professionalism, as manifested through a commitment to carrying out professional responsibilities, adherence to ethical principles and sensitivity to a diverse patient population.
- vi. System-based practice, as manifested by actions that demonstrate an awareness of and responsiveness to the large context and system of health care and the ability to effectively call on system resources to provide care that is of optimal value.

b. Institute of Medicine Quality Aims

- i. Safety: Avoiding injuries to patient from the care that is intended to help them.
- ii. Timely: Reducing waits and potentially harmful delays for both those who receive and who give care.
- iii. Effective: Providing services based on scientific knowledge to all who could benefit and refraining from providing services to those not likely to benefit (avoiding underuse and overuse, respectively)
- iv. Efficient: Avoiding waste, including waste of equipment, supplies, ideas and energy
- v. Equitable: Providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location and socio-economic status.
- vi. Patient centered: Providing care that is respectful of and responsive to individual patient preferences, needs and values and ensuring that patient values guides all clinical decisions.

1. Methods of measurement

- a) Other direct observation by more senior residents and attending on work and teaching rounds, management of individual patients, observation of procedures (Patient care, IOM Quality Aims)

- b) Pre and post tests based on assigned readings administered at beginning of month and subsequent month (Medical knowledge) *are we doing this?*
- c) Monitoring and recording of adverse events as determined at morning report and by report of nurses to attending (Patient care, practice based learning, professionalism).
- d) Monitoring of patient complaints to nurses, attendings, hospital. Scores on patient satisfaction surveys (Patient care, PBL, Systems-based practice, IOM Quality Aims)
- e) Prospective monitoring of compliance with specific patient care guidelines such as community acquired pneumonia, acute coronary syndrome, alcohol withdrawal, potassium infusion, and other protocols (Patient care, SMP)
- f) Graded essays and presentations on topics germane to patients seen on rotation, submitted to portfolio as directed by attending (Medical knowledge, PBL).
- g) Attendance at required conferences (Professionalism, PBL).
- h) Work hours report to ensure no more than 80 hours work per week in accordance with RRC guidelines (SBP, Professionalism).
- i) Monitoring of UHC cost, LOS, and outcome data for team and individual members (Patient care, SBP, IOM Quality Aims)
- j) Formal grading of patient evaluation and management via One 45 system (all competences).

## 2. Provision of Feedback

- a. Daily feedback is to be given to residents by superiors regarding performance in all domains as appropriate: encouraging good/excellent behavior, and facilitating recognition of areas needing improvement and means to improve.
- b. Mid rotation feedback is to be given to residents by superiors regarding overall performance in all 6 competencies and all 6 quality domains. When possible this should be written, with specific goals for improvement during the remainder of the rotation.

3. Documentation of evaluation: Evaluation will be documented by completion of forms above, written documentation of significant negative or positive feedback (to program director), and end of rotation completion of One 45 on line evaluation by the attending, as well as peer evaluations by residents.
  
4. Transmission of evaluation to resident
  - a) End of rotation outbrief: at end of rotation, attending will meet with resident to discuss performance and means of improvement.
  
  - b) Written evaluation on One 45.
  
  - c) Compilation of all reports into personal performance file and resident portfolio.

## **DEFINITION OF LEVEL OF RESIDENT SUPERVISION BY FACULTY IN ALL PATIENT-CARE ACTIVITIES**

Attending faculty physicians are ultimately responsible for the outcome of all patient care in both the medical and legal sense. They delegate this care in order to train residents how to care for patients themselves. Supervision is graded to the level of training of the resident and education is individualized to the needs and level of the individual trainees on the ward team.

The PGY-1 is responsible for up to 10 patients at one time. The PGY-1 is the primary caregiver to the patient as is identified as the “patient’s doctor.” He develops the diagnostic and therapeutic plan after discussion with the PGY-2/3 and attending, and is responsible for the implementation of all diagnostic and therapeutic management, to include procedure, retrieval and assessment of diagnostic tests and coordination of multidisciplinary, consultative, and discharge related resources.

The PGY 2/3 is responsible for up to 20 patients at one time. He supervises the PGY-1 and sub-intern and students in performance of duty, writes admission history, physical and initial plan of care, facilitates interpretation of diagnostic and therapeutic outcomes and discharge planning. This resident is responsible for timely and complete dictated summaries, but may delegate this duty to the PGY-1, but not any medical student. He mentors and teaches subordinates and nursing and other ancillary care-givers, develops case reports and clinical research appropriate to case managed, and prepares discussion of cases for management conference, morbidity/mortality conference, show and tell, and other departmental

conferences. PGY-3 residents are expected to conduct greater quantity and quality of teaching, mentoring, and quality improvement activities than PGY-2 residents.

The attending is the final level of responsibility to the educational and service mandates of the ward experience. The attending identifies the specific education needs of each of the subordinate members of the ward team and facilitates their maximum competency by supervising, evaluating, giving feedback, and teaching appropriate to each team member, while assuring that excellent patient care is provided.

## **ACGME MILESTONES**

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The ACGME Milestones in clinical competency and observable professional activities will be used in all rotations to establish progression in competency commensurate with training. The specific milestones being assessed are:

### **PATIENT CARE**

- PC 1: Gathers and synthesizes essential and accurate information to define each patient's clinical problems
- PC 2: Develops and achieves comprehensive management plans for each patient
- PC 3: Manages patients with progressive responsibility and independence
- PC 4: Skill in performing procedures
- PC 5: Requests and provides consultative care

### **MEDICAL KNOWLEDGE**

- MK 1: Clinical knowledge
- MK 2: Knowledge of diagnostic testing and procedures

### **SYSTEMS BASED PRACTICE**

- SBP 1: Works effectively within an inter-professional team (e.g. peers, consultants, nursing, ancillary professional and other support personnel)
- SBP 2: Recognizes system error and advocates for system improvement
- SBP 3: Identifies forces that impact the cost of health care, and advocates for, and practices cost-effective care.
- SBP 4: Transitions patient effectively within and across health delivery systems

### **PRACTICE BASED LEARNING AND IMPROVEMENT**

PBL 1: Monitor practice with a goal for improvement

PBL 2: Learns and improves via performance audit

PBL 3: Learns and improves via feedback

PBL 4: Learns and improves at the point of care

### **PROFESSIONALISM**

PROF 1: Has professional and respectful interactions with patients, caregivers and members of the inter-professional team (e.g. peers, consultants, nursing, ancillary professionals and support personnel)

PROF 2: Accepts responsibility and follows through on tasks

PROF 3: Responds to each patient's unique characteristics and needs

PROF 4: exhibits integrity and ethical behavior in professional conduct

### **INTERPERSONAL AND COMMUNICATIONS SKILLS**

ICS 1: Communicates effectively with patients and caregivers

ICS 2: Communicates effectively in inter-professional teams (e.g. peers, consultants, nursing, ancillary professionals and other support personnel.)

ICS 3: Appropriate utilization and completion of health records

## **TEACHING METHODS**

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### **BEDSIDE INSTRUCTION**

Bedside teaching rounds on all subjects pertinent to specific patient at hand. This teaching method constitutes majority of minimum 4.5 hrs weekly teaching rounds with attending physician.

### **SMALL GROUP DISCUSSION**

Team rounds or in team conference discussing specific cases, general concepts appropriate to specific cases.

### **PERSONAL FEEDBACK**

Daily as indicated to specific residents by attending. Summary evaluations are provided at mid- and end-rotation.

## **EVALUATION AND REVIEW OF WRITE UPS**

All write ups, progress notes, and discharge summaries will be reviewed by attending, with written corrections and comments to resident as indicated for improvement. Attendings are expected to complete one formal inpatient medical record review of each resident during the rotation.

## **DIDACTIC LECTURES**

Residents are expected to attend afternoon report, noon conferences, and Medicine Grand Rounds while on service. Our three year block lecture schedule reviews core content, and should be supplemented with self-directed reading using the Harrison's Curriculum and patient pathology as a guide. Residents are expected to present case management discussions at morning report on assigned dates, in accordance with case management format.

## **ASSIGNED READINGS**

Residents are expected to have working knowledge acquired by developing a reading schedule, on their own time, of no less than one hour per day.

## **EDUCATIONAL RESOURCES TO BE USED – CHECK REQUIREMENT**

- Required reading: Harrison's, and prompted by patient pathology/didactics.
- Likely opportunistic reading: The Washington Manual, *Up to Date*, other on-line resources as appropriate.
- Pathological material: biopsies, smears, cytology, autopsy material. Residents are encouraged to look at all specimens personally.
- Other educational resources to be used: Pre and Post testing as developed.

## **HARRISON'S CURRICULUM PLAN**

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- ❖ Residents will be assigned chapters below as reading assignments
- ❖ Set chapters will be discussed each week



- ❖ Residents will be assigned an individual chapter or chapters throughout the year to present during Wednesday AR (date may be changed due to residents in clinic)
  - Residents in Clinic will not present but will still provide study guides
- ❖ Each resident will formulate a study guide reviewing the material in their chapter(s)
  - This study guide will form the basis for resident evaluation
    - Failure to turn in timely work will result in professionalism violation and assignment of more chapters/study guides
  - Study Guides will be distributed to the housestaff as shared study material
- ❖ Harrison's AR are NOT a time for powerpoint presentations of topics but for discussion of the week's readings and areas of concern (high yield areas and/or confusing subjects)
- ❖ Conference will be every Wednesday at 3pm
- ❖ Goals
  - Improve residents self-directed learning skills
  - Reinforce concepts seen on Wards and in Clinics with reading materials
  - Produce study materials for subsequent use in Board Preparation

**Please see accompanying Blocks below with dates**

**General Internal Medicine Block (11) (7/14-8/17) (4 weeks)**

- Chapter 4 Screening and Prevention of Disease
- Chapter 8 Medical Evaluation of the Surgical Patient
- Chapter 20 Syncope
- Chapter 25 Confusion and Delirium
- Chapter 74 Vitamin and trace Mineral Deficiency and Excess
- Chapter 78 Evaluation and Management of Obesity
- Chapter 79 Eating Disorders
- Chapter 82 Prevention and Early Detection of Cancer
- Chapter 122 Immunization Principles and Vaccine use
- Chapter 241 The Pathogenesis, Prevention, and Treatment of Atherosclerosis
- Chapter 247 Hypertensive Vascular Disease

**Cardiology Block (12+2) (8/18-9/29) 1 week ECG at end of GIM Block and 4 weeks Cards.**

- *Chapter 227 Physical Examination of the Cardiovascular System*
- *Chapter 228 Electrocardiography*
- Chapter 229 Noninvasive Cardiac Imaging
- Chapter 232 The Bradyarrhythmias

- Chapter 233 the Tachyarrhythmias
- Chapter 234 Heart Failure and Cor Pulmonale
- Chapter 237 Valvular Heart Disease
- Chapter 238 Cardiomyopathy and Myocarditis
- Chapter 239 Pericardial Disease
- Chapter 243 Ischemic heart Disease
- Chapter 244 Unstable Angina and NSTEMI
- Chapter 245 STEMI
- Chapter 248 Diseases of the Aorta
- Chapter 249 Vascular Diseases of the Extremities

**Nephrology (10 assignments) (10/1-10/22) 4 weeks.**

- Chapter 279 Acute Kidney Injury
- Chapter 280 Chronic Kidney Disease
- Chapter 283 Glomerular Diseases
- Chapter 285 Tubulointerstitial Diseases of the Kidney
- Chapter 281/282 Dialysis/Transplantation in Treatment of Renal Failure
- Chapter 286 Vascular Injury to the Kidneys
- Chapter 287 Nephrolithiasis
- Chapter 44 Azotemia and Urinary Abnormalities (Focus on Clinical Context)
- Chapter 45 Fluid and Electrolyte Disturbances
- Chapter 47 Acidosis and Alkalosis

**Pulmonary Critical Care (13) (10/29-11/16) 4 weeks; This includes Critical care as well.**

- Chapter 250 Pulmonary HTN
- Chapter 252 Disturbances of Respiratory Function
  - Sections on “Approach to the Patient” in Gas Exchange section
  - Clinical Correlations Section
- Chapter 264 Disorders of Ventilation
  - Sections on Hypoventilation Syndromes and Hyperventilation only
- Chapter 254 Asthma
- Chapter 260 Chronic Obstructive Pulmonary Disease

- Chapter 257 Pneumonia
- Chapter 261 Interstitial Lung Diseases
- Chapter 255 Hypersensitivity Pneumonitis ...
- Chapter 256 Occupational and Environmental Lung Disease
- Chapter 263 Disorders of the Pleura and Mediastinum
- Chapter 265 Sleep Apnea (Short Chapter), Chapter e51 Altitude Illness
- Chapter 268 Acute Respiratory Distress Syndrome
- Chapter 270 Approach to Patient with Shock
  - Brief review of Types of Shock

**Heme/Onc (20) (11/17-1/11) 6 weeks (with Holiday Schedule in between)**

- Chapter 87 Cancer of the Skin
- Chapter 88 Head and Neck Cancer
- Chapter 89 Neoplasms of the Lung
- Chapter 90 Breast Cancer
- Chapter 97 Gynecologic Malignancies
  - Condense Breast and Gyn Cancers
- Chapter 91 GI Tract Cancer
- Chapter 92 Tumors of the Liver and Biliary Tree
- Chapter 93 Pancreatic Cancer
  - Condense GI malignancies together
- Chapter 94 Bladder and Renal Cell Carcinomas
- Chapter 98 Soft Tissue and Bone Sarcomas
- Chapter 99 Carcinoma of Unknown primary
- Chapter 100 Paraneoplastic Syndromes
- Chapter 103/105 Fe Deficiency and Megaloblastic Anemias
- Chapter 106-108 Hemolytic, Aplastic Anemias and PCV
- Chapter 109 Acute and Chronic Myeloid Leukemia
- Chapter 110 Malignancies of Lymphoid Cells
- Chapter 111 Plasma Cell Disorders
- Chapter 112 Amyloidosis

- Chapter 116 Coagulation Disorders
- Chapter 117-118 Arterial and Venous Thrombosis/Anticoagulant drugs.

**Gastroenterology (12) (1/12-2/8) 4 weeks**

- Chapter 292 Disease of the Esophagus
- Chapter 293 Peptic Ulcer Disease and Related Disorders
- Chapter 294 Disorders of Absorption
- Chapter 295 Inflammatory Bowel Disease
- Chapter 297 Diverticular Disease and Common Anorectal Disorders
- Chapter 304 Acute Viral Hepatitis
- Chapter 305 Toxic and Drug-Induced Hepatitis
- Chapter 306 Chronic Hepatitis
- Chapter 307 Alcoholic Liver Disease
- Chapter 308 Cirrhosis and its Complications
- Chapter 311 Diseases of the Gallbladder and Bile Ducts
- Chapter 313 Acute and Chronic Pancreatitis

**Infectious Disease (8, large topics...) (2/9-3/8) 4 weeks. This is a difficult section to assign readings for as there are multiple chapters on less common infections that are board favorites.**

- Chapter 130 Sexually Transmitted Infections
- Chapter 128/129 Acute Diarrheal and C. Diff
- Chapter 125/126 Infections of soft tissues and Osteomyelitis
- Chapter 124 Infective Endocarditis
- Chapter 189 HIV: AIDS and Related Disorders
- Chapter 165 Tuberculosis
- Section 16 Fungal Infections
  - Focus on clinical aspects with Diagnoses, clinical context and treatment
- Section 18 Protozoal Infections
  - Focus on clinical aspects with Diagnoses, clinical context and treatment

**Rheumatology/ Allergy Immunology (13) (3/9-4/5) 4 weeks (including 1 week for Allergy)**

- Chapter 332 Osteoarthritis
- Chapter 333 Gout and Crystal-Associated Arthropathies
- Chapter 321 Rheumatoid Arthritis

- Chapter 334/335 Infectious Arthritis, Fibromyalgia
- Chapter 319 SLE
- Chapter 320/324 Antiphospholipid Antibody Syndrome/ Sjogren's Syndrome
- Chapter 323 Systemic Sclerosis and Related Disorders
- Chapters 322/327/328 Acute Rheumatic Fever, Behcet's, relapsing Polycondritis
- Chapter 329 Sarcoidosis
- Chapter 388 Polymyositis, Dermatomyositis and Inclusion Body Myositis
- Chapter 325 The Spondyloarthritides
- Chapter 326 The Vasculitis Syndromes
- Chapter 316 Primary Immune Deficiency Diseases

**Endocrinology (10) (4/6-5/3) 4 weeks**

- Chapter 344 Diabetes Mellitus
- Chapter 353 Disorders of the Parathyroid Gland and Calcium Homeostasis
- Chapter 354/355 Osteoporosis and Paget's Disease and Other Dysplasias of Bone
- Chapter 339 Disorders of Anterior Pituitary and Hypothalamus (Large!)
  - Focus on Prolactin, GH, Gonadotropins and DI
- Chapter 341 Disorders of Thyroid Gland
- Chapter 342 Disorders of Adrenal Cortex
- Chapter 346 Disorders of the Testes and Male Reproductive System
- Chapter 347 The Female Reproductive System, Infertility and Contraception
- Chapter 349/351 Disorders of Sexual Development/ affecting Multiple Endocrine Systems
- Chapter 357/360 Hemochromatosis/Wilson's Disease

**Neurology (10) 5/4-5/31 (4 weeks) Also have several Psychiatry topics in here.**

- *Chapter e42 The Neurologic Screening Exam (watch the video)*
- Chapter 369 Seizures and Epilepsy
- Chapter 370 Cerebrovascular Diseases
- Chapter 381 Meningitis, Encephalitis, Brain Abscess and Empyema
- Chapter 382/382 Chronic and Recurrent Meningitis/ Prion Diseases
- Chapter 371 Dementia (relatively short)
- Chapter 372 Parkinson's Disease and Other Movement Disorders

- Chapter 376 Trigeminal Neuralgia, Bell's Palsy, and Other Cranial Nerve Disorders
- Chapter 385/386 Guillain-Barre Syndrome/Myasthenia Gravis
- Chapter 391 Mental Disorders (LONG!)
- Chapter 394 Cocaine and Other Commonly Abused Drugs

**Last Block (13) is kept for Board Review series similar to this year.**

## **EXPECTATIONS OF RESIDENTS AND ATTENDING AS TEACHERS**

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### **ROLE OF THE PGY-1**

They instruct students how to write orders, do certain procedures, arrange testing and consultations, and find and interpret laboratory and study results. They discuss on a daily basis management issues relating to jointly managed patients. They read, correct, and countersign student's daily progress notes, and they contribute to case-related teaching that occurs on work rounds, attending rounds, and seminars.

### **ROLE OF THE PGY-2/PGY-3**

Residents review the expectations of the student on the ward service and set standards that are specific to the service and to the resident's teaching style. Residents are expected to engage case-based teaching around cases handled by students, specifically at times of decreased patient management activity, such as at night, on call, and prior to scheduled conferences. This entails ensuring adequate data collection (appropriate history, physical and lab results) by the student, reviewing the student's understanding of each problem and management plan, reviewing each student write-up; practice and coach the student in mock-presentation of the case before the student presents to the attending, and assist the student in gaining knowledge of key principles of pathophysiology and case-management pertinent to the rotation. Residents are also to provide immediate and on-going feedback to students on all aspects of their performance, as well as provide summative evaluation at mid and end of rotation.

## **LINES OF COMMUNICATION**

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Multiple lines of communication are necessary to ensure both educational and patient care objectives.

Patient/Family/Nurse communication: The primary line of communication is from the patient to his or her "physician," the PGY-1 or subintern. This physician should be the first to see patients daily, be the first to

enter the room on work rounds, and present cases at the bedside at teaching rounds, unless the MSM-3 student is presenting. Major request and needs are to be expressed by the patient and nurses to the PGY-1 and solved at that level first. Additionally, significant counseling of the patient, such as results of diagnostic test, planned therapy, “bad news,” advance directives, etc., is the duty of the PGY-1 to initiate and complete. If communication problems exist between the patient or nurse and PGY-1 or subintern, the patient or nurse will next pursue communication with the PGY-2/3. If communication is unsuccessful here, the attending will be called. Any failure of communication above the level of the PGY-1 will be evaluated by the attending, with appropriate feedback.

Orders are to be written by the PGY-1 except in only rare and emergent circumstances by other on the team at the PGY2/3 or attending level.

The attending is to be called by the PGY2/3 on each admission within 4 hours of acceptance. The attending is to be informed of the tentative diagnosis, management issues, and prognosis in order to determine his need to personally evaluate the patient within a timely manner. The attending will see all patients and write his note within 24 hours of admission.

For consultations, the primary line of communication should be between the attending and attending consultant. The attending physician should sign all consult requests after discussing the reason for the consultation with the residents. The attending may delegate calling in of consultation by the resident if the typical procedure involves first discussion at a resident or fellow level. Consultation recommendations are to be implemented only after discussion by the attending and residents and discussion of decisions between the PGY-1 and patient.

## **PROGRESSIVE PATIENT CARE RESPONSIBILITY OF RESIDENTS**

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For each year of the program, residents will have increasing patient care, leadership, teaching, and administration responsibility. They demonstrate their competency within the context of the patient care and educational responsibilities expected of them.

### **PGY-1 (CATEGORICAL AND PRELIMINARY)**

PGY-1 residents (interns) will attain competency in the following areas: Humanism, Professionalism, Medical Ethics, Clinical Method, Continuity of Care, Medical Interview, Physical Diagnosis, Clinical Pharmacology, Medical Informatics. They will attain in-depth knowledge of clinical conditions found in inpatients, most of whom are severely ill, with complex medical problems. They will learn the basic “rules” of medical care and apply them to their patients in an increasingly personalized manner. They will engage in supervised, meaningful care of limited numbers of patients to achieve these competencies.

They will learn and be tested on key competencies of data gathering and physical examination in non-patient care settings.

Categorical interns are responsible for continuity care of a panel of patients. Interns are responsible to provide pertinent and timely education to students working with them.

## **PGY-2**

PGY-2 residents will further develop and expand those competencies acquired as interns, and begin to acquire remaining competencies . They will engage in supervised, meaningful care of increased numbers of patients who have increasing complexity and ambiguity. Care will be increasingly personalized and individualized to meet patient needs.

PGY-2 residents are responsible for leading their inpatient ward team, teaching interns and students, participating in journal club, subspecialty conference and morning report teaching. They will learn the competencies of practice-based learning and systems based practice through participation in seminars in medical economics and scholarly activities such as evidence-based resident report and journal club.

## **PGY-3**

PGY-3 residents continue to expand and refine competencies to qualitative and quantitative standards of excellence before graduation, enabling them to meet criteria to sit for the examination of the American Board of Internal Medicine and achieve passing score. They will see more patients in ambulatory and consultative settings, demonstrate refinement of the 6 core competencies and 6 quality competencies to all areas of internal medicine practice, and increasingly foster improvements in their own care and the care provided by the health care system.

PGY-3 residents are responsible for leading their inpatient ward teams, participating in hospital quality assurance activities, teaching subordinates and peers to include a noon conference and increased numbers of other conferences. PGY-3 residents are expected to engage in scholarly activity, to include noon conferences, journal club, written case reports, published research, and/or paper presentations, and reports and essays pertinent to clinical rotations as outlined below.

## **ATTENDING SUPERVISION POLICY**

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### **DEFINITIONS**



Supervision - Supervision refers to the dual responsibility that an attending physician has to enhance the knowledge of the resident and to ensure the quality of care delivered to each patient by any resident. Such control is exercised by observation, consultation and direction. It includes the imparting of the attending physician's knowledge, skills, and attitudes by the attending physician to the resident and ensuring that patient care is delivered in an appropriate, timely, and effective manner.

## **POLICY**

The intent of this policy is to ensure that patients will be cared for by clinicians who are qualified to deliver care and that this care will be documented appropriately and accurately in the patient record. This is fundamental, both for the provision of excellent patient care and for the provision of excellent education and training. Faculty supervision of residents assures resident education. The quality of patient care, patient safety, and the success of the educational experience are inexorably linked and mutually enhancing. Incumbent on the clinical educator is the appropriate supervision of the residents as they acquire the skills to practice independently and simultaneously provide the highest standard of patient care.

## **SCOPE**

- A. Attending physicians are responsible for the care provided to each patient, and they must be familiar with each patient for whom they are responsible. Fulfillment of that responsibility requires personal involvement with each patient and with each resident who is participating in the care of that patient. Each patient must have an attending physician of record whose name is recorded in the patient chart. It is recognized that other attending physicians may, at times, be delegated responsibility by the attending physician of record. In this case, the attending physician of record is responsible to be sure that the residents involved in the care of the patient are informed of such delegation and can readily access an attending physician at all times and the attending of record, if necessary.
- B. Within the scope of the training program, all residents must function under the supervision of an attending physician. Backup must be available at all times through more senior residents and appropriately credentialed attending physicians. The levels of supervision are:
  1. Level 1 - The attending physician is physically present and directly involved in the care/procedure.

2. Level 2 - The attending physician is present in the operative/procedural suite or on the unit and immediately available for consultation.
  3. Level 3 - The attending physician is immediately available in the facility.
  4. Level 4 - The attending physician is off-site and able to be present in the hospital within a reasonable amount of time.
- C. In order to ensure patient safety and quality patient care while providing the opportunity for maximizing the educational experience of the resident in the ambulatory setting, it is expected that an appropriately privileged attending physician will be available for supervision during clinic hours. Patients followed in more than one clinic will have an identifiable attending physician for each clinic. Attending physicians are responsible for ensuring the coordination of care that is provided to patients.

## **POLICY STANDARDS**

Quality graduate medical education can occur only in settings that are characterized by the provision of high quality patient care. As a practical matter, preparing future practitioners to meet patients' expectations for excellence requires they learn in environments epitomizing the highest standards of medical practice. Even more important, as an ethical matter, justifying the participation of residents in the care of patients requires adherence to uncompromised standards of quality medical care.

- A. The attending physician of record is responsible for the quality of all of the clinical care services provided to his or her patients.
- B. All clinical services provided by resident physicians must be supervised appropriately to maintain high standards of care, safeguard patient safety, and ensure high quality education, based on patient acuity and a resident's graduated level of responsibility.
- C. Attending physicians directly responsible for the supervision of patient care services provided by resident physicians must be as available to participate in that care as if residents were not involved; the presence of residents to "cover" patients on inpatient services or to provide care in ambulatory settings does not diminish the standards of availability required of the physician of record.
- D. Attending physicians are responsible for determining when a resident physician is unable to function at the level required to provide safe, high quality care to assigned patients, and must

have the authority to adjust assigned duty hours as necessary to ensure that patients are not placed at risk by resident physicians who are overly fatigued or, otherwise, impaired.

## PROCEDURE

- A. All patient care performed by residents during training will be under the supervision of an attending physician credentialed to provide the appropriate level of care. The specifics of this supervision must be documented in the medical record by the attending physician or resident according to Medical Staff rules and regulations.
- B. The supervising/attending physician must be immediately available to the resident in person or by telephone 24 hours a day during clinical duty. Residency Program Directors must assure this occurs. Residents must know which supervising/attending physician is on call and how to reach this individual.
- C. Inpatient supervision: The supervising/attending physician must obtain a comprehensive presentation from the resident including a history and physical with co-signed attending attestation for each admission. This must be done within a reasonable time, but always within 24 hours of admission. The supervising/attending physician must also require the resident to present the progress of each inpatient daily, including discharge planning. All required supervision must be documented in the medical record by the resident and/or the supervising/attending physician according to Medical Staff rules and regulations.
- D. D. Outpatient supervision: The supervision/attending physician must require residents to present each outpatient's history, physical exam and proposed decisions. All required supervision must be documented in the medical record by the resident and/or the supervising/attending physician according to Medical Staff rules and regulations.
- E. Consultative Service supervision: The supervising/attending physician must communicate with the resident and obtain a presentation of the history, physical exam and proposed decisions for each referral. This must be done within an appropriate time but no longer than 24 hours after completion by the resident of the consultation request. All requires supervision must be documented by the resident and/or the supervising/attending physician according to Medical Staff rules and regulations.
- F. Procedural supervision: The supervising/attending physician must ensure that procedures performed by the resident are warranted, that adequate informed consent has been obtained and that the resident has an appropriate level of supervision during the procedure. The level of supervision (according to the four levels outlined previously in this policy) must match both the

resident's ability to determine the appropriateness of the procedure and the resident's ability to perform the procedure. All required supervision must be documented by the resident and/or the supervising/attending physician according to Medical Staff rules and regulations.

- G. Emergency supervision: During emergencies, the resident should provide care for the patient and notify the supervising/attending physician as soon as possible to present the history, physical exam and planned decisions. All required supervision must be documented by the resident and/or the supervising/attending physician according to Medical Staff rules and regulations.
- H. Each department develops specific guidelines concerning resident supervision and submits them to the GMEC for approval. These must include the following key principles:
1. Clinical responsibilities must be conducted in a carefully supervised and graduate manner, tempered by progressive levels of independence to enhance clinical judgement and skills.
    - This supervision must supply timely and appropriate feedback about performance, including constructive criticism about deficiencies, recognition of success, and specific suggestions for improvement.
    - Resident supervision must support each program's written educational curriculum.
    - Resident supervision should foster humanistic values by demonstrating a concern for each resident's well-being and professional development.
    - Faculty and residents must be educated to recognize the signs of fatigue and adopt and apply policies to prevent and counteract the potential negative effects.
  2. Residents are supervised by teaching staff in accordance with these established guidelines.
  3. Faculty call schedules are structured to assure that support and supervision are readily available to residents on duty.
  4. The quality of resident supervision and adherence to the above guidelines are monitored through annual review of the resident's evaluations of their faculty and rotations by the GMEC (see Evaluations of Rotations and Faculty Members by Resident Policy).
  5. For any significant concerns regarding resident supervision, the appropriate Residency Program Director will submit a plan for its remediation to the GMEC for approval.

## **AMBULATORY AND CONSULTATIVE ROTATIONS (REQUIRED AND ELECTIVE)**

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Ambulatory and Consultative Care experiences are extremely important in preparing residents for the bulk of their future practice. Residents will select these “non-ward” months after declaring their track and discussing their desires with their advisor. In general, patients are seen both in the clinics and in inpatient consultation. Depending on the rotation percentage of ambulatory time, zero, 50 or 100% month credit will be given for “Meaningful Patient Responsibility” for rotations listed.

Patients with acute and chronic illnesses in the named specialties are seen during the rotation. Unless specified, rotations are at the VA or both VAMC and GRU. Application for specific non-ward rotations will be approved by the Program Director contingent upon the chosen track of resident, performance on in service exam subspecialty components, and availability of teaching space on the rotation for the month desired. Residents should plan their non-ward rotations early in the academic year and must have their request submitted by the 5<sup>th</sup> of the previous month.

### **CORE ROTATIONS**

For more detailed information about each rotation, visit the IM Website.

<http://www.gru.edu/mcg/residents/internalmed/>

### **ELECTIVES ROTATIONS**

Gastroenterology Consults/Clinics

Cardiology Consults/Clinics

Cardiology EP

Neurology Inpatient or Outpatient

University Hospital – Hospitalist Rotation

ER

Geriatric Clinics

Rheumatology Consults/Clinics

Pulmonary Consults/Clinics

Endocrine Consults/Clinics

Nephrology Consults/Clinics

Infectious Disease Consults/HIV Clinic

Women’s Health

Sports Med/Orthopedics/Rheum (Musculoskeletal)

Rehabilitation-(VAMC Spinal Cord Unit)

WIC (walk-in clinic) VAMC or GRU

Dermatology Clinic/Consults

Ophthalmology

Research Month (needs defined and approved research protocol and mentor, completion of Clinical Trials Competency 4 module training prior)

Off Campus Elective (maximum one month at US ACGME approved program, see policy for approval)

## **SUPERVISED CARE OF LIMITED NUMBERS OF HOSPITALIZED PATIENTS AND CONCURRENT EDUCATIONAL ACTIVITIES**

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All patient care will be supervised by a designated attending physician who is responsible not only for the outcome of the patient, but along with the resident, attainment of the educational competencies associated with that patient or type of care. Each rotation has specific detailed curriculum located on the GRU Internal Medicine Website. <http://www.gru.edu/mcg/residents/internalmed/>

Residents are expected to know and complete specific requirements of each rotation listed therein. Attendings will provide equal emphasis on patient care and education during the time available.

### 1. General Medicine Wards

Patients with moderate to severe acute and chronic medical problems requiring hospitalization. Competencies primarily relate to management of complex, very ill patients with infectious, pulmonary, gastrointestinal, metabolic, rheumatologic, and neurologic diseases within the hospital, and planning for discharge for continuity of care and maximal well being, incorporating palliative care principles and practice.

### 2. MICU

Patients with severe complex acute and chronic medical problems requiring hospitalization in the intensive care unit. Competencies relate primarily to care of severely ill patients with altered physiology and include procedure required to diagnosis and appropriate manage such patients.

### 3. Cardiology and CCU

Patients with complex cardiac problems requiring care by cardiologists. Competencies relate primarily to the management of cardiovascular diseases and their impact on patients with additional morbid conditions.

#### 4. Hematology/Oncology (GRU)

Patients with sickle cell disease, malignancy undergoing chemotherapy and other special therapy requiring expertise of an Oncologist. (This rotation includes ambulatory oncologic care). Competencies relate primarily to management of acute and chronic pain, altered physiology and sepsis

#### 5. Transplant (GRU)

Infectious complications of renal disease and psychologic, economic, and cultural impact of renal disease.

#### 6. Infectious Disease Consults

Patients with HIV, osteomyelitis, cellulitis, endocarditis, pneumonia and other acute, suspected, or chronic infectious diseases. Competencies relate clinical epidemiology, infection control, anti-microbial use, discharge planning (including hospice and palliative care), and public health issues. Residents are expected to be familiar with and appropriately implement IDSA and other guidelines in the management of patients.

#### 7. Gastroenterology Consults

Patients with gastrointestinal bleeding, cirrhosis, inflammatory bowel disease, cholecystitis and cholangitis, as well as other hepatic and gastrointestinal problems. Competencies are similar to those in general internal medicine.

#### 8. Night Float

Patients necessitating admission at night or weekend due to acute problems. Inpatients with after hours medical problems. Competencies relate primarily to timely decision making and management of acute problems in multiple patients at one time.

#### 9. Consultation

Patients, mostly on surgical services or emergency room, necessitating general internal medicine consultation.

Time Management: Residents on all rotations will abide with RRC work hour rules and balance service to education. The primary role of the resident is to be educated and trained in the provision of service to the sick. This requires time for reflection, self-study, personal and family development, recreation, physical exercise and spiritual growth. Residents will report difficulties in limitation of work hours, and honestly and accurately report duty hours performed. It is the responsibility of the attending to proportion and facilitate service requirements to balance and promote educational and personal time.

## **SUPERVISED CARE OF LIMITED NUMBERS OF AMBULATORY PATIENTS**

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All patient care will be supervised by a designated attending physician who is responsible not only for the outcome of the patient, but along with the resident, attainment of the educational competencies associated with that patient or type of care.

Location: GRUor VA or Christ Community Clinic

Teaching methods: 30 min didactic case review based on Yale curriculum and in the clinic. Daily patient care feedback from attending physician. Every 6 months clinic evaluation completed by attending on One45. Assigned readings; Yale curriculum and associated curriculum.

Scope: Teaching and patient care integrate medical problems, health promotion, cultural, socioeconomic, ethical, occupational, environmental, behavioral issues, practice based learning and health systems improvement issues.

### 1. Continuity Care Clinic: All years

Residents care for patients with continuing health care needs, often previously hospitalized. Competencies relate primarily to continuity of care and preventive care, integrative disciplines, and specific organ/system based competencies of general internal medicine primary care practice.

Continuity clinics are held by specific residents at GRU, VA, and Christ Community Clinic (Augusta). All clinics will have similar organization and standards, to include use of the Yale Ambulatory Curriculum, and a clinic multi-disciplinary “huddle” prior to the start of the clinic which takes place every 2-3 months. Each clinic resident will engage in quality improvement projects related to their continuity clinic, which will be presented at research conference and/or MM conferences during their Q/I rotation.



2. Subspecialty clinic: Residents will be performing a subspecialty elective in the outpatient setting. With special request, residents may have the option of rotating with specific attendings in specific specialty care areas.

Residents care for patients with continuing health care needs in a subspecialty of interest. Competences as above, with special development of knowledge and skills related to the subspecialty.

3. Emergency Medicine: One month as PGY-2 or PGY-3 (GRU and VA ED)

Residents will care for patients with acute medical problems and needs requiring immediate attention or felt by the patient to require such attention. Competencies relate primarily to integrative disciplines, cardiac, pulmonary, drug abuse, psychiatric, and metabolic diseases listed above.

Residents will develop competencies in decision making, triage and rapid evaluation and management of acutely ill patients. They will all serve as consultants in internal medicine to the emergency department during this rotation.

4. Women's Health /Adolescent Medicine (GRU OB-GYN dept) PGY-3: 2 weeks required or may elect 4 weeks

Residents will care for patients with sexually transmitted diseases, women's health screening, adolescent evaluation and health care pertinent to women's health issues. Residents will develop competencies in women's health and adolescent medicine

5. Geriatrics (GRU): PGY-3: 2 weeks required or may elect 4 weeks continuous throughout the year

Residents will manage geriatric patients in conjunction with faculty at GRU. Residents will learn about longitudinal care of geriatric patients to include outpatient visits and end of life care.

Point of contact: Dr. Dean Harrell.

7. Community Health: To provide residents a supervised opportunity to manage and educate patients and the public in an inner city community context, thereby enhancing competencies of systems based practice, professionalism and communication to foster the health of the future communities in which they practice.

Specific Objectives:

- 1) To increase knowledge and understanding of social/economic and spiritual determinants of health.
- 2) To increase communication skills and cultural knowledge by caring for diverse patients as well as providing health education to patients and the public
- 3) To develop competency in practice based learning and knowledge of methods of community health assessment
- 4) To foster professionalism in caring for a diverse patient population

Location: Christ Community Health Services, Augusta, Georgia

Duration: Residents may choose this as their continuity care experience.

8. Neurology: PGY-2- 4 weeks, required

Residents manage patients with neurologic diseases and symptoms in the consultative and outpatient setting. Primary competencies in Neurology are to include; physical diagnosis and management of acute and chronic neurological disease expected of a general internal medicine practice. Residents will be expected to participate in the neurology didactics.

9. International Peru Elective: PGY2 or PGY3: 4 weeks (supervised outpatient, community medicine elective in a developing country with direct supervision and feedback from the local physician providers in Cusco, Peru)

There will be an emphasis on public health, preventative care, and the general practice of patient care in underdeveloped country with poor access to care.

Application for this elective includes: Personal statement explaining why resident desires this elective, resident must be in good academic standing, and must be approved by committee reviewal under the direction of the chief residents and APDs.

## PROGRAM REQUIREMENTS

### DIDACTIC CURRICULUM

Didactics are designed to integrate, supplement, and broaden experience and knowledge in the rapidly developing fields encompassed by internal medicine. Students learn from their mentors and peers, through literature review, and by study and analysis in preparing timely topics. The didactic curriculum does not replace patient care. The didactic curriculum is designed as an annual block curriculum covering core ABIM topics. For example, topics for noon conferences are assigned to each subspecialty department on a monthly basis and are presented by faculty in that field of medicine. Other departmental didactics will include ABIM required curriculum. For example, afternoon report, pharmacy interdisciplinary conference, Harrisons reading club, etc.

Additional topics include information from the basic medical sciences, psychosocial, economic, and cultural aspects of health and illness, as well as population dynamics, health care quality and management, and personal, family, community, and national/international aspects of health and disease.

Residents are expected to attend 60% of the required scheduled didactic conferences.

Attendance is taken at all conferences. It is the responsibility of the resident to make certain attendance is tabulated. Failure to achieve attendance goals, will result in review and possible remediation as determined by the CCC. The CCC ( Clinical Competency Committee) accepts hour-per-hour alternative education such as, assigned self-study, or tested video/computer study.

The following are the key didactic and patient care conferences:

- Night Medicine Hand Off Conference: Night Float resident or Night call team transfers care to receiving physicians (on-call daytime attending and resident) through discussion of cases, and bedside rounds as appropriate (7:30-8:30, daily).
- Afternoon Report Conference and bedside rounds as appropriate (Monday to Friday 3-4pm in the Peacock Medicine Library). Scheduled presentation by residents of case management issues, graded by protocol format with attending and resident discussion.
  - ❖ Scheduled presentations by ward teams on cases
  - ❖ Journal Club: critical review of the latest evidence-based medical literature with the topic selected by the resident's choice. Required for PGY2s.
  - ❖ Resident report: Evidence-based discussion of current medical topic by resident. Must use evidence-based format outlined by program director to achieve competency scores in practice-based learning, medical knowledge and communication

- ❖ Harrison's Reading Club – Every Wednesday - weekly scheduled reading assignments with discussion and preparation material prepared by housestaff. This will follow our overall annual block curriculum that coincides with the ABIM.
  - ❖ Clinical Pharmacology/Adverse Drug Reaction Conference (every other Tuesday). PGY2/3 ward residents can report and discuss adverse outcomes with representative of department QI, Allergy Program, and PharmD/Clinical Pharmacology Programs. Mini-lecture on ADE topic provided by the pharmacists.
  - ❖ MKSAP review based on the didactic subspecialty block schedule.
  - ❖ X-ray rounds (as scheduled by Radiology). Review and teaching on current cases managed by ward teams at GRU and VA.
- Noon conferences: Noon Conference (M, W, Th, F): Key management topics pertinent to the practice of general and subspecialty internal medicine and preparation for the ABIM. The schedule of lectures and discussions (with pre and post MKSAP questions) is based on 120 top topics and repeated every 18 months. Some conferences will be given by residents.
    - ❖ Research Conference (Noon First Thursday of each month) Departmental and Resident Research
    - ❖ Medicine Grand Rounds: every Tuesday at 1200PM in the Small Auditorium BC-140. Topics of current general interest to internists by faculty and guest speakers.
    - ❖ Acute Care Lecture Series (Noon M,W,Th,F) July-August : Acute Medical Problems Presentations
    - ❖ Interdisciplinary Conference: (Wed Noon): Medical Ethics, Practice Management, Health Care Evaluation, Information Mastery, Interdisciplinary Medicine)
    - ❖ Clinical Pathologic Conference twice a year
    - ❖ Housestaff Administrative Meeting and Periodic Examinations (Last Fridays of each block)
    - ❖ Morbidity/Mortality/Improvement Conference (last Thursday of each block) – a blame-free environment to review unexpected outcomes or near misses with a focus on root cause analysis.
    - ❖ PGY-2 Leadership Seminar (At beginning PGY-2 year): Discussion and role play of major issues of leadership, teaching, time management, feedback and evaluation.
- Board Review: board review has evolved into a continual process over the course of the academic year. The overall curriculum is based directly off the ABIM core topics and as such follow our block curriculum. Our noon conference didactics, Harrison's Reading Club assignments and MKSAP review will all mirror this curriculum for consistency and reinforcement.
  - Subspecialty conferences: Residents pursuing a specific subspecialty are encouraged to attend subspecialty conferences held outside of core conferences noted above.

## SPECIAL EDUCATIONAL EXPERIENCE

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Special educational experiences further supplement and broaden the competencies of the resident by providing a frame of reference and view of the practice of medicine. These include required and optional/encouraged experiences listed below:

### Required

- Clinical Evaluation Exercise (CEX): Bedside evaluation of diagnostic and decision making skills of the resident. Four of these mini-CEX are to be performed in the PGY-1 year.
- Annual ACP Inservice Examination held for each categorical resident early in the Academic Year. Performance is evaluated by the Program Director with feedback on areas for improvement based on ABIM core topics.

## SCHOLASTIC REQUIREMENTS

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Residents are expected to complete the following scholastic requirements for the rotations noted below:

- All residents, all rotations: All residents will submit monthly reports of adverse drug reactions, report all “near misses” through the Patient Safety Net (PSN) variance report entry on [paws.gru.edu](http://paws.gru.edu). All residents will participate in Quality Improvement projects throughout their time in training including but not limited to their Quality Improvement rotation.
- PGY 2 and PGY 3 residents will participate in the Harrison’s Curriculum and complete directed readings of Harrison’s Essentials of Internal Medicine. This is available online through Access Medicine on Library webpage. PGY2 residents will also receive self-evaluation Q&A books
- All categorical PGY1 residents will receive and are expected to read The Washington Manual of Medical Therapeutics.
- Practice Profile: Residents will participate in performance monitoring of their continuity clinic. The resident will also describe all activities considered and actions undertaken to improve his or her outcomes.
- Research elective: residents are encouraged to participate in a research elective and afterward are required to present at the Rahn Peacock Research Day to showcase their work.

The residents each have the following scholastic requirements for use in the didactic curriculum: Copies of these products must be submitted to the resident personal file for credit to be annotated.

### PGY-2

- Completion of at least one Evidence-based Medicine Conference (also called “Resident Report”) according to prescribed format with grading and entry into portfolio.

- Completion of at least one approved Journal Club presentation under the supervision of a faculty member in the subject area of the topic chosen.

### PGY-3

- Preparation of a board review topic with handout during May/June of PGY3 year. Topic is assigned by Program Director based on In-Service Exam scores
- Completion of at least one Evidence-based Medicine Conference presentation according to prescribed format with grading and entry into portfolio.

## RESIDENT EVALUATION AND PROMOTION

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### RESIDENT COMPETENCY

Resident competency will be evaluated and documented semiannually by the Residency Clinical Competency Committee according to the methods outlined in the GRU Internal Medicine Residency Curriculum. Residents are expected to be familiar with this policy and program.

### ADVISOR PROGRAM

Each resident is assigned a faculty advisor who will be his or her primary mentor and advisor for the length of the residency. Advisors will meet the resident at least 2 times per year and assist the resident in completing all requirements including rotations, procedures, completion of required scholastic papers, research paper and administrative and professional requirements.

### COMPETENCY EVALUATION TOOLS

- ❖ Monthly One 45 Summary Evaluation: Residents are expected to discuss their evaluation with their attending physician at mid-month informally and at the end of the rotation before leaving the service.
- ❖ Direct Observation by attendings, program director, chief residents at Afternoon Report, conferences, and in working on wards (Patient care, communication, PBL, SBP)
- ❖ 360 degree evaluation by nurses, students, others performed at least semiannually by nurses, monthly on One 45 by residents (patient care, professionalism, Institute of Medicine quality aims, Practice Based Learning)
- ❖ Formal written examinations: EKG, ACP Inservice, and ad hoc exams as determined by the program director (Medical Knowledge)
- ❖ Chart Reviews: Admission notes, progress notes, and dictations are formally reviewed and graded by the program director (inpatient) and clinic attending (outpatient).
- ❖ Patient satisfaction surveys/Complaints (Professionalism) are performed in continuity clinics and wards and placed in portfolio after review by the program director.

- ❖ Procedure Documentation log (Patient care, PBL). Residents are expected to complete approximately 50% of ABIM recommended internal medicine procedures by the end of PGY-1 and all of recommended procedures by the end of PGY-2 year in order to advance. These procedures will be documented in One45 and the ABIM procedure log book provided each resident.
- ❖ Self-assessment instrument will be completed twice yearly by residents and discussed with advisors/program director (All competencies and IOM quality aims).
- ❖ Validated reflective thinking on case vignettes (case conferences, Morbidity and Mortality conference) (Medical Knowledge, PBL)
- ❖ Critique of written and oral communication by peers and faculty, particularly of noon conference presentation. (Medical Knowledge, Communication)

Permanent records of evaluations, report cards, and counseling are maintained in a Resident Portfolio in the Residency Program Office. It is the responsibility of the resident to review his or her own record frequently.

## **CRITERIA FOR ADVANCEMENT OF RESIDENTS**

Residents are evaluated continuously by advisors, the program directors, and biannually by the Resident Clinical Competency Committee (CCC) according to standards set forth by the ACGME.

Residents will be scored for each set of milestone competencies and must achieve a cumulative score listed below for each milestone in each of the 6 competencies before graduation to the next PGY level and are promoted and graduated by committee vote based on achievement of milestones noted above. The scores are:

PGY 1: Level 2  
 PGY 2: Level 3  
 PGY 3: Level 4

Successful completion of individual rotations is based on the attending evaluation (One45), mid-month counseling, and specific behaviors and activities during the rotation, as judged by the CCC under due process to include documentation of prior expectations (goals and objectives of performance), resident knowledge of potential deficiencies, and impartial investigation of the facts. Rotations considered to be unsuccessful or failing will be remediated using standardized remediation plans mandated by the CCC.

The Program Director completes a semi-annual Resident Report Card outlining resident progress in completion of scholastic, procedural, and administrative requirements of the program, and summarizing scores in the 6 competencies obtained during rotations, chart review, and scholastic activities.

Residents are evaluated semiannually by the CCC based on completion of duty and quality of performance as measured using the evaluation tools listed above, as well as meeting of milestones listed in the Criteria for Advancement of Residents. The CCC vote determines promotion of each resident. The

program director completes an annual report on competency and progress to the American Board of Internal Medicine, documenting satisfactory completion of the academic year. After the PGY-3 year, the program director also recommends to the ABIM the suitability of the resident to sit for the ABIM certifying examination.

Each specific Rotation Curriculum can be found and reviewed on the House Staff website at <http://www.gru.edu/mcg/residents/internalmed/curriculum/index.php>

## **ACADEMIC REMEDIATION, PROBATION, AND DISMISSAL FROM THE PROGRAM**

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These are accomplished according to written policies of the Department and the Medical College of Georgia Graduate Medical Education Committee, in keeping with due process:

Residents will be counseled promptly for perceived deficiency in meeting milestones in any of the 6 core competencies. Such counseling will be performed by attending, advisor, chief resident, or program director as appropriate, and documented in the academic record of the resident. The following process will take place:

1. Attending or supervising resident will meet with and counsel resident with issue
2. Attending or supervising resident must submit in writing to Chief Residents and Program Director issues that need to be addressed via one45 evaluation system and email.

The program director may write specific letters of counseling, censure, or reprimand as he or she deems appropriated. Such letters will be reviewed by the CCC, which may vote to remove or sustain such information in the permanent academic record of the resident.

Residents may be placed on academic remediation or probation by the CCC in order to accomplish specific remediation of weaknesses. Standardized remediation plans and templates are used for this purpose with modification as required by the CCC. Such action should be viewed as an educational, not punitive action. Periods of remediation or probation are up to 3 months, with one 3 month period of extension if the CCC agrees that progress has been made. Residents on remediation or probation will be assigned a specific advisor to facilitate remediation and report on progress to the CCC. All records relating to probation will be a permanent part of the academic record.

Residents will be dismissed for blatant unprofessionalism, or failure to successfully complete remediation during probationary periods. All dismissals are subject to due process according to Department and GRU policies.

## **PROGRAM EVALUATION**

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The Program is evaluated by the following methods:

- ❖ Resident written evaluation of Attending's and the IM Program as a whole
- ❖ Post-graduate written inquiry (letter sent to graduates 9 months after)
- ❖ ABIM Certification in Internal Medicine Pass/Scores
- ❖ In-service Training Examination Scores
- ❖ Yearly Internal Review (by faculty and residents using formal questionnaires)
- ❖ Biannual External Review
- ❖ RRC Review
- ❖ Weekly housestaff/Chief Resident/Program Director Meetings
- ❖ Resident formal and informal input into the IM Program curriculum.

## ADVISOR MEETING WITH ADVISEE

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### EXPECTATIONS FOR THE MEETING

- ❖ Get to know your new advisee(s) at a personal level including professional goals with career advisement
- ❖ Review evaluation of rotations with advisee
- ❖ Bi-annual evaluations via the Residency Feedback Form
- ❖ Fill out the appropriate information on the Resident Performance Summary (The areas in black are the responsibility of the advisor, the areas in blue are the housestaff, and the red one is the program directors.) Please make sure that you review:
  - Certified procedures
  - Attendance to lectures
  - All rotation evaluations
- ❖ Keep track and review the attendance to lectures. Regarding the attendance to lectures these are the expectations:
  - Every housestaff officer is **expected to have a minimum of 60% attendance** to the required conferences. This is a requirement for promotion/graduation to the next level.
  - If the houseofficer (HO) has LESS than 60% of the expected attendance at your first meeting with them, this is considered the **first offense** and a formal citation will be placed in the HO's file. Document that you warned them and inform them of future consequences if violation of the expectation. The **second offense** of not meeting attendance expectation will result in a permanent citation placed in the HO's file and they will be brought up in Clinical Competency Committee. **The third offense** will result in the HO being evaluated for possible dismissal from the program.

- It is important that you inform your advisees of these issues in your first meeting and document this in his/her file. **Remember tracking data is extremely important and would avoid concerns with future problems.**
- ❖ Have the residents sign the forms, evaluations, and the summary of your encounter with them. If you notice that the evaluations of the advisee are sub-optimal (score less than 4 in the ABIM evaluation form done by faculty supervising the HO) or if you notice that there are some active problems with the advisee that concern you, contact Dr. Merchen (Program Director) or Dr. Carson (Chair of the Clinical Competency Committee) at your earliest convenience. Help will be provided for the houseofficer as soon as possible. We will help you in putting your advisee on the right track immediately. You must take leadership in helping your advisee and facilitate the process for remediation of probation. You must develop a plan and you must Drs. Merchen and Carson of your plan. If you deem necessary, please document the issue in the resident's file. It is the responsibility of the advisor to identify active issues on the advisee that need attention and/or remediation.

## **RESIDENT WORK HOURS AND WORK HOUR MONITORING**

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The Department of Medicine recognizes that education and patient care are integrally related. All graduate medical education programs have a responsibility to the resident to provide training in continuity of patient care. The Medicine Residency Training Program provides through its duty hours and call schedules an appropriate balance between patient care and teaching/training programs in an environment conducive to both resident education and patient care. This environment ensures wherever possible that undue stress and fatigue among residents is avoided.

The Department of Medicine fully supports the Resident Work/hours policy established by the ACGME with the following expectations:

- A maximum of 80 hours per week averaged over four weeks, inclusive of all in-house activities
- Continuous hours on duty are limited to 24 + 4 for residents above PGY1
- PGY1 will work no more than 16 hours continuously.
- Ten-hour period of rest and personal activities must be provided between all daily duty periods and after in-house call
- Houseofficers will be provided with one day in seven free from all educational and clinical responsibilities, averaged over a four-week period, inclusive of call. One day is defined as a continuous 24 hour period free from all clinical, educational and administrative duties
- Adequate back-up through resident physicians or supervising staff physicians will be available and utilized as needed to assure that patient care is not jeopardized by resident stress or fatigue.

Resident training is a full-time responsibility. It encompasses the formal curriculum, the individual learning opportunity through independent study time, and clinical exposure including the service component of patient care. It is GRU institutional policy (HS 16.0) that the program director must be informed and approve of activities outside the educational program (i.e. moonlighting). Written

permission for moonlighting must be obtained by the house officer from his/her program director with official notification of the GME Office of the moonlighting activity. Outside activities must not interfere with the resident's performance in the educational process defined in the agreement between the institution and the resident.

The facilities afforded the residents are there to ensure an appropriate environment for learning and providing patient care. This shall include food service capabilities during assigned duty hours and suitable on-call rooms suitable for each resident on night duty in the hospital.

## **PROCEDURE**

1. Residents will annotate time in, time out, and hours in the hospital for each day of service on all rotations including days off. Records will be kept of hours worked at both VA and GRU. If any time is spent elsewhere, it will be so indicated. In-house moonlight will be included, but not moonlighting out of either GRU or the VA.
2. Hours should be logged at least weekly.
3. Residents will receive oral and written counseling regarding violations of the 80 hour, 24+4, one day off in 7, ten hour rule or any other rules instituted by the RRC, OSHA, state, federal, or other credible authorities.
4. Residents with repeated violations of work hour rules will be prosecuted by the RPEC committee, with due consideration of programmatic, patient-care, and faculty contributions to the excess hours.

## **RESIDENT SUPERVISION**

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The Department of Medicine residency training program will provide for appropriate supervision for all residents. The attending physician has both an ethical and legal responsibility for the overall care of the individual patient and for the supervision of the resident involved in the patient's care.

The attending staff, based on direct observation and knowledge of each resident's skills and ability, must determine the level of responsibility according to each resident and this may vary with the clinical circumstances.

Supervision does not imply constant observation. Faculty schedules must be structured so that they are immediately available for consultation and support. Constructive criticism and praise for excellence are important elements of supervision and serve to highlight areas believed by the teaching staff to be important.

Evidence of resident supervision must be documented in the form of signed notes in patients' charts and other records such as an indication of the level of attending presence in procedure notes.

Sub optimal clinical, academic, or personal performance will be met with appropriate counseling, the development of remedial programs, or other measures designed to assist each resident in achieving the goals and objectives of the Department of Medicine residency program.

Faculty and residents must be educated to recognize the signs of fatigue and adopt and apply policies to prevent and counteract the potential negative effects of fatigue.

## **RESIDENT ADMINISTRATIVE REQUIREMENTS**

### **GENERAL ADMINISTRATIVE REQUIREMENTS**

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#### **PERFORMANCE OF DUTY**

Residents are expected to be prompt and dutiful in assumption of all patient care and administrative duties. Residents are expected to know, understand and abide by the Department Policy on Professionalism. Residents on wards are expected to arrive in time to conduct personal “pre-rounds” on their patients (PGY-1 on all patients, PGY2/3 on almost all patients), to be completed by 0900. At 0900 each team is expected to begin work rounds as a team, visiting each patient expeditiously, and discharging all appropriate patients in order to clear beds by 1100.

#### **DICTATION OF CHARTS**

Interns/Residents are expected to dictate charts of patients prior to or at the time of discharge. Death charts are the responsibility of the intern/resident who was primarily taking care of the patient. However, it is the intern’s responsibility to fill out the death paperwork at the time of the patient death. MICU and Cardiology-CCU patients will be dictated only by PGY2 or PGY3 residents during July and August to ensure quality of the dictation.

#### **INCOMPLETE AND DELINQUENT RECORDS**

Residents are expected to check their inboxes weekly to verify they have no dictations or signatures to complete. Delinquent records may result in withholding of paycheck, additional back-up call duty, letter of reprimand added permanently to your personnel file, and/or temporary suspension pending CCC review. All records must be up-to-date with none older than 7 days.

#### **USMLE 3 EXAMINATION**

Residents will successfully complete USMLE/COMLEX 3 by the end of their PGY 1 year. This is a requirement for promotion to the PGY 2 level.

## **REQUIRED PROCEDURES**

At the end of training, as part of the evaluation required for admission to the Certification Examination in Internal Medicine, program directors must attest to each resident's knowledge and competency to perform the following procedures. To assure adequate knowledge and understanding of the common procedures in internal medicine, each resident should be an active participant for each procedure five or more times.

Residents must have documented successful performance of their procedures in their One45 portfolio and logbook with annotation by an attending that the procedure was appropriately considered and accomplished. In order to complete the PGY-3 year, the complete number of procedures must be successfully completed and documented.

- Central Venous Line
- Naso-gastric Intubation
- Thoracentesis
- Arterial Puncture: Arterial line
- IV Insertion
- PAP smear
- Venapuncture
- Arthrocentesis
- Lumbar Puncture
- Paracentesis

## **CONFERENCE/LECTURES ATTENDANCE POLICY**

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Attendance must be a minimum of 60% total:

- Grand Rounds (Tuesday's at noon)
- Internal Medicine Afternoon Report (Weekdays at 3pm)
- Noon Conferences
- Journal Clubs
- IRCC (Wednesday's at noon)
- Dainer's Unknown
- Morbidity and Mortality
- Morning Report

Attendance by trainees is calculated based on the total number of available conferences during the year. Attend will be calculated by the chart below:

Rotation	Morning Report	Noon Conference	Afternoon Report
Inpatient	EXCUSED	REQUIRED	REQUIRED
Outpatient	REQUIRED	REQUIRED	EXCUSED

The IM Housestaff office will calculate conference attendance monthly, and the percent attendance by residents for that month and the year to date for each individual conferences and individual feedback will be provided via email or direct contact.

On December 1 of each year, the cumulative attendance for the first 5 months will be reviewed. Housestaff below 60% will each have an additional 3 days back-up call assigned in the ensuing 6 months. Any resident not at 100% for AM report during Ambulatory block and resident will receive Saturday night crossover.

On June 1 of each year, PGY-2 and categorical PGY-1 attendance for the previous 6 months will be reviewed. Housestaff below 60% will each have an additional 3 days back-up call assigned in the ensuing 6 months. Any resident not at 100% for AM report during Ambulatory block and resident will receive Saturday night crossover.

On June 30 of each year, PGY-3 and preliminary PGY-1 cumulative attendance for their entire time in the program will be reviewed. They will be required to make up additional conferences to meet the required 60% in the next academic year prior to receiving certificates for completion of residency or internship, respectively.

## **DICTATIONS AND MEDICAL RECORDS**

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Proper discharge planning, including the timely completion of dictations, is a crucial step in attaining our goals for quality patient care. Dictated narrative summaries should be timely, accurate, and concise.

Dictated narrative summaries are also important in attaining the competencies for Practice-based Learning & Improvement (#3), Professionalism (#5) and System-based Practice (#6), and will affect your evaluation in these areas. Continual refining of your knowledge, skills, and habits in this part of your “real world” training will enhance your work ethic, effectiveness, and professionalism as a physician. It will also help you to develop administrative and leadership skills that will be of value to you in every facet of your life.

In order to help all of us achieve these goals, review the following policies and procedures.

## **PROCEDURE**

- The House Officer who discharges/transfers a patient is responsible for the discharge dictation. This may either be a PGY1, PGY2, or PGY3. These dictations should be done at the time of discharge. During high volume rotations/months PGY2 & 3 residents will assist the interns with dictations so that they are completed in a timely manner. Residents, use common courtesy- if a patient is being discharged on your intern's day off, please dictate the discharge. Students are **NOT** allowed to dictate discharge or death summaries.
- Death dictations should be completed by the intern primarily taking care of the patient. If a patient expires overnight or on the weekend when either the NF intern or cross-cover on-call intern is temporarily taking care of the patient, the death dictation will be the responsibility of the intern primarily taking care of the patient. The dictation should be completed the following morning when the primary intern arrives at work. Death dictations are not the responsibility of the NF or cross-cover intern. However, the NF or cross-cover intern is responsible for the death packet paperwork. Deaths that occur under the initial care of the NF resident prior to the primary team accepting the patient will be the responsibility of the NF resident who admitted the patient since this is the only resident who has evaluated the patient.
- Patients who are being discharged to nursing homes or assisted care facilities usually require a STAT discharge summary to be faxed prior to transfer. This is to be done the day prior to discharge, and then adding an addendum on the day of discharge to facilitate a timely transfer.
- All patients that leave AMA (against medical advice) must be dictated regardless of their hospital length of stay.
- By the 6<sup>th</sup> of every month, the Chief Medical Resident (CMR) will be notified by both the GRU and VA medical records department of any outstanding dictations. The CMR will then email each house officer on the list and let them know of their delinquencies. If dictations are not completed by the end of the month, disciplinary actions will be taken.
- Complicated patients extending over the end of a calendar month or transferred to another unit or service should have an interim narrative dictated.
- Delay in dictations will have the following consequences:
 

Failure to fulfill the requirements of this policy affects competency in #3 (Practice-based learning and improvement), #5 (Professionalism) and #6 (System-based practice) as mentioned above. Therefore, the following disciplinary action will be taken.

  - First failure to fulfill the requirements: a warning letter added to your personnel file
  - Second failure to fulfill the requirements: a letter of reprimand added to your personnel file permanently.
  - Third failure to fulfill the requirements: probation for unprofessional behavior
  - Fourth failure: consideration for non-renewal of contract

In addition to providing exemplary patient care, the payoffs for investing a minimal amount of time needed to following these procedures will be a well-coordinated and efficient Team and a reduction in

time-draining administrative headaches. You will develop self-discipline, hone your leadership skills, and earn the respect of both your mentors and your peers.

## DISCHARGE/DEATH NARRATIVE SUMMARY OUTLINE EXAMPLE

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**Admit Date:**

**Discharge Date:**

**Attending Physician:** (Attending of record at time of discharge)

**Primary Care Physician and Address:** If unknown, state unknown

**Source of Admission:** (e.g. GRU ER, direct admit from another, specified ER, HemOnc Clinic, etc).

**Reason for Admission:** (Age, Gender, admitted for evaluation/management of Altered mental status, vomiting, abdominal pain, dyspnea, wheezing, mass, etc)

**History of Illness:** (When did disease causing illness start? What is current stage? If previously admitted state condition at last discharge, including appropriate clinical parameter such as PFT, ABG, Weight, CD4, Mental Status. Describe patient's course leading to admission, emphasizing clinical symptoms and signs with full description of functional status, what medicines were used as outpatient for this illness, and how compliant patient was with therapy, and pertinent positives/negatives in the review of systems)

**Medications:** (Patient's medication list on admission)

**Past History:** (List key continuing medical diagnoses, to include stage; surgeries, psychiatric diagnoses, allergies, advanced directives).

**Physical Exam:** (Admission vital signs, weight, general appearance, mental status exam, and findings, negative and positive to reason for admission and outcome)

**Pertinent Laboratory:** (Key laboratory only pertinent to discharge diagnoses)

(List all x-ray tests performed chronologically, with results)

(List all positive microbiology results by date)

(List all pathology/cytology/genomic results by date)

(All lab test results pending at discharge should be stated as such-along with who is to follow up these tests)

**Hospital Course:** (Summarize briefly each of the following:

- a. Location and categories of care given: (e.g ward 5W acute diagnostic and therapeutic, MICU intensive/resuscitative care, 6S palliative care)



- b. Diagnostic Interventions
- c. Therapeutic Interventions
- d. Complications and Medical Errors
- e. Outcome and condition at discharge (Include objective and subjective measures, such as discharge peak flow, ABG, weight, ADI, MMSE, et.)
- f. Time and manner of death: State if and when patient made DNR, palliative or terminal care given, ACLS performed, autopsy/organ donation request and family reasons if not accepting).

**Prognosis:** (Life expectancy, functional prognosis, etc)

**Disposition:**

- a. Where discharged to such as home, nursing home, home health, hospice, rehabilitation center, community psychiatry, morgue;
- b. Who (by name) is responsible for care such as self, specific family member, primary care physician, rehab center, nursing home
- c. When patient is to be followed up by primary care physician (by name); other specialty appointments, referrals
- d. What patient or family is to do if they have problems

**Immunizations Administered:** (pneumococcus, influenza, immune globulin, others)

**Consultations:** (List chronologically, name of consultant, service)

**Procedures:**(List all procedures in chronological order)

**Discharge Diagnoses:** (Use ICD-9 Code with physiological status as appropriate, with first diagnosis being the diagnosis prompting admission; all diagnoses bearing on course and outcome should be listed, especially psychiatric diagnoses such as personality disorders, depression, etc)

**Discharge Medications:** (Complete list of discharge medications including full name, dose, frequency, and duration that exactly matches the list of medications after discharge medication reconciliation)

**Discharge Instructions:**

- a. Medicines
- b. Diet
- c. Activity (include smoking, drinking, exercise)

**Who should get this narrative:** (primary physician, referring physician, consultants to be following patient, nursing home, home health agency, etc.)

## CLINIC POLICY

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*Please see Resident Clinic Handbook for in depth detail*

During ambulatory blocks, you will be assigned Monday/Thursday or Tuesday/Friday clinics (all day clinics). On the other days of the work week, the resident will be expected to attend his/her s(elective). Prior to each ambulatory block, each resident will receive e-mail notification from an office specialist in the housestaff office with detailed information about your s(elective) schedule. The housestaff office expects 100% attendance at the AM conference on clinics days. Attendance is mandatory. If you cannot make it, you must inform the housestaff office and the medical chief residents.

Intern Orientation for GRU Clinics: First day of each clinic for each cohort (A/B/C)

All categorical residents will have two full days of continuity clinic per week during their ambulatory blocks.

Each clinic will begin with at 7:45am with a 30 minute case-based didactic session with the attending physician on a topic in ambulatory general internal medicine based on the Outpatient Yale Curriculum. The first patient appointment will be scheduled at 8:20am and 1:00pm for morning and afternoon clinics, respectively, to allow time for the clinic conference. **Residents are expected to arrive in clinic on time for the clinic conference.**

The patient panel consists of adult patients in a primary care setting followed longitudinally. The residents are the primary care physicians for this group of patients.

Residents are expected to arrive promptly to begin patient care. The nursing staff will obtain vital signs and place patients in assigned rooms. Residents are expected to evaluate the patient with a full H&P if are seeing them for the first time as a transfer of care from a previous provider, even if they are an existing patient in the clinic. Follow-up patients require a focused practice site note, including a review of their medication list with completion of medication reconciliation process.

After seeing the patient, the resident will discuss the patient and his/her problem list with the assigned attending physician. The attending is required to see all patients new to the clinic, as well as any who are acutely ill or have active issues. The attending physician will also see ALL intern patients for the first 6 months of training.

If you miss continuity clinic for ANY unapproved or unscheduled reason, you are required to make that clinic up at a later time – NO EXCEPTIONS. This is a requirement by the Internal Medicine ACGME guidelines, and there will be no exceptions. If the absence is planned and APPROVED, you are responsible for your own coverage. Notify the Chief Residents and the Housestaff Office.

**FOR ALL RESIDENTS WITH CLINICS AT GRU**

Must check your inbox daily while on ambulatory and address any issues as necessary. When on inpatient block, your firm will cover. If you have a question on what to do, contact your attending.

For residents currently on vacation, MICU/CCU, and night float: the Q/I resident and firm will handle all inbox messages and patient care related issues.

ALL clinic notes must have legible and complete list of CURRENT medications. This is not only helpful for you in staying organized and updated on your patients medications, but also for your proxy when covering and posed with medication questions as well as the admitting team in hospital who will be referencing your notes.

All PGY2 and PGY3 residents on elective and selective are required to attend additional Friday afternoon or morning clinic respectively. The clinic will have patients scheduled for you to see as this is an additional continuity clinic for you...this is not an acute care clinic or walk in clinic!

In summary, categoricals will have 2 full days of clinic, per week, every ambulatory block.

In summar, prelims will have 1 full day of clinic, per week, every ambulatory block.

Residents are expected to arrive to clinic at 7:45 a.m. every morning. After 3 tardies you will receive Saturday night intern crosscover. Chronic repeat offenders will receive extra back up and a repeat of Saturday night cross cover.

The continuity care experience at Christ Community Clinic has similar requirements and protocols.

## INPATIENT EXPECTATIONS

### NIGHT MEDICINE

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#### INTERN NIGHT FLOAT

- An intern will be assigned to night float duty both at GRU and at the VA for at least a two week rotation.
- Interns are expected to work every day for their assigned night rotation from 7pm to 7am, with the exception of Saturdays:
  - At GRU on Saturday, the intern on first back-up will work the GRU night float shift from 7pm to 7am.
  - At the VA on Saturday, the on-call VA night float resident will cross-cover the floor patients in addition to handling new admissions from 7pm to 7am.

- Duties will consist of:
  - Receiving check-out and maintaining cross-coverage responsibility of the ward services' cohort for their respective hospital (GRU: Transplant, Blue, Green, Orange and Red. VA: Blue, Gold and Yellow)
  - Handling acute issues on patients
    - In the event of an acute event, the intern is expected to write a brief note summarizing it and updating the assessment and plan
    - In the event of critical patient deterioration necessitating transfer to the ICU, the cross-covering intern is expected to write a transfer note that will summarize the hospital stay as well as the acute events preceding transfer.
    - Any changes in patient status should be conveyed to the primary attending for that team.
  - When appropriate, handling medication issues or talking to family, etc.
  - Responding to Rapid Response calls and Code Blues
  - Communicating and discussing with the supervising senior resident regarding any urgent medical issues or any concerns in patient care
  - Interns will be expected to hand-off patients utilizing a standardized format (I-PASS). Hand-off will be periodically evaluated.
  - Intern responsibilities do not include admissions and consults

## **NIGHT FLOAT TEAM**

- Night float team will be comprised of 5 medical residents (PGY2 and PGY3) who will rotate night duties throughout their assigned block.
  - The areas of coverage will include: GRU Night Float resident, VA Night Float resident, GRU Utility Float resident and VA Utility Float resident
  - The exception to this will be for blocks 2 (7/25/15 through 8/21/15) where there will be 6 assigned residents due to the presence of a Night Help resident.
- Each resident will receive ONE day off before rotating to a new area of responsibility on the Night Float team.

## **GRU AND VA NIGHT FLOAT RESIDENT (NIGHT FLOAT TEAM)**

- Duties will consist of:
  - Admitting new patients overnight for hematology-oncology, nephrology and general medicine patients. Patients will be admitted either from the emergency room or as direct admissions/accepted transfers.

- At the VA this may also include neurology patients as they lack an inpatient service.
- Supervising and advising the cross-covering night float intern
- Assisting in any procedures that need to be performed
- Assisting the Utility Float Residents as needed
- While at GRU, assisting the MICU resident and fellow with admissions as needed
- Responding to any Code Blue. Interns are expected to be the primary responders to rapid response calls, however the resident should also respond if available or if the intern requests their assistance
- GRU Utility Float will cover between GRU MICU and GRU CCU. Day team will provide coverage when no utility resident is available.
- VA Utility Float will cover CCU and MICU.
- Night float residents are assigned shifts from 7pm to 7am the next morning.
  - Admissions by the overnight resident stop at 7am. The following period is to be dedicated to quality check-out and review of overnight events as well as bedside teaching by the attending physicians
- Housestaff are expected to discuss new admissions or critically-ill patients with the on-call attending. Overnight this is expected to occur via phone. In the mornings after the call day is ended, the overnight resident and the attending(s) of record are expected to meet and review overnight admissions to their respective services.
  - Specialty service patients (hematology-oncology and transplant) will need to be discussed with the on-call fellow for that respective service at time of admission
- The night float resident is allowed to admit up to 10 admissions total for their overnight duty.
  - Overflow admissions after 10 may be done with assistance by the Utility Float resident if available.
  - In the event of the night float resident reaching the cap on new admissions and lack of available help in-house, the back-up resident will be activated for additional assistance

## **GRU NIGHT FLOAT RESIDENT SPECIFICS**

- Subject to the general rules of night float as detailed above
- Residents will admit to the hematology-oncology service (Blue Medicine), transplant service (Yellow Medicine), and the inpatient medicine ward services (Red, Orange and Green)
- Ensure that all admissions are not Family Medicine patients (they have their own inpatient service) or a readmission to another service such as the Hospitalists.
  - The window for readmissions is that same block and it resets when a new block begins. For example, if a patient was discharged from Green Medicine in Block 2 and was due to

be admitted back to the hospital on the first day of Block 3, the patient would go to the on-call team for that day and would NOT be a readmission.

- At GRU, the night float resident is expected to work from 7pm to 7am. The resident will be on-call for hematology-oncology, transplant and continuity patients for the entire night regardless of call days.
- The Inpatient Hospitalist will admit all non-continuity general medicine admissions from 7pm to 1am every day.

## MEDICINE CALL DAYS

- The night float resident will be on-call for hematology-oncology, transplant and medicine continuity admissions all night.
- The Inpatient Hospitalist will admit all non-continuity general medicine admissions from 7pm to 1am every day.
- From 1am to 7am the night float resident will be on-call for general medicine admissions. Admissions (continuity patients and general medicine) will count towards day team's admissions (up to 10 new patients + 2 ICU transfers).
  - The night float resident will have a cap of FOUR (4) new general medicine patients (including continuity) during this 1am to 7am time period. Any general medicine admissions in excess of this will roll back to the hospitalists (excluding continuity patients and bouncebacks)
- If the previous day team reaches their census cap or caps on new admissions, any further continuity patients should roll to the next day call team.

## HOSPITALIST CALL DAYS

- The night float resident will be on-call for hematology-oncology, transplant and medicine continuity admissions all night.
- The Medicine team receiving continuity and general medicine patients will be designated on the schedule as the continuity call team and is alternated every 4th day.
- The Inpatient Hospitalist will admit all non-continuity general medicine admissions from 7pm to 1am every day.
- The Continuity Call team has a total cap of 4 new patients for that 24 hour period.
- From 1am to 7am the night float resident will be on-call for general medicine admissions.
  - **The night float resident will have a cap of FOUR (4) new general medicine patients (including continuity) during this 1am to 7am period.** Any general medicine admissions in excess of this will roll back to the hospitalists (excluding continuity patients and bouncebacks)

- If the continuity call team caps at their limit of 4 patients, any further admissions will roll over to the Red Medicine team and count towards their next call-day.
  - Example: Orange is on continuity-call and receives 2 continuity admissions before 7PM. The night float resident receives 1 continuity admission before 1am and then 2 general medicine admissions at 2am.
  - Orange Medicine caps at 4 admissions and Red Medicine will have 1 general medicine admission as a roll-over to start their call day.
  - Any further admissions would go to Red Medicine.

## **OVERNIGHT CONSULTS**

Any overnight medicine consults may be done by the night float resident if they are available; prudence will dictate that a non-urgent consult may be seen by the day team if needed. Consults will be staffed by the Orange attending, and should be added to the Orange team list for follow up through the weekends. Otherwise they can be deferred until the morning for the consult resident at checkout.

## **VA NIGHT FLOAT RESIDENT SPECIFICS**

- Subject to the general rules of night float as detailed above
- Residents will admit to the inpatient medicine ward services (Blue, Gold and Yellow)
- At the VA, the night float resident will admit patients up to the on-call team's cap (10+2) or 20 total for a team. Admissions after this will go towards the next day's call team's census.
- The VA night float resident will be responsible for cross-coverage of the inpatient ward services on Saturdays in addition to their admission duties
- Responding to Code Blues and rapid response calls
- Responsible for VA consults staffed by the on-call teaching attending

## **VA UTILITY FLOAT RESIDENT**

- Duties will consist of:
  - Receiving check-out and maintaining cross-coverage responsibility for the Cardiology and MICU services' cohorts at the VA
  - Performing overnight admissions/transfers to the Cardiology and MICU services that have been accepted by the on-call fellows or attending's.
  - Performing any needed procedures
  - Responding to Code Blues and rapid response calls
- Utility float residents are assigned shifts from 7pm to 7am the next morning

- Admissions by the overnight resident stop at 7am. The last hour is to be dedicated to quality check-out and review of overnight events as well as bedside teaching by the attending physicians
- New admissions or urgent issues need to be discussed with the on-call fellow for the respective service, or the attending if needed.

## GRU UTILITY FLOAT

- Duties will consist of:
  - Receiving check-out and maintaining cross-coverage responsibility for the cardiology service's cohort of patients when on cardiology and for the MICU services cohort of patients when on MICU.
  - Performing overnight admissions/transfers to the Cardiology or MICU service that have been accepted by the on-call fellow or attending
  - Perform any needed procedures
  - The GRU utility float resident will also be expected to provide assistance with admissions to the CCU or MICU resident when they have received in excess of 5 admissions or have multiple pending admissions.
- Utility float residents are assigned shifts from 7pm to 7am the next morning when on Cardiology
  - Admissions by the overnight resident stop at 7am. The last hour is to be dedicated to quality check-out and review of overnight events as well as bedside teaching by the attending physicians
  - When on MICU cover 7pm – 7am
- After the overnight call has ended, the Utility Float will be expected to check-out their new admissions to the MICU and Cardiology daytime teams. In the morning after the call day is ended, the overnight resident and the attending(s) of record are expected to meet and review overnight admissions to their respective services.

**Concerns or issues with night duties should be brought to the attention of the chiefs or house-staff office and Program Director immediately.**

## GRU MEDICINE WARD/UNIT DAYS OFF POLICY

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The Department of Medicine residency training program GRU Medicine Ward/Unit Days off policy states:

- Every resident physician should get 4 days off per month (on average 1 day / week)
- The resident cannot take off on any call or clinic day. Residents are encouraged to take off weekend days.



- Interns cannot take off on any call day.
- Being off two days in a row should be clearly communicated to and approved by the attending on service and the chief resident in advance.
- Interns may not take off the last two days of the rotation without prior approval from the resident taking over the service and the chief resident. This is for patient care and continuity.
- For inpatient medicine wards, call starts at 0700 and finishes at 1900.
- Leave / Sick Days: no later than 7:30 am on the morning of the absence, the resident is to call the housestaff office (721-2423) and send an email indicating the following: name, rotation, attending, clinic day, and a phone number where you can be reached. The chief resident should also be notified of your absence as soon as possible so they can arrange coverage. A note from your physician must accompany leave beyond 48 hours due to illness. On the weekend, you should notify the Chief Resident as soon as possible! Please see Leave/Sick Policy and Back-up policy for further details.
- Residents may work up to 80 hours a week (7 day period) averaged over a 4-week period. Residents working over 80 hours on average need to let the chief residents and Program Director know immediately.
- Work hours are logged in One45. If anyone on any of the teams is in danger of violating work hour rules, the chief resident must be notified immediately.
- If you are in danger of going over the work hour limits, please report it immediately so that you can be relieved of duties and coverage can be contacted. Housestaff Admin in BI-5070 or call 721-2423.
- Interns start the Monday of each block and residents start the Saturday before each block

## SPECIAL CIRCUMSTANCES

- Please fill out Death Certificates as completely as possible. Please remember that Cardio-pulmonary arrest is **NOT** a cause of death. Be as specific as possible. Only address the highlighted areas on the death certificates. Remember that interns need guidance and assistance with every aspect of a patient's death for the first three blocks of the academic year.
- DNR orders must be signed by the attending within 24 hours.
- Please write a procedure note for every procedure, even if the procedure was not successful. Proper attending/fellow supervision is required on all procedures performed.
- Procedures are documented in the One45 system, with documentation of supervising attending and any comments for complications noted.
- TPN orders must be renewed daily by noon.
- Restraint orders must be renewed daily, please sign the stamp on the doctor's order sheet and document reason for restraints. This should be done by noon everyday.

- Physicians are responsible for obtaining consent for all procedures and transfusions. If there is a chance that a patient may require a transfusion after hours, then the primary team should obtain consent- this is not the night float intern's responsibility.
- Please fill out the medication reconciliation form within 24 hours of admission or transfers at both the VA and GRU.
- All Blue and Yellow medicine patients that are admitted must be checked out to the on call fellow for that perspective service, this includes nights and weekends.
- All patients >65 years old, admitted for hip fracture are to be admitted to Medicine. Comprehensive care, including pre-op risk stratification will be provided. Ortho will be the consultative service.

## **READMISSIONS**

- Any patient that is discharged from a service and re-admitted during the same block with similar presenting concerns will be re-admitted to the service that they were discharged from.
- Any patient who leaves AMA and gets re-admitted to the hospital during the same block will be readmitted to the team they were on previously.

## **CODE 99**

- The code team consists of the on-call medicine resident, one of the on-call medicine interns, and either the CCU or ICU on-call resident. Code pagers will be issued to these residents and need to be transferred to the appropriate house staff on a daily basis.

## **CHECKOUT**

- Interns are responsible for checking out all inpatients to the on-call or night float interns.
- If an intern is off, the resident is responsible for checking out the interns' patients.
- Do not check out critical radiographic data.
- Do not leave until all patients are stable.
- Renew fluids, restraints, etc during the day- this is not the night float intern's responsibility.
- Check out list can be found on the shared drive after logging onto citrix. Go to the medicine housestaff folder, and click on it. Find the team that you are on and pick either intern A or intern B and enter in the appropriate data. Before closing out save your data. You can also print this list to give to the on-call or night float intern.

## **TRANSFERS FROM THE MICU**

- When a patient is ready to be transferred out of the MICU, the intern or resident from the MICU team will contact the on-call medicine resident who will be accepting the patient.
- The MICU intern or resident is responsible for the transfer note and modifying micu to floor orders. A daily progress note is not sufficient as a transfer note. It is the responsibility of the accepting team to review the orders and place the transfer order.
- There is no time cut-off for transfers. You must accept the patient at any time (unless there has been a clinical change since the decision to transfer).
- Patients should not come out to the floor, without official acceptance by the appropriate team.
- If a patient needs to be transferred out of the MICU at night, the night float resident will accept the patient and check out the patient to the appropriate team in the morning.

## GRU - WARDS/MICU/CCU

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### WARDS

- ❖ Back-up resident is available every night when needed, but the unit float or moonlighting resident should be called first. Chief Medical Resident should be notified of the need to activate back-up.
- ❖ Back-up intern is available if an intern is sick and one is absolutely necessary for the team to survive a night call.
- ❖ 10 plus 1 patient cap per intern, sub-interns are allowed to have up to 4 patients.
- ❖ Interns **MUST** write an H/P on every new patient. Use the General Admission H&P template in Powerchart. Charts will be reviewed.
- ❖ Resident **MUST** enter a note for every new patient that they admit – focus on HPI, DDx, assessment and plan. Resident must write a full H&P on all sub-I admissions. Discuss—not being practiced
- ❖ All admissions/transfers require the electronic Medication Reconciliation to be filled out within 24 hours.
- ❖ Interns should also write a daily progress note. When an intern is off, the resident will write daily progress notes on this intern's patients. **Don't let COPY AND PASTE propagate inaccurate documentation.** Resident will write daily progress note on sub-I patients daily. When resident is off, interns will assume responsibility for sub-I patients including daily notes.
- ❖ Discharge summaries are required at the time of discharge. Resident – if your intern is off, then you are responsible for the discharge summary.
- ❖ Off-service notes are required on every patient at the end of the month, unless the patient has been in house < 3 days.
- ❖ Count your work hours. Do not work more than an 80 hr/week (average), but **DO NOT** check out when a patient is unstable and may require a transfer to ICU.

- ❖ Remember to check out your patients to a covering intern. Residents check out for interns when they are off. Include allergies, detailed medication list, and code status on all checkout sheets.
- ❖ You are required to forward your pager to the covering physician when you leave (after 5 PM on weekdays). NEVER make your pager “unavailable”.
- ❖ Do NOT leave until all of your patients are stable.
- ❖ Do NOT check out critical radiographic data. You may give the radiologist your beeper number and go home, but only if it is a non-emergent procedure.
- ❖ Do NOT check out patients who are undergoing procedures (endoscopy, bronchoscopy, etc.). You must be available to discuss results and complications with patients and families.
- ❖ Consults are called only by interns or residents. Call as early as possible, and complete the paper forms or Powerchart orders as indicated.
- ❖ Even if you have completed your daily routine early, do not check out before 4PM on a weekday. Spend your free time on teaching. Do not forward beepers until 5PM.
- ❖ A resident must be present in-house at all times to cover Code 99. This is the responsibility of the long-call resident unless they specifically make arrangements with MICU resident or other residents for coverage.
- ❖ Residents pre-round with their team prior to rounding with an attending physician.
- ❖ Rounds with attending are to be 9-11AM on Monday – Friday.
- ❖ It is one of our primary responsibilities to teach medical students and other residents. Set a goal to teach them at least 5-10 minutes a day.
- ❖ Checkout
  - MONDAY - FRIDAY
    - 07:30-08:00 Checkout: On-Call Attending, Chief Resident, night float resident and intern, unit float resident, and medicine resident on-call. Admitting housestaff from overnight call will briefly review each admission, as well as, any important management issues related to patients in the Medicine Service.
  - SATURDAY AND SUNDAY
    - 0700-0800 Checkout: same as above.

## MICU

- ❖ The MICU team consists of 2-3 interns, 3 residents, one fellow and one attending physician, and possibly sub-interns.
- ❖ The day team is responsible for admissions until 7PM. After that you check out to the night resident.
- ❖ Remember 80hr week and the 24+4 rule when the resident is leaving night float. Noon conference is required on MICU rotations.

- ❖ The resident on nights is expected to stay for attending rounds to discuss new patient admissions on the last day he is on nights.

## **CARDIOLOGY/CCU**

The continued growth in the volume and acuity on the inpatient cardiology/CCU service has surpassed maximum capacity under the current structure. In order to continue to provide excellent, efficient patient care and a high quality educational experience for our fellows, residents, and students, the current “CCU” service will divide into two separate inpatient services: a CCU Team and a Cardiovascular (CV) Ward Team.

- ❖ Goals and potential benefits include improvements in
  - ❖ Quality and safety in patient care
  - ❖ Patient throughput and length of stay
  - ❖ Patient satisfaction
  - ❖ Attending supervision of team and patient care activities
  - ❖ Education experiences for fellows, residents, and students

### **Structure**

CCU Team:

- ❖ Attending
- ❖ Fellow (Rounding)
- ❖ R2 or R3
- ❖ Intern

CV Ward Team

- ❖ Attending
- ❖ R2 or R3
- ❖ 2 Interns
- ❖ Sub-I
- ❖ 1-2 MS3
- ❖ Fellow (Liason)

The above housestaff allocations are minimum per month, with some months allotting 1-3 additional housestaff between the 2 teams.

### **Admissions/Patient distribution**

- ❖ The CCU Team will admit patients to the CCU (or cardiology patients meeting CCU criteria to other hospital ICUs) and follow them in continuity until the time of hospital discharge.

- If the patient census becomes unbalanced between the cardiology services or the CV Ward Team approaches a cap as determined by the number of housestaff and ACGME guidelines, the CCU Team may take cardiology floor admissions. This will be facilitated by the fellow.
- ❖ The CV Ward Team will admit cardiology floor patients and follow them in continuity until the time of discharge.
  - If a patient's clinical status deteriorates warranting a higher level of care, that patient will be transferred to the CCU Team.
  - If a patient requires temporary monitoring in the CCU with anticipation of rapid return to the telemetry floor, i.e. post-procedure, the patient will remain on the CV Ward Team
  - If the patient census becomes unbalanced between the cardiology services or the CCU Team approaches a cap as determined by the number of housestaff and ACGME guidelines, the CV Ward Team may take CCU Team floor transfers. This will be facilitated by the fellow.
- ❖ The ED will contact the CCU fellow with all potential cardiology admissions, who will then triage the patient to the CCU or CV Ward team and contact the appropriate resident
- ❖ ECC/outside hospital transfers during daytime hours will contact the CCU attending, who will then triage the patient to the CCU or CV Ward team and contact the appropriate resident

### **Overnight Coverage**

- ❖ A single overnight R2 or R3 will cover overnight admissions and CCU/floor calls for both teams
- ❖ The resident will be supervised and supported by the on call fellow and/or attending as appropriate.
- ❖ The resident schedule is available through the Medicine Housestaff Office, and will be distributed to the Division of Cardiology and the Nursing Units on a monthly basis.
- ❖ The overnight resident will round with the CCU team on overnight admissions and critically ill patients at 7:30 am for no more than 30 minutes, freeing the resident to round with the CV Ward team at 8:00 am on overnight floor admissions

### **CONSULTS**

- ❖ The Orange Medicine resident at GRU will cover MCG and the VA from 7am to 5pm when IM is on call, and 7am to 7 pm when the hospitalists are on call.
- ❖ The MCG consult attending will vary based on call coverage
- ❖ The long call resident will cover from the hours of 5pm to 7pm when IM is on call. The night float resident will cover from 7pm to 7am Sun-Friday. On Saturdays when IM is on call, the on call resident will see and staff new consults and hand them off to the orange medicine team in the AM. On Saturdays when the hospitalists are on call, the Orange medicine resident will see and staff all consults. Consult attending will attend on the weekend.
- ❖ VA on-call team will handle consults at the VA on weekends.

## TEAM REPORT

Members of the respective ward team (residents and interns, not students) present a case that was admitted to their service during the month. Case presentation should flow like a detailed IM History and Physical, and include all pertinent information contained in such. The final diagnosis should be known to facilitate discussion at the end of the session. A literature search should also be utilized to further lend to discussion. A faculty member typically attends to this conference. The Chief Medical Resident will moderate as needed.

## VAMC - WARDS/MICU/CCU

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### WARDS

- ❖ There are currently three Medicine ward teams at the VAMC.
- ❖ All admission H&Ps, clinical notes and documentation, and orders are completed using the VAMC Computerized Patient Record System (CPRS).
- ❖ From Sunday to Friday, Teams are on call every third day from 7:00 AM to 7:00 PM, with Night-Float residents covering from 7:00 PM to 7:00 AM. The teams accept to their service all admissions during a 24-hour period from 7:00 AM on their call day to 7:00 AM the next day. If a team is over the cap of patients for their service, the overflow admissions are assigned to the team on call the next day.
- ❖ A back-up resident is available every night when needed, but the unit float or moonlighting resident should be called first. The Chief Medical Resident should be notified of the need to contact the back-up resident for assistance.
- ❖ Back-up intern is available if an intern is sick and one is absolutely necessary for the team to survive a night call.
- ❖ 10-patient cap per intern, sub-interns are allowed to admit and follow up to 4 patients.
- ❖ Interns **MUST** write a complete H/P on every new patient. Use the generic H/P template in CPRS. Charts may be reviewed periodically.
- ❖ Resident **MUST** enter a note for every new patient that they admit – focus on HPI, DDx, assessment and plan. Resident must write a complete H&P on all sub-I admissions.
- ❖ All H&Ps for admissions must include the VAMC Medication Reconciliation template using the tool incorporated into CPRS.
- ❖ Interns should also write a daily progress note. When an intern is off, the resident will write daily progress notes on this intern's patients. **When using the COPY AND PASTE feature in CPRS the notes should be edited to avoid inaccurate documentation.** Resident will write daily progress note on sub-I patients daily. When resident is off, interns will assume responsibility for sub-I patients including daily notes.

- ❖ Bounce backs are extra admissions and they do not count towards the cap.
- ❖ Discharge summaries are required by the time of discharge. When the intern is off, the Resident is responsible for the discharge summary.
- ❖ Off-service notes are required on every patient at the end of the month, unless the patient has been hospitalized < 3 days.
- ❖ Carefully document your work hours. Interns are not allowed to work more than an 80 hr/week (average), but DO NOT check out any patient that is unstable and may require a transfer to ICU.
- ❖ Remember to check out your patients to a covering intern. Residents check out for interns when interns are off. You must include allergies, detailed medication list, and code status on all checkout sheets. Remember to forward your pager to a covering person (after 5:00 PM).
- ❖ Do NOT leave until all of your patients are stable.
- ❖ Do NOT check out critical radiographic data.
- ❖ Do NOT check out patients who are undergoing procedures (endoscopy, bronchoscopy, etc.). You must be available to discuss results and complications with patients and families.
- ❖ Consults are called only by interns or residents. Call as early as possible, and complete the paper forms or Powerchart orders as indicated.
- ❖ Spend your free time learning about your patients and their medical problems. Do not forward beepers until 5:00 PM.
- ❖ A resident must be present in-house at all times to cover Emergency Codes. This is the responsibility of the long-call resident unless they specifically make arrangements with MICU resident or other residents for coverage.
- ❖ Residents must pre-round with their team prior to formal rounds with an Attending physician.
- ❖ Rounds with Attending physician should take place between 9:00-11:00AM on Monday – Friday.
- ❖ Check-out rounds after Night-float shifts occur every morning at 7:30 AM, and must include the Night-Float resident and the Medicine Team Attending and Resident who is accepting the Night-Float admissions.
- ❖ It is one of our primary responsibilities to teach medical students and other residents. Set a goal to teach them at least 5-10 minutes a day.
- ❖ Checkout
  - MONDAY - FRIDAY
    - 07:30-08:00 Checkout: should include the IM Program Director or designee, Chief Resident, night float resident and intern, unit float resident, and medicine resident on-call. Admitting housestaff from overnight call will briefly review each admission, as well as, any important management issues related to patients in the Medicine Service.
  - SATURDAY AND SUNDAY



- 0700-0800 Checkout: same as above.

## MICU

- ❖ The MICU team consists of one intern, one resident, one Fellow and one Attending physician, and occasionally sub-interns.
- ❖ The team is responsible for admissions until 5:00 PM on weekdays. After that you check out to the MICU/CCU intern or resident on call.
- ❖ There will be one resident in CCU and one resident in MICU. Both residents are expected to arrive at work no later than 7:00 am and stay to 5:00 pm. Residents may arrange to alternate leaving at 5:00 pm, but a MICU or CCU resident must be in house until 5:00 pm to cover admissions and codes.
- ❖ On Saturdays, MICU and CCU residents will alternate staying in house for 24 hour call and cross cover for both services. After all work is done the leaving team can check out to the covering resident. Check out of new overnight admissions will occur at 7:00 AM on Sundays. The resident covering both services on Saturdays should leave by 11:00 am (24+4)
- ❖ Attendance to Noon conference is required on MICU rotations.
- ❖ Transfers back to the Spinal Cord Unit require a stat dictation and delayed admit orders. The accepting Spinal Cord physician should be notified that morning or the day prior to transfer.

## CARDIOLOGY/CCU

- ❖ The Cardiology/CCU team consists of 1 residents, 1 intern, one Cardiology Fellow and one Cardiology Attending physician.
- ❖ The team is responsible for admissions until 5:00 PM on weekdays.
- ❖ Work flow is identical to MICU as described above.

## CONSULTS

- ❖ The IM Consult resident at GRU will work on Monday to Friday from 7:30 a.m. to 5:00 p.m. at GRU, and also cover IM consults at the VAMC.
- ❖ The IM Consult Resident will staff consults with the VAMC Teaching Attending Physician, who will vary based on call coverage schedules. The VAMC on-call medicine team will cover consults between the hours of 5:00 PM to 7:30 AM on weekdays and on Saturdays, Sundays and holidays.

## TRANSFERS

- ❖ All transfers from one service to another within the VAMC (i.e. from Surgical specialties to Medicine or from Medicine to Surgery) should be done only after discussion between Attending physicians in charge of both services. The Chief Resident does NOT decide this matter.
- ❖ The Chief Resident will be responsible for approving and coordinating transfers from outside facilities to the VAMC on weekday between 7:30 AM and 5:00 PM. If an outside facility physician is requesting to transfer an inpatient after 5:00 PM on weekdays or on weekends or holidays, then that referring physician must page the on-call Medicine Attending to discuss the transfer.
- ❖ Transfers from outside facilities will be coordinated by the VAMC OD.

## **DAYS OFF**

- ❖ Every resident and intern must get 4 days off each month (average 1 day per week).
- ❖ The resident may not take a day off on any call day. Residents are encouraged to take weekend days off.
- ❖ Interns may not take-call days off.
- ❖ Taking off two days in a row should be cleared by the Chief Resident and the Team Attending physician.
- ❖ Interns may not take off the last two days of the rotation without approval from the resident taking over the service.

## **DISCHARGE POLICY**

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### **PURPOSE**

To outline policy and procedures to provide highest quality discharge planning implementation in the patients managed by the residents of this program.

### **APPLICABILITY**

All Medicine wards and services, including ICU at the Georgia Regents University.

### **POLICIES**

- Patients are to be discharged only after optimal hospital benefit has been achieved in terms of safety, efficacy, and efficiency of management of the medical problem requiring hospitalization.

- Patients are to be discharged only after patients and their families demonstrate to the discharging nurse and physician their understanding of the reasons for the hospitalization and the discharge plans which have been accomplished to ameliorate or prevent the processes leading to re-hospitalization.
- Patients should be discharged only after their primary care physician has been notified of the patient's hospitalization and a follow-up appointment has been scheduled. **This is the responsibility of the house officer caring for the patient and should be dictated into the narrative summary.**
- Patients are to be discharged only after they receive proper education and understand the reason for their hospitalization. They should also understand the immunizations that are offered or were received, discharge medications and diet, updated advanced directives and/or POLST (Physician Orders for Life-Sustaining Treatment), activity instructions, follow up appointments, and what to do for annotated likely problems.
- Patients are to be discharged only after they or their surrogate decision maker/care-giver have received a copy of the documentation noted in document above. They should be instructed to give this material to their primary care physician at their next follow-up appointment.
- Patients transferred to other hospitals or nursing homes will have dictated summaries which include discharge plans accompany them during transfer. **Residents should anticipate at least 2 hours for completion of a STAT dictation.** For routine patients, dictated narrative summaries should be dictated within 24 hours of discharge, but must be dictated by 72 hours. A copy of the hospital dictation should always be forwarded to the patient's primary care physician.
- **Discharges should be completed by noon to maximize nursing assistance, transportation, and final family conferences. Precipitous or evening discharges are not desirable.**

## PROCEDURES

- **Upon admission, the resident will include in his evaluation include risk assessment, discharge planning needs, and anticipated Length of Stay and date of discharge.**
- Patients determined to be high risk will be discussed with the discharge planning team within 24 hours of admission or the next weekday.
- All patients will be discussed with the discharge planning team at daily at the discharge planning meeting held in the team room (exact day of the week to be determined by the team members).
- Residents are encouraged to arrange and conduct family meetings that include the discharge planning team and appropriate consultants when enhanced palliative care, hospice, or transfer to other facilities is anticipated.
- Residents will notify nursing staff, patients and families of pending discharge at 48 and at 24 hours prior to anticipated discharge, in order for them to make transportation and other arrangements.

- Decision as to the timeliness of discharge should be made predominantly on clinical rather than laboratory criteria. If you are planning to discharge a patient the following morning, think about if you really need labs on the morning of discharge, as this may delay your discharge plans.
- **Nearly all patients should be discharged or transferred by noon. This should be accomplished by writing discharge orders specifying time of discharge and dictating the summary the afternoon before discharge.**
- Family members should be encouraged to arrive to pick up the patient at 1000.
- **Nursing home and hospital transfer patients should also be moved by noon.**
- Residents and attendings will give final instructions on the morning of discharge when the family is present and all instruction sheets are available.

## QUALITY IMPROVEMENT

The Discharge Planning and Palliative Care Subcommittee of the Resident Patient Care Quality Improvement Committee will train residents to implement these policies and procedures.

The same subcommittee will conduct outcome studies of the quality of procedural implementation, quality of dictated summaries, satisfaction of patients and primary care physicians, length of stay, and return hospitalization.

- The results of the outcome studies will be used to modify the policies and procedures noted above.

## BACK-UP POLICY

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The back-up resident or intern will only be utilized for appropriate coverage.

- The back-up resident or intern is not to be used for planned absences and is only to be called in the event of an emergency or excessive workload on inpatient services.
- Examples of appropriate activation of backup:
  - Excessive workload/duty hour violation
  - If you are hospitalized
  - Note from a physician indicating your illness (required if >48 hours)
  - Emergency Family Leave/Family Death

In order to activate the back-up resident or intern for excessive workload, you must contact the Chief Medical Resident (CMR).

- If a house officer cannot perform his or her duties due to illness or an emergency, he/she must call the housestaff office no later than 7:30 a.m. on the morning of the absence and send an email indicating the following: name, rotation, attending, clinic day, and a phone number where they can be reached.

- The house officer should then call the CMR and inform him/her of their absence.

Back-up call shift starts from 7:00 a.m. (on the scheduled day) and lasts until 7:00 a.m. the following day. You may be called at any time so be available by pager and/or cellphone.

- It is your responsibility to know when you are on back-up.
- The Back-up Schedule is available on Desire2Learn (D2L) and on the departmental webpage (<http://www.gru.edu/mcg/residents/internalmed/schedules.php>)

Failure to be available when you are either 1<sup>st</sup> or 2<sup>nd</sup> back-up will result in:

- Professionalism Violation
- Academic Remediation
- Additional Back-up days
- Repeat offenses will result in immediate recommendation to the Clinical Competency Committee (CCC) to consider a period of Probation.

The CMR will then arrange coverage for clinical duties if needed. The 1<sup>st</sup> back-up intern or resident will be called first, followed by the 2<sup>nd</sup> back-up intern or resident. In a crisis situation where the 1<sup>st</sup> and 2<sup>nd</sup> back-up inter/resident have already been pulled, then available elective rotators will be pulled.

## CONSULT RESIDENT

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The consult resident is responsible for all general internal medicine consults at GRU and the VA. They will perform the initial consultation evaluation and will continue to follow them daily or sign off as deemed appropriate

The resident (R2 or R3) duties:

- Will work M-F from 7:00 a.m. to 5:00 p.m.
- It is the responsibility of the consult resident to checkout any consults to the on-call resident that need following over the weekend, and to check in from the NF/UF/on-call resident to determine if any new consults need staffing
- The Consult resident will staff all GRU consults to the Orange medicine Attending
- The Consult resident will staff all VA consults to the Gold medicine Attending.
- The rotation will be in 2 week blocks.
- Appropriate consultations may include a wide variety of internal medicine sub-specialties including but not limited to evaluation/management of AKI, Diabetes management, pre-operative risk stratification, etc. Consultations should not be automatically deferred to sub-specialty service unless appropriate (Cardiology for a myocardial infarction)

- Consult resident may be called upon to assist with inpatient or outpatient workflow.

## GENERAL POLICIES

### RESIDENT STRESS AND FATIGUE POLICY

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The goal of this policy is to assist the Department of Medicine in its support of high quality education and safe and effective patient care. The Department of Medicine is committed to meeting the requirements of patient safety and resident wellbeing. Excessive sleep loss, fatigue, and resident stress are serious matters. In the event that any resident experiences fatigue and/or stress that is interfering with his/her ability to safely perform his/her duties, they are strongly encouraged and obligated to report this to his/her senior resident or attending on service or the chief resident.

Appropriate backup support will be provided when patient care responsibilities are especially difficult and prolonged, and if unexpected needs create resident fatigue sufficient to jeopardize patient care during or following on-call periods.

All attending's and residents are instructed to closely observe other residents for any signs of undue stress and/or fatigue. Faculty and other residents are to report such concerns of sleepiness, tardiness, resident absences, inattentiveness, or other indicators of possible fatigue and/or excessive stress to the supervising attending, chief residents, and/or Program Director. The resident will be relieved of his/her duties until the effects of fatigue and/or stress are no longer present.

### PAGER POLICY

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#### OVERALL

Paging units supplied to the House officers work statewide depending on location and terrain. Departments appropriate to the needs of house officer provide pagers. Pagers cost approximately \$25.00 to replace and should be carefully maintained.

#### INPATIENT INTERNS

Your pager should be on and not forwarded every weekday from 7:30 to 5pm unless you are off. If interns are off, the pager should be forwarded to the resident covering the patients during the day. At 5pm on weekdays or when the interns are checking out, the pager must be forwarded to the intern receiving checkout. At 7pm, anyone checking out should forward their pager to the night float intern. PLEASE

ensure that your pager is either on and can be answered by you or is forwarded to the appropriate person to facilitate nurses being able to contact the covering physician. Your pager should never be “unavailable” at any time. You **must** unforward your pager **on arrival** to the hospital each morning (0730 at the latest).

## **INPATIENT RESIDENTS**

Your pager should be on and not forwarded every weekday from 7:30 to 5pm unless you are off. If residents are off, the pager should be forwarded to one of the interns on your team during the day. At 5pm on weekdays or when you leave the hospital, the pager should be forwarded to the intern receiving checkout. Please ensure that your pager is either on and can be answered by you or is forwarded to the appropriate person to facilitate nurses being able to contact the covering physician. You must unforward your pager on arrival to the hospital each morning (0730 at the latest).

## **OUTPATIENT INTERNS/RESIDENTS**

If an intern or resident is on an outpatient rotation, they must be available by pager Monday through Friday from 7:30am to 5pm. At the end of the day and on weekends, the pager may be forwarded to the answering service (721-8400). Remember to unforward your pager by 7:30 am.

## **VACATION INTERNS/RESIDENTS**

Residents and interns on vacation should forward their pager status to the admissions pager 1-5718.

**No pager will ever be turned off and no one should ignore a page they receive at any time.** Pagers should not be forwarded to cell phones during work hours (elective or not) as this is a violation of the pager policy. If you leave your pager at home, you must go up to the 8<sup>th</sup> floor to the IS communications department (1-1652) to get a replacement pager for the day. In addition, if your pager is not working properly, you must IMMEDIATELY take the pager to the IS communications department on the 8<sup>th</sup> floor to get it evaluated.

## **ON CALL/CODE PAGERS**

It is the responsibility of the person on call to carry the assigned pager (either the resident or intern).

The upper level resident (moonlighter or unit float) may “claim” the pager during their shift, but **MUST** return the pager to the appropriate team member when their shift is done.

## PROFESSIONALISM IN MEDICINE

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### DEFINITION

According to the ABIM, professionalism is a set of values that includes altruism, accountability, excellence, duty, honor and integrity, and respect for others. The AAMMC MSOP (Medical School Objective Programs) includes a similar set of values, focusing on altruism and dutifulness as central values. The ACGME Outcomes Project definition includes each of the values mentioned, as well as compassion, commitment to ethical behavior in several domains, and responsiveness to patients' culture, age, gender, and disabilities.

Overall, professionalism comprises the attitudes, behavior, and interpersonal skills defined as essential in relating to patients and educating them, their families, and other health care professionals. Professionalism includes the ability and willingness to communicate effectively, to accept responsibility, to write comprehensive notes, and maintain timely and legible medical records, to be available as a consultant to other physicians when needed, and to evaluate critically the new medical and scientific information relevant to the practice of medicine.

The Internal Medicine Residency Program at Georgia Regents University is committed to seriously address issues of professionalism. In this evolving field, so vital to who we are as physicians, we will use the following tactics to appropriately foster professionalism among the Housestaff of the Internal Medicine Residency Program.

- Focus on fostering positive attributes of professionalism
- Demonstrate concerns for learners, individually and as a group
- Facilitate faculty role modeling
- Measure professional attitudes and behaviors among learners

### EXPECTATIONS OF PROFESSIONALISM

- It is your responsibility to be available on pager during working clinical hours and during on call duties. (see pager policy). If you need to leave your assigned clinical responsibilities for whatever reason during working clinical hours, please notify the housestaff office (ext 1-2423). **DO NOT TURN YOUR PAGER OFF**, be available on pager.
- If a clinic you were assigned to attend has been canceled for whatever reason, please notify the housestaff office about this issue. You can use your time for reading. Be available on pager, we might need to contact you for any reason.
- If you need to be absent from a clinical responsibility that was assigned to you, and the absence is not cleared by the Program Director or the Associate Program Directors, this violation will be



grounds for unprofessional behavior. You are expected to attend your assigned clinical responsibilities on a timely and professional manner at all times.

- Remember in order to be eligible for board certification, you are required to have **33 MONTHS** of meaningful patient experience (Mandated by the ABIM). If you are sick longer than the time allocated annually, you have visa problems, accidents, acts of war, pregnancy, need to be out of the country for non clinical assignments, etc., once you come back, you need to pay back day by day the time you took to take care of your personal matters. This delay will make the termination of your training later than June 30 of the specific year it was planned for your graduating class. By the ABIM rules and regulations you cannot pay back your absence with vacation days.

## **EXAMPLES OF UNPROFESSIONAL ATTITUDES**

Arrogance, entitlement, selfishness, complacency, haughtiness, anger, contempt, envy, laziness, sarcasm, mediocrity, apathy, cynicism, lewdness, greed, imprudence, impetuosity, aggravation, hostility, sloth, alienation, infidelity, egotism, misanthropy, condescension, annoyance, deceit, snobbishness, dissoluteness, ingratitude, discourtesy, foolishness, flippancy, flirtation, grouchiness, intemperance, exclusiveness, evasiveness, prejudice, self-indulgence, stubbornness, detachment, distrust, disorder, disloyalty, insincerity, and immodesty.

## **EXAMPLES OF UNPROFESSIONAL BEHAVIOR**

Lying, cursing, inappropriate display of emotions, tardiness, absence, failure to assume responsibilities, insult, abuse, intemperance, argument, lack of thoroughness, sexual harassment, lack of documentation, misdocumentation, poor follow-through, unreliability, dereliction, negligence, and abandonment.

## **WHAT ARE THE CONSEQUENCES OF UNPROFESSIONAL ATTITUDE AND BEHAVIOR FOR RESIDENTS?**

- Attitude and behavior establish personal reputation. Nothing is so damaging to reputation than unprofessional attitude or behavior. Ignorance may be excused or forgotten, never unprofessionalism.
- Unprofessionalism negates patient care outcome.
- Unprofessionalism pollutes the working environment.
- Unprofessionalism leads to constricted work opportunity.
  - The Program Director(s) must certify that each resident satisfactorily displays professional attitude, behavior, and interpersonal skills before advancement to the next post-graduate year and to take the ABIM certifying examination. This certification is based on daily observation by attendings, peers, patients, and ancillary staff and relayed

to the Program Director(s) on monthly and extemporaneous reports and augmented by counseling statements and progress reports collected in the resident training file.

- The current and future Program Directors must answer the following standardized questions for licensure and credentials based on written reports in the resident training file:
  - Have you ever received reports of poor medical practice by this physician or have you discussed concerns you had about his/her practice with medical staff officers at a hospital? Yes or No
  - Have you ever received reports of poor relationships between this physician and other members of hospital staff? Yes or No
  - Are you aware of any derogatory information about this physician with respect to his/her ability to practice medicine? Yes or No
  - Does he/she enjoy professional respect among his/her colleagues and in the community where he/she practices? Yes or No
- Letters of recommendation ask similar questions for professional employment. Needless to say, in the current environment, negative answers to the above or similar questions prompt specific detail, further investigation, and often missed opportunity.

## **DOCUMENTATION AND DUE PROCESS FOR ALLEGED UNPROFESSIONAL ATTITUDE AND BEHAVIOR**

- All persons observing unprofessional attitudes and behaviors of residents are encouraged to document these in writing and send it to the Program Director(s). Anonymous letters will be accepted, but will not carry the weight of signed observations. Hearsay will not be accepted.
- Monthly attending evaluations of “3” or less (out of 9) on professionalism will have documentation specific to the rating given, and carry the same weight as item (1) above.
- All accusations of unprofessional attitude and behavior will result in the following:
  - Prompt presentation of the documentation to the accused by the Program Director or His/Her designate.
  - Counseling of the accused housestaff
  - Documentation of counseling if attitude or behavior is substantiated.
  - Further investigation of this or other instances involving the resident as determined necessary by the Program Director.
  - Placement of Counseling and Investigative Reports into the Permanent Resident File, as deemed appropriate by the Program Director(s).
  - Appropriate disciplinary action by the Program Director(s). This could include one or more of the following:
    - Verbal and written counseling.

- Letter of reprimand.
  - Forfeiture of vacation time.
  - Temporary suspension from duty.
- These actions will become part of the permanent record of the trainee.
  - Repeated or egregious unprofessional attitude or behavior will additionally result in the following:
    - Discussion of the resident at called meeting of the Residency Clinical Competency Committee
    - The resident may represent himself or herself at this meeting, according to GRU Policy.
    - The CCC may institute one or more of the following disciplinary actions:
      - Probation for up to 3 months.
      - Dismissal from the program.
    - The resident has right of appeal according to GRU Policy.

## **DRESS CODE**

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All housestaff are expected to dress professionally in appropriate attire and maintain a neat and clean appearance. Professional attire is slacks and a shirt and tie for males, and slacks/skirt and a blouse for females. You may wear scrubs and tennis shoes only if you are on-call, in the MICU, CCU, or Night float/Unit float. All housestaff should wear clean, long white coat, and you must have your identification badge clearly visible while you are in the hospital.

Appearances that have the potential to offend or distract patients must be avoided. Examples of these appearances include but are not limited to:

- Easily visible tattoos or body piercing (i.e.: lip, eyebrow, tongue);
- Unusual hair coloring or style;
- Casual clothing (i.e.: jeans, shorts, sandals, and shirts without collars for men);
- Revealing or ill-fitting clothing;
- Unwashed or unkempt appearance; and
- Limit the use of cologne, perfume, or after shave as some of your patients or colleagues are allergic to them.

Always remember that medicine is a profession and you are expected to dress professionally at all times. If you are dressed inappropriately, you may be pulled from your clinical activities and asked to change clothing before being able to return.

## LEAVE POLICY

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### VACATION LEAVE

Each housestaff officer is given 21 days off per academic year. This will be requested and scheduled prior to the completion of the academic year schedule. If any HO needs to request a day off outside of their schedule vacation days, they must follow the approval process as outlined below:

- An approval form must be completed and submitted to the Housestaff Office no later than two months prior leave date with dates of requested leave, reason for leave, and signature of resident that will be covering and what they will be covering.
- Form will be reviewed by Program Coordinator, Chief Residents and Program Director and signatures acquired if approved.
- Additional leave will not be officially approved unless all above personnel have signed off and the form has been approved with above signatures. **DO NOT PLAN TO TAKE THESE DAYS OFF WITHOUT PRIOR APPROVAL.**
- Anyone found to take days off without prior approval will lose vacation days to be equivalent with unapproved days and will include extra backup/cross cover as needed and to be decided by Chief Residents. Repeat offenders will be brought up to the Program Director and the Clinical Competency Committee with disciplinary actions that may include: professionalism letter, probation, remediation and other decisions as deemed appropriate by Program Director to include/up to dismissal from program.

If you need to change your vacation for personal reasons (coordination with family members, out of town plans, etc) and its <60 days from the date of your previously scheduled vacation, then there will be no clinic cancellation and the house officer is responsible for finding their own clinic coverage. If the change is requested >60 days in advance from the date of your previously scheduled vacation, then the house officer should submit dates of change in email or writing to the housestaff office. The paperwork will then be processed and clinics canceled accordingly.

### SICK LEAVE

Per the GME, each houseofficer is granted 14 calendar days for medical leave according to their contracts each academic year. A house officer may accrue a maximum of 21 calendar days of medical leave by carrying over only 7 days of unused medical leave from the previous year.

Time taken as leave will be accounted for in the following sequence:

- Medical leave with full stipend and all benefits until exhausted, then

- Annual leaves until exhausted, then
- Leave of absence without stipend or benefits (LWOP)

The GME office must be notified in writing of medical leave, FMLA, or LWOP at least 2 weeks prior to house officer's leave

If a house officer is not able to perform his/her duties due to illness or an emergency, he/she must call the housestaff office no later than 7:30 am on the morning of the absence and send email indicating the following: name, rotation, attending, clinic day, and a phone number where you can be reached. The chief resident should then be notified so that clinical coverage can be arranged for as needed.

Sick leave for more than 48 hours must be accompanied by a physician's note.

It is never appropriate to send text pages via cell phone or pager to request sick leave or to report that you will be out on sick leave. Text messages and phone calls will not be accepted as notification. Resident must send EMAIL to Coordinator and Chief Residents.

Unexcused absences will result in a warning letter placed in the resident's file and loss of a vacation day. If you are out of vacation days, you will be required to make up unexcused absences at the end of your residency training without pay. Unexcused absences are in violation of the Professionalism policy and are subject to disciplinary action, which may include forfeiture of vacation time, repetition of a rotation, and/or probation (see Professionalism policy for details).

Trainees may take up to 1 month (30 days) per year of training for vacation, parental or family leave, or illness (including pregnancy-related disabilities) combined. Training must be extended to make up any absences exceeding 1 month (30 days) per year of training.

## **MATERNITY AND EXTENDED LEAVE (FROM GME POLICY HS 4.0)**

The department is responsible for informing the GME office in writing if the house officer will be on leave for longer than 2 weeks or if the house officer has exhausted annual and/or medical leave and needs to be placed on leave without pay (LWOP). A copy of written statement from the house officer's physician must be on file in the GME office.

## **EMERGENCY FAMILY LEAVE**

If there is an unanticipated absence due to family emergency, the housestaff office must be notified immediately with the following information: name, rotation, attending, clinic day, and a phone number where you can be reached.

## INTERVIEW/FELLOWSHIP LEAVE

3<sup>rd</sup> year residents/5<sup>th</sup> year research residents may be allowed interview/fellowship leave not to exceed 4 days per academic year, subject to confirmation by their Program Director. Requests should be made through notifying the housestaff office and the CMR in writing. Any additional days need to be coordinated with vacation time. Anyone found to take additional unapproved days please see Vacation Policy for actions.

**Vacation changes, sick leave days, CME days, and other days of absence are strictly documented. Please see the appropriate person ONLY to facilitate your request in order to avoid confusion and to ensure that any necessary paperwork is properly expedited.**

**Failure to follow these procedures is considered to be “unprofessional behavior.”**

## TRAVEL POLICY

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**(Effective September 2013)**

Per GRU policy a travel authorization form must be completed for all travel. The authorization must be approved by the Program Director prior to making arrangements to travel. This includes but not limited to off campus requests and any travel not reimbursed by the program.

Program support is available for a limited number of residents annually.

The Residency Program will only consider supporting travel for an oral presentation (excluding ACP). A poster without an oral presentation will not be supported.

We are not able to support international travel.

If you are doing research with a specialty (GI, Cardiology, etc.) and planning on attending one of their conferences, you should reach out to those sections to cover your travel prior to requesting approval from the Housestaff Office.

The Chiefs and the Housestaff Office must be notified of any travel to a conference at least 2 months prior to the date (email with oral presentation approval must be submitted to the Housestaff administration). If you require time away from a rotation, the Chiefs must approve, but it is YOUR responsibility to find coverage.

If you travel to the ACP regional which other residents attend, you should plan to share a room and carpool to the event.

Receipts should be turned into the housestaff office within one week of your return, or you will not be eligible for reimbursement.

#### Hotel

- Hotel original receipt with a balance of \$0.00 is required for reimbursement. The person who pays for the hotel is the only one who can be reimbursed.
- The program may be unable to give you full hotel room coverage. If you are traveling to a regional or national meeting, you should plan accordingly.
- If traveling within the state of Georgia a tax exemption sheet must be obtained from the Housestaff Administration prior to departure. This must be turned into the hotel to receive exemption from occupancy tax. You will not be reimbursed for this charge.

#### Transportation

- Airline ticket and boarding passes (originals required, no copies accepted)
- Taxi and/or shuttle receipts (originals)
- Parking receipts (originals)
- Mileage allotment dictated by the State

#### Registration

- Must have a copy of your registration and a brochure from the meeting

#### Meals

- Meal allotment dictated by the State.
- If you are taken out to dinner or the meeting program indicates that a meal is provided at the conference or by the hotel (continental breakfast), you will not be reimbursed for that meal.
- The program does not reimburse for alcohol.

## AWAY ROTATIONS

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Away rotations are a privilege which may be granted contingent upon the house officer's standing in their program and the ability to benefit from the extramural educational opportunity.

Justification stating what experience will be gained and why it can't be obtained at GRU will be needed.

At least six months' notice is required. Away rotations are only granted during elective time.

1<sup>st</sup> year house officers should not expect away rotations to be granted.

2<sup>nd</sup> and more senior house officers may be allowed not to exceed 4 weeks per academic year, subject to confirmation by their Program Director that their progress in training is sufficiently satisfactory to permit the absence(s).

**Every request for off campus activities MUST receive prior approval. The initial request should be made through notifying the housestaff office and the CMR.**

## MOONLIGHTING

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- House Officers at Georgia Regents University may engage in Professional Activities outside the educational Program (moonlighting) only with prior written consent from the Program Director and Senior Associate Dean for Graduate Medical Education with a copy on file in the Graduate Medical Education Office and the House Officer's Training file. (See web link below for moonlighting approval form)
  - NOTE: U.S. Code of Federal Regulations governing exchange visitor Program allows an exchange visitor who holds a J visa to receive compensation only for activities that are part of the designated Training Program. An exchange visitor who engages in unauthorized employment shall be deemed to be in violation of his/her Program status and is subject to termination as a participant in an exchange visitor program. Moonlighting is strictly prohibited for J visa holders.
  - NOTE: House Officers in H-I B status may not work for other employers or in positions other than those described in the GRU H-I B petition without applying for additional H-I B sponsorship.
- Even when permitted, House Officers must not be required to engage in moonlighting, because Residency education is a full-time endeavor. The Program Director must ensure that moonlighting does not interfere with the ability of the House Officer to achieve the goals and objectives of the educational program.
- All moonlighting that occurs within the Residency Program must be counted toward the 80-hour weekly limit on duty hours. (ACGME Common Program Requirements VI.G. I.)
- All House Officers engaged in moonlighting must be licensed for unsupervised medical practice in the state where the moonlighting occurs. It is the responsibility of the moonlighting House Officer and the Institution hiring such a House Officer to moonlight to determine whether such licensure is in place, adequate liability coverage is provided and whether the House Officer has the appropriate training and skills to carry out assigned duties. The Georgia Regents University cannot insure the activities of a House Officer while they are moonlighting.
- The Georgia Regents University requires that the Program Director acknowledge in writing that he/she is aware that the House Officer is moonlighting and that this information is made part of the House Officers folder and a copy on file with the Graduate Medical Education Office.



Moonlighting approval is contingent upon the resident being in compliance with duty hours, dictations and professionalism. Additionally, the resident must score 30<sup>th</sup> percentile or greater on the in service exam to qualify for moonlighting.

The official GRU House Officer Moonlighting policy is available at

[http://www.gru.edu/mcg/residents/hspolicies/documents/hs\\_16\\_house\\_officer\\_moonlighting\\_with\\_letter.pdf](http://www.gru.edu/mcg/residents/hspolicies/documents/hs_16_house_officer_moonlighting_with_letter.pdf)

## CLOSING

## SUMMARY

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It is of paramount importance that residents establish and guard their professional reputations during the three years of residency. More than medical knowledge, one's professional reputation defines his or her career.