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DEPARTMENT *of*  
INTERNAL MEDICINE  
James H. Quillen College of Medicine

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EAST TENNESSEE STATE UNIVERSITY

2015-2016  
Internal Medicine  
Residency Handbook

**East Tennessee State University  
Quillen College of Medicine  
Department of Internal Medicine**

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## CONTACTS

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Office Fax	439-6386
HVMC Facility Coordinator – Rita Forrester	224-5075
JCMC Facility Coordinator– Tawana Holland	431-6431
VAMC – Chief's Office – Birgit Goldfarb and Stephen Culbertson	926-1171, Ext. 2196
Pager Problems – Call Residency Office	439-6283
GME Office – Sissy Shipley (Insurance Issues)	439-8023
Security Offices:	
VAMC	926-1171, Ext. 7197
ETSU	439-4480
Clinics:	
JC MEAC	439-7280
Kingsport MEAC	246-7931
VA	926-1171, Ext. 7637
Payroll	439-6123
Medical Record Offices	
JCMC	431-5459
BRMC	844-3526
HVMC	224-6192
VAMC	979-7816

## **COMPACT BETWEEN RESIDENT PHYSICIANS AND THEIR TEACHERS**

Residency is an integral component of the formal education of physicians. In order to practice medicine independently, physicians must receive a medical degree and complete a supervised period of residency training in a specialty area. To meet their educational goals, resident physicians must participate actively in the care of patients and must assume progressively more responsibility for that care as they advance through their training. In supervising resident education, faculty must ensure that trainees acquire the knowledge and special skills of their respective disciplines while adhering to the highest standards of quality and safety in the delivery of patient care services. In addition, faculty are charged with nurturing those values and behaviors that strengthen the doctor-patient relationship and that sustain the profession of medicine as an ethical enterprise.

### **Core Tenets of Residency Education Excellence in Medical Education**

Institutional sponsors of residency programs and program faculty must be committed to maintaining high standards of educational quality. Resident physicians are first and foremost learners. Accordingly, a resident's educational needs should be the primary determinant of any assigned patient care services. Residents must, however, remain mindful of their oath as physicians and recognize that their responsibilities to their patients always take priority over purely educational considerations.

### **Highest Quality Patient Care and Safety**

Preparing future physicians to meet patients' expectations for optimal care requires that they learn in clinical settings epitomizing the highest standards of medical practice. Indeed, the primary obligation of institutions and individuals providing resident education is the provision of high quality, safe patient care. By allowing resident physicians to participate in the care of their patients, faculty accepts an obligation to ensure high quality medical care in all learning environments.

### **Respect for Residents' Well-Being**

Fundamental to the ethic of medicine is respect for every individual. In keeping with their status as trainees, resident physicians are especially vulnerable and their well-being must be accorded the highest priority. Given the uncommon stresses inherent in fulfilling the demands of their training program, residents must be allowed sufficient opportunities to meet personal and family obligations, to pursue recreational activities, and to obtain adequate rest.

### **Commitments of Faculty**

1. As role models for our residents, we will maintain the highest standards of care, respect the needs and expectations of patients, and embrace the contributions of all members of the healthcare team.

2. We pledge our utmost effort to ensure that all components of the educational program for resident physicians are of high quality, including our own contributions as teachers.
3. In fulfilling our responsibility to nurture both the intellectual and the personal development of residents, we commit to fostering academic excellence, exemplary professionalism, cultural sensitivity, and a commitment to maintaining competence through life-long learning.
4. We will demonstrate respect for all residents as individuals, without regard to gender, race, national origin, religion, disability or sexual orientation; and we will cultivate a culture of tolerance among the entire staff.
5. We will do our utmost to ensure that resident physicians have opportunities to participate in patient care activities of sufficient variety and with sufficient frequency to achieve the competencies required by their chosen discipline. We also will do our utmost to ensure that residents are not assigned excessive clinical responsibilities and are not overburdened with services of little or no educational value.
6. We will provide resident physicians with opportunities to exercise graded, progressive responsibility for the care of patients, so that they can learn how to practice their specialty and recognize when, and under what circumstances, they should seek assistance from colleagues. We will do our utmost to prepare residents to function effectively as members of healthcare teams.
7. In fulfilling the essential responsibility we have to our patients, we will ensure that residents receive appropriate supervision for all of the care they provide during their training.
8. We will evaluate each resident's performance on a regular basis, provide appropriate verbal and written feedback, and document achievement of the competencies required to meet all educational objectives.
9. We will ensure that resident physicians have opportunities to partake in required conferences, seminars and other non-patient care learning experiences and that they have sufficient time to pursue the independent, self-directed learning essential for acquiring the knowledge, skills, attitudes, and behaviors required for practice.
10. We will nurture and support residents in their role as teachers of other residents and of medical students.

### **Commitments of Residents**

1. We acknowledge our fundamental obligation as physicians—to place our patients' welfare uppermost; quality health care and patient safety will always be our prime objectives.
2. We pledge our utmost effort to acquire the knowledge, clinical skills, attitudes and behaviors

required to fulfill all objectives of the educational program and to achieve the competencies deemed appropriate for our chosen discipline.

3. We embrace the professional values of honesty, compassion, integrity, and dependability.
4. We will adhere to the highest standards of the medical profession and pledge to conduct ourselves accordingly in all of our interactions. We will demonstrate respect for all patients and members of the health care team without regard to gender, race, national origin, religion, economic status, disability or sexual orientation.
5. As physicians in training, we learn most from being involved in the direct care of patients and from the guidance of faculty and other members of the healthcare team. We understand the need for faculty to supervise all of our interactions with patients.
6. We accept our obligation to secure direct assistance from faculty or appropriately experienced residents whenever we are confronted with high-risk situations or with clinical decisions that exceed our confidence or skill to handle alone.
7. We welcome candid and constructive feedback from faculty and all others who observe our performance, recognizing that objective assessments are indispensable guides to improving our skills as physicians.
8. We also will provide candid and constructive feedback on the performance of our fellow residents, of students, and of faculty, recognizing our life-long obligation as physicians to participate in peer evaluation and quality improvement.
9. We recognize the rapid pace of change in medical knowledge and the consequent need to prepare ourselves to maintain our expertise and competency throughout our professional lifetimes.
10. In fulfilling our own obligations as professionals, we pledge to assist both medical students and fellow residents in meeting their professional obligations by serving as their teachers and role models.

This compact serves both as a pledge and as a reminder to resident physicians and their teachers that their conduct in fulfilling their obligations to one another is the medium through which the profession perpetuates its standards and inculcates its ethical values.

For more information about the Compact, go to [www.aamc.org/residentcompact](http://www.aamc.org/residentcompact).

## **RESIDENT ELIGIBILITY**

Resident applicants must meet the following qualifications for appointment to the Quillen College of Medicine residency programs:

1. Graduates of medical schools in the U.S. and Canada accredited by the Liaison Committee on Medical Education (LCME), or
2. Graduates of medical schools in the U.S. and Canada accredited by the American Osteopathic Association (AOA), or
3. Graduates of colleges of osteopathic medicine in the United States accredited by the American Osteopathic Association (AOA), or
4. Graduates of medical schools outside the United States and Canada who have received a currently valid certificate from the Educational Commission for Foreign Medical graduates prior to appointment.

## **RESIDENT SELECTION**

Residents are selected on a fair and equal basis without regard to sex, race, age, religion, color, national origin, disability, or any other applicable legally protected status. Performance in medical school, personal letters of recommendation and official letters of recommendation, achievements, and humanistic qualities will be used in the selection process. The Sponsoring Institution must ensure that its ACGME accredited programs select from among eligible applicants on the basis of residency program-related criteria such as their preparedness, ability, aptitude, academic credentials, communication skills, and personal qualities such as motivation and integrity.

All programs will participate in the NRMP and will select residents according to NRMP policies and procedures. Each program will develop specialty specific criteria according to its own program's needs and those of the institution. These criteria may encompass personal, professional and educational characteristics of the candidate.

The enrollment of non-eligible residents may be a cause for withdrawal of accreditation of the involved program.

## **RESIDENT BACKGROUND CHECK POLICY**

1. Review and approval of a completed Criminal Background Check (CBC) is a precondition to employment for new resident and fellow physicians. Based on requirements mandated by the State of Tennessee (T.C.A. § 63-1-149), Quillen College of Medicine will not employ any resident or fellow who appears on any state's sexual offender registry, the national sex offender public registry website coordinated by the United States Department of Justice, any state adult abuse registry, or the Tennessee Department of Health's elder abuse registry. The CBC may also reveal information not contained in the above registries that could disqualify one from being considered for employment. In addition, all residents will undergo background checks through the VA hospital system.
2. If the VA reports a positive background check, the involved resident may be immediately removed from all clinical activities and placed on leave with pay for 30 days. The resident's department will be responsible for all salary and benefits incurred while the resident is on leave.
3. If review of the resident's administrative documents reveals dishonesty (or failure to disclose) related to the positive background check, the resident will be terminated.
4. Within 48 hours of notification of the background problem, the Executive Associate Dean for Graduate Medical Education will appoint one Program Director and one Chairman (neither of whom will come from the resident's department) to a subcommittee chaired by the Executive Associate Dean for Graduate Medical Education. This subcommittee will review all appropriate information and may interview the resident involved and other appropriate personnel. Within fourteen (14) days, they will forward recommendations for a course of action to the Executive Associate Dean for Graduate Medical Education. The Executive Associate Dean for Graduate Medical Education will forward the subcommittee's recommendation to the Dean, with comments regarding the recommendation.
5. The Dean will meet with the Chair of the involved department to discuss the subcommittee's recommendations. The Dean may meet with the involved resident.
6. The Dean will deliver his decision regarding the resident within 30 days from the notification by the VA of the concern.
7. The resident shall have the right of due process, through the Vice President for Health Affairs, regarding this decision.



## New Innovations™

All the residency programs at East Tennessee State University use a web-based, residency management system called New Innovations ([www.new-innov.com](http://www.new-innov.com)). Internal Medicine uses this system for posting call schedules, logging procedures, and duty hours as well as the evaluation process. When you begin the program, you will be given a log-on and password, both of which you can change once you log on. Failure to complete your duty hours in a timely manner could result in the next month's check **not being direct deposited**.

## SOCIAL NETWORKING GUIDELINES

The Graduate Medical Education Committee recommends that residents and fellows exercise caution in using social networking sites such as Facebook or Twitter. Items that represent unprofessional behavior posted by residents on such networking sites are not in the best interest of the University and may result in disciplinary action up to and including termination. Residents and fellows are expected to exhibit a high degree of professionalism and personal integrity consistent with the pursuit of excellence in the conduct of his or her responsibilities. They must avoid identifying their connection to the University if their online activities are inconsistent with the values or could negatively impact the University's reputation.

If using social networking sites, residents and fellows should use a personal e-mail address as their primary means of identification. Their University e-mail address should never be used for personal views. Residents who use these websites must be aware of the critical importance of privatizing their websites so that only trustworthy friends have access to the websites/applications.

In posting information on personal social networking sites, residents may not present themselves as an official representative or spokesperson for a residency/fellowship program, hospital, Department of Veterans Affairs or the University. Patient privacy must be maintained and confidential or proprietary information about the University or hospitals must not be shared online. Patient information is protected under the Health Insurance Portability and Accountability Act (HIPPA). Residents have an ethical and legal obligation to safeguard protected health information and posting or e-mailing patient photographs is a violation of the HIPPA statute.

## **INTERNAL MEDICINE RESIDENCY AND FELLOWSHIP DRESS CODE**

### **PURPOSE:**

This policy is written to guide RESIDENTS AND FELLOWS of the East Tennessee State University, Internal Medicine Residency and Fellowship Programs in presenting a professional image by outlining reasonable and appropriate appearance in the workplace. Appropriate dress and personal grooming are components of a safe and professional environment. Every resident and fellow represents the standards and professional image set forth by the department and by the medical profession.

It is the responsibility of all residents and fellows to dress appropriately for the workplace and to foster confidence and trust in patients, families, visitors, and staff through professional behavior and appearance.

### **GUIDELINES:**

1. All residents and fellows shall wear their white lab coats and display current identification badge, in a location that is easily visible to patients, visitors, and staff, when on duty or on medical center premises.
2. General attire must be clean and neat at all times.
3. Appropriate attire is considered to be dress shirts (preferably ties), dresses, pantsuits, blouses, skirts, sport coats, dress slacks, and shirts with collars.
4. Jeans, tennis shoes, shorts, skirts three inches or more above the knee, tube tops, low cut tank tops, t-shirts, midriff tops, sundresses without a jacket or blazer, see-through and low cut blouses, sweatpants, sweatshirts, and leather attire are considered unreasonable and inappropriate attire for the workplace.
5. When direct patient care responsibilities necessitate physical contact do not wear large bulky jewelry or jewelry that may inadvertently cause injury to patients.
6. Hair should be neatly arranged in such a manner that it does not fall on patients or be grabbed by a patient. Facial hair should be neatly groomed to present a professional image.
7. Perfume, cologne, or other fragrance products should be moderately used to avoid being offensive or causing discomfort to others.
8. Undergarments should not be visible through outer clothing.
9. Shoes must be closed-toed in the patient care areas (no flip-flops or sandals). Shoes should be of reasonable height and comfortable enough for the resident or fellow to be able to respond to any type of emergency in a healthcare setting.
10. Visible body piercing must be conservative and jewelry must be small in size.
11. CDC requires that fingernails be kept clean and short for patient care and for the proper fit of gloves or other protective equipment. Artificial Nails are not permitted.
12. Scrubs need to be covered when leaving patient care areas.

### **COMPLIANCE:**

All residents and fellows are expected to comply with this policy. Any reporting to duty dressed in a manner inconsistent with this policy will be counseled appropriately and may be asked to correct attire.

## RESIDENT'S AND FELLOW'S ASSISTANCE PROGRAM

East Tennessee State University, Quillen College of Medicine's Resident Assistance Program (RAP) is a confidential counseling and referral service for East Tennessee State University Medical School residents and their families. The purpose of the program is to encourage self-referral so that you can be helped with training issues, personal and marital concerns before they lead to more serious difficulties. The first six visits are free and subsequent visits are covered by resident health insurance with the normal deductible and co-pay applied.

As resident physicians, you should strive to manage professional and personal stress, to maintain your own health and well-being so that you can maximize your ability to provide quality health care to your patients.

Stress is part of everyone's life. It can become overwhelming when it is not managed properly which in turn can lead to physical, mental and spiritual difficulties. The RAP is here to provide you with help in managing stress in both your personal and professional lives through confidential counseling, education, and in some cases medication. This includes assistance with marriages and other relationships. Below are listed some causes of excessive stress:

- |                                     |   |
|-------------------------------------|---|
| -Lack of staff or attending support | -Unresolved bereavement issues              |
| -Too much responsibility            | -Culture issues                             |
| -Trying to be perfect               | -Sexual orientation issues                  |
| -Lack of sleep                      | -Sexual harassment                          |
| -Marriage and family issues         | -Too many hours on call                     |
| -Physical illness                   | -Both husband and wife are residents        |
| -Excessive anxiety                  | -Depression                                 |
| -Social isolation                   | -Don't feel part of the residency community |

Contact: Phillip Steffey, M.Div., L.C.S.W.  
(423) 854-0342

## **INTERNAL MEDICINE RESIDENCY LEAVE POLICY**

### **Purpose:**

The American Board of Internal Medicine requires all internal medicine trainees to successfully complete 11 out of 12 months each year of training for a total of 33 in a 3-year period in order to be eligible for the internal medicine board exam. If a resident's total leave time (including annual leave, administrative leave, leave without pay, and medical leave) exceeds 1 month per year, promotion to the next level or your graduation date will be delayed. This excessive leave time will need to be made up the next academic year. You will have to seek approval from the program director to extend your residency because of ACGME and funding restrictions as to number of residents. Also, note that training must be completed by August 31 in order to be eligible for the board exam offered in August.

### **Policy:**

As outlined in the University Resident Handbook, residents/fellows are allowed:

1. Three weeks' Vacation/ Annual Leave - 15 working days – per academic year. Weekends and Holidays do not count. Check with your rotation preceptor to see if a particular holiday applies to the assigned rotation.
2. 12 Sick Days per academic year
3. 5 Administrative Days total in 3 years
4. Educational Leave as approved by the Program Director

No more than two weeks of vacation leave – 10 working days – may be scheduled during any rotation.

In general, residents will not be approved for more than one away activity during a rotation (vacation, conference leave, CME activity, etc.) as this often adversely affects both the educational and patient care continuity of the rotations.

**Scope:** All IM Residents

### **Procedure by Leave Type:**

#### **A. Vacation/Annual Leave**

1. Residents are REQUIRED to submit vacation leave requests for the entire year by the first of April of the current year. Incoming residents must comply with the same requirements. Schedules will be completed by May of the current academic year. At least two weeks of your annual leave should be taken in week blocks. The remaining five days may be used as single days in order to have a long weekend or single day travel. These must be submitted at least 3 months in advance. Failure to meet this prescribed time frame will result in denial of leave.
2. Leave is granted based on level of training and/or first-come, first approved policy.
3. Leave requests are not considered approved until the resident receives approval from the residency office. Arrangements and purchase of tickets or fees SHOULD NOT

occur until the resident receives notification of leave approval. Failure to adhere could possibly result in the loss of resident's money.

4. No more than 10 working days of scheduled leave may be taken during any one month of rotation.
5. No leave for travel outside of the US will be approved during the final 60 days of a currently valid non-resident visa until the visa has been approved.
6. For overseas travel, residents must understand the risk of travel delays and the potential of lengthening the residency duration required to meet the ABIM requirements.
7. For those residents who must renew their visa status, this should be accomplished during planned vacations. Additional time off or educational leave will not be granted to accomplish visa renewal.
8. If a resident is delayed by more than 60 days from returning to his/her residency assignments because of travel outside of the US, his/her status as a resident in the Internal Medicine Residency of ETSU may be terminated. Resumption of residency will require reapplication for admission to the IM Residency Program and is not guaranteed.
9. Residents MAY NOT schedule vacations during Inpatient Medicine, Night Float, Critical Care, or during the first week of the Emergency Medicine rotation.
10. In order to provide appropriate care and coverage during the efflux of senior residents, vacations during the last two full weeks of June will not be granted (except for departing seniors and departing preliminary residents.)
11. During the influx of new residents there will be NO vacations granted during the 1st two weeks of July.

## **B. Sick Leave**

1. Sick Leave is approved for up to 12 working days per year and shall accumulate with the unused amount of sick leave carried forward.
2. Sick leave with pay may be taken when sickness, injury, or pregnancy prevents the residents/fellow's performance of duty or when a member of his/her immediate family is actually ill and requires the resident/fellow's attention.
3. Residents/Fellows are not paid for unused sick leave.
4. If you are out due to illness, even if you "called-in sick" and received verbal permission, you MUST submit a form request the first day you return to duty.
5. Residents/Fellows are required to notify the chief resident AND rotation and clinical attendings as soon as possible when "calling in" sick AND must submit a Leave Request Form on the first day back to duty.
6. The resident/fellow must provide a health care provider's statement to return to duty for periods of sick leave of two consecutive work days or longer. This must be provided to the Program Coordinator.
7. If a resident/fellow shows a pattern of reporting in sick on Monday, Friday, or prior to or after a holiday, the Program Director may require a note from the residents or fellow's physician to justify the absence.

### **C. Family Leave**

Residents/Fellows are entitled to the provisions of the Family Medical Leave Act of 1993. This leave is without pay, but use of accrued sick and vacation leave may be used as part of the family leave. In order to be considered eligible under the FMLA guidelines, a resident/fellow must (1) have worked for the University for at least 12 months; and (2) have worked at least 1,250 hours during the year preceding the start of the leave. Eligible residents/fellows may take Family and Medical Leave for the birth of a child and the care of such newborn child; for the placement of a child with the resident/fellow for adoption or foster care; for the care of the resident's spouse, child, or parent who has a serious health condition; or for the fellow's own serious health condition that prevents him/her from performing the essential functions of his/her position. Residents/Fellows should be aware that this time will not be counted toward board eligibility. The Program Director and resident/fellow will be responsible for establishing a make-up schedule in compliance with the Board requirements of the particular specialty. If a husband and wife are both residents/fellows and are eligible for Family and Medical Leave, the total number of work weeks of leave for birth, adoption, and foster care placement to which both are entitled is limited to 12 work weeks.

### **D. Maternity & Paternity Leave**

Maternity and Paternity leave may be taken out of accumulated sick leave, vacation time, or leave without pay in the event the resident/fellow has not met the eligibility requirements for FMLA. Please refer to the University Resident Handbook. Excessive leave will extend the period of residency. All female residents/fellows, returning to work after the birth of a child, must submit to the Residency/Fellowship Office, a release from OB/GYN physician before returning to work.

### **E. Leave of Absence, Military Leave, and Bereavement Leave**

Please refer to the University Resident Handbook.

### **F. Leave for Interview Dates**

1. Each resident/fellow applying for fellowships or employment may take up to total of five administrative leave days for interviews during entire residency/fellowship with PRIOR APPROVAL by the Program Director.
2. Additionally, residents may utilize their annual leave or leave without pay for interviews. Use of educational leave for interviews is not permitted. If annual leave is to be utilized, residents must obtain the signature of the Program Director as previously stated in this policy.
3. The Residency/Fellowship Program understands that invitations for fellowship interviews often occur with little advanced notice and offer only a single or limited number of days to interview. Employment interviewing typically offers more flexible scheduling. Residents should negotiate job interview times with employment recruiters around elective rotations. Recruiters are very much aware of resident's clinical responsibilities and are accustomed to scheduling dates to accommodate residents. If the resident must schedule an interview during a ward month, then the resident must exhaust all possibilities for coverage

before contacting the PGY IV chief for use of the back-up schedule. All back up coverage MUST be paid back.

4. As soon as an invitation is received, the resident/fellow must contact the Chief, supervising attending and continuity clinic.
5. Residents/Fellows must have sufficient administrative or annual leave days available; no additional leave will be granted. Residents anticipating the need for fellowship interview leave should schedule their leave periods accordingly.
6. A leave request must be submitted and approved.
7. The resident is responsible for coordinating with the PGY IV Chiefs to arrange coverage for patient care during absences.

#### **G. Leave for Presentations at Regional and National Meetings (Educational Leave)**

1. With Program Director's approval, educational leave may be used for conference presentation travel and for required exams and or recertification.
2. If accepted for presentation and if approved by the sponsoring Division Chief resident may be provided travel and presentation material reimbursement.
3. Once accepted at a national meeting, the same submission must not be resubmitted for regional conferences.
4. A travel request MUST be filled out for any resident going to a conference or an away rotation – even if the university is not paying for the travel – this is for liability coverage.
5. An arrangement for appropriate continuation of patient care duties in his/her absence is the responsibility of the presenting resident and must be approved by the PGY IV chiefs.
6. 3<sup>rd</sup> year residents are eligible for 5 days of education leave to attend a Board Review course. The leave request must include a copy of the paid receipt for the course. If the length of course exceeds 5 days, then the resident must utilize annual leave or leave without pay.

#### **H. Leave Request Process**

NO verbal requests – All leave must be submitted and approved through the proper process.

1. Leave for vacation must be given received by the residency office **at least** three months prior to the month of the requested vacation. Failure to meet this prescribed time frame will result in denial of leave.
2. Effective June 1, 2014 leave will be processed through New Innovations. You may access this link by going to Schedules>Make a Request>fill in dates> >Choose type of leave>Choose who will receive request (your program Coordinator)>Review>Submit.
3. Completed and approved forms will be received in the Residency/Fellowship Office to be filed with time sheet at the end of each month which is tracked by the GME Office.
4. You will receive a confirmation email from the residency/fellowship office within 30 days of submission. Please follow up on request if you do not receive confirmation email.
5. If you are "Not Assigned to Duty" on a rotation, i.e. ER, you must adhere to the leave request process if you plan to be out of town.

6. Call assigned to a resident/fellow on the published roster for the month has to be done by the named resident. Exchanging call after the published roster is on New Innovations is PROHIBITED.
7. Hours logged into New Innovations must match leave request. If time requested is different from form, you must correct this with the residency/fellowship office.
8. Be sure to observe all of the back-up policies.

Suggestions: Please take all of your vacation each year, you deserve it, you need it, and it will help you. It is best to even out your time off over several rotation blocks. This will keep you from missing too much from any single rotation – you will better appreciate time off periodically and you will impose less on your residents/fellows. When you return, be sure to check in with those that covered for you.

## **ACADEMIC CONFERENCE ATTENDANCE**

### **Policy:**

Since residents are in an advanced training program, academic conferences are very important and an essential part of your training. Therefore, the QCOM IM Residency Program requires **100%** attendance and participation of conferences and educational curriculums sponsored by department:

1. Academic Half Day –
  - Department of Medicine Education Conference
  - Longitudinal Board Review
  - Core Conferences
  - Journal Club
  - Quality Improvement and Safety

### **Procedure:**

1. Residents are responsible for their ID cards to scan in and out of conference.
2. The IM residency office will track attendance using the New Innovations™ Conference Module.
3. To accommodate leave, call and post call, the Academic Half Day will be recorded and should be viewed at the first opportune time following the original presentation. It will be the responsibility of the resident to notify the Residency Office to ensure credit for any conference viewed online.
4. It is expected that residents will arrive on time and that beepers will be passed to the chief or the fellows on the service.
5. Cell phones and pagers should be set to vibrate.
6. Med/Psych residents are expected to adhere to this policy when assigned to medicine rotations.



## **WORKER'S COMPENSATION INFORMATION FOR ETSU RESIDENTS AND FELLOWS**

As soon as possible after an accident occurs (including needle sticks), you should inform your supervisor or attending then call the worker's compensation call center at **866-245-8588** (toll- free) and complete an accident form via telephone. Information obtained by the call center enables the claims adjuster to determine whether your injury is compensable under the worker's compensation law. Your supervisor will be contacted to verify the incident. A claim number will be given if it is determined the injury is compensable under worker's compensation. The claim number should then be given to the health care provider or the pharmacy for payment by worker's compensation. The forms required for a worker's compensation injury from the Human Resources website should be completed with the claim number noted and forwarded to Human Resources on the next business day.

### **CONTACT INFORMATION:**

Jodi Epps – Human Resources during business hours – (423) 439-4787  
Debra Shaw – GME office after hours and weekends – (423) 302-9280

## IM Resident Duty Hour Policy

### Purpose:

To develop a process for ensuring compliance with ACGME Duty Hour Requirements as described in the Common Program Requirements.

### Policy:

Resident Duty Hours in the Learning and Working Environment are vital in educating our residents and faculty as they relate Professionalism, Personal Responsibility and Patient safety. The learning objectives of each of the Quillen College of Medicine Residency Programs must be accomplished by an appropriate blend of supervised patient care responsibilities, clinical teaching and didactic educational events while assuring against any compromise by excessive reliance of residents to fulfill non-physician service obligations. A culture of professionalism supporting patient safety and personal responsibility is instituted by each QCOM Residency Program Director and must ensure each Resident/ Fellow and Faculty member demonstrate an understanding and acceptance of their personal role in:

- Patient safety and welfare
- Patient and family centered care
- Fitness for duty
- Time management before, during and after clinical assignment
- Recognition of impairment, including illness and fatigue in themselves and their peers
- Healthcare Quality Indicators
- Honest and accurate reporting of duty hours, patient outcomes and clinical experience data

### Definitions:

**Attending Physician:** Any appropriately credentialed and privileged member of the medical staff who accepts full responsibility for a specific patient's medical/surgical care.

**Duty Hours:** Duty hours are defined as all clinical and academic activities related to the program; i.e., patient care (in and out patient), administrative duties relative to patient care, the provision for transfer of patient care, time spent in house during call activities, and scheduled activities, such as conferences. Duty hours DO NOT include reading and preparation time spent away from the duty site.

**External Moonlighting:** Voluntary, compensated, medically-related work performed outside the institution where the resident/fellow is in training or at any of its related participating sites.

**Faculty:** Any individual who has received a formal assignment to teach resident/fellow physicians.

**Fatigue Management:** Recognition by either resident/fellow or supervisor of a level

of resident /fellow fatigue that may adversely affect patient safety and enactment of solution to mitigate the fatigue.

**Fitness for Duty:** Mentally and physically able to effectively perform required duties and promote patient safety.

**Scope:** All Internal Medicine Residents

**Procedure:**

1. Duty Hours must be limited to 80 hours per week, averaged over a four week period.
2. Time spent by residents in Internal and External Moonlighting must be counted towards the 80 hour Maximum Weekly Hour Limit.
3. Residents must be scheduled for a minimum of one day free of duty every week (when averaged over four weeks or a calendar month.) At home call cannot be assigned on these free days.
4. Duty periods for PGY-1 residents must NOT exceed 16 hours in duration.
5. Residents/Fellows in the final years of education (PGY II and III as defined by ACGME's IM RRC) may be scheduled to a maximum of 24 hours continuous duty in the hospitals. The IM Residency Program encourages residents to use alertness management strategies in the context of patient care responsibilities. Strategic napping, especially after 16 hours of continuous duty and between the hours of 10:00 p.m. and 8:00 a.m. is strongly suggested.
6. It is essential for patient safety and resident education that effective transition in care occurs; residents are allowed to stay on site for additional four hours to ensure transition of care. In unusual circumstances residents/fellows may remain beyond scheduled duty to continue care on a single patient. Extensions for this reason should be discussed with the PGY- IV Chief or the Attending.
7. Residents must not be assigned additional clinical responsibilities after 24 hours of continuous in-house duty.
8. PGY-I residents must have ten hours free of duty between duty periods.
9. Residents/Fellows in the final years of education (PGY-II and III as defined by ACGME's IM RRC) must be within the context of the 80 hour, maximum duty period length and the one-day-off-in seven standards.
10. Residents/Fellows in the final years of education (PGY II and III as defined by ACGME's IM RRC) with circumstances of return - to - hospital activities with fewer than eight hours away from the hospital must be monitored by the Chief Resident/Fellow and the

Program Director.

11. Residents/Fellows in the final years of education (PGY-II and III and above as defined by ACGME's IM RRC) must be prepared to enter the unsupervised practice of medicine and care for patients over irregular or extended periods. This must occur within the context of the 80 hour, maximum duty period length and the one-day-off in seven standards.
12. In unusual circumstances, residents/fellows in the final years of education (PGY-II and III and above as defined by ACGME's IM RRC), may remain beyond their scheduled period of duty or return after their scheduled period of duty to provide care for a single patient. Justification for such extensions of duty are limited to reasons of required continuity of care for a severely ill or unstable patient, academic importance of the events transpiring, or humanistic attention to the needs of the patient or family. Such episodes should be rare, must be of the residents' own initiative, and need not initiate a new "off duty period" nor require a change in the scheduled "off duty period". Under such circumstances, the resident must appropriately hand over care of all other patients to the team. Additionally, the resident must document the reasons for remaining or returning to care for the patient in question and submit that documentation to the Program Director. The Program Director must review this documentation and track both individual and program-wide episodes of additional duty to the departmental duty hour's committee.
13. Residents/Fellows must not be scheduled for more than six consecutive nights of night float.
14. Residents/Fellows in the final years of education (PGY-II and III and above as defined by ACGME's IM RRC) must not be scheduled for in-house call more frequently than every third night (when averaged over a four-week period.)
15. Time spent in the hospital by the resident while assigned at home call must count toward the 80 hour work week.
16. Residents/Fellows are permitted to return to the hospital while on at-home call to care for new or established patients. While this return would be included in the 80 hour weekly maximum, it will not initiate a new "off-duty period."
17. PGY-II and III residents may moonlight with the approval of the Program Director. All moonlight hours must be included in the 80 hour weekly maximum. PGY I residents are not allowed to moonlight.
18. Senior Residents will be held accountable for all duty hour violations reported by interns on New Innovations.

19. Faculty will be held accountable for all duty hour violations reported by senior residents on New Innovations.
20. Documented falsification of duty hour reporting or counseling others to falsify duty hour reports will result in immediate probation.
21. Faculty are at risk of losing the privilege of having residents assigned to them if, after investigation, they are found to be the cause of the duty hour violations of their assigned residents.
22. Duty hours are monitored by the IM Program Director and Residency Coordinator. Outliers are discussed at the level of the PEC and by the Quillen College of Medicine GME Office. Corrective actions are developed, tracked and trended for all confirmed work hour violations.

4/2014

## EAST TENNESSEE STATE UNIVERSITY INTERNAL MEDICINE RESIDENCY PROGRAM

### MOONLIGHTING POLICY

Review the attached Institutional “Moonlighting Policies” of East Tennessee State University Quillen College of Medicine.

Moonlighting is not recommended. However, the Internal Medicine Residency program at East Tennessee State University DOES ALLOW moonlighting for second and third year residents **ONLY when not on a ward rotation** and when the resident is **not on back-up call**. **PYG-1 residents are NOT allowed to participate in moonlighting**. The ACGME requires that the Residency Program Director monitor all moonlighting activities – internal and external. Because of this requirement and to ensure that moonlighting does not interfere with the resident’s training and education, moonlighting requests must be submitted to the Residency Program Director IN WRITING for approval and after approval, the resident must provide the Program Director with a moonlighting schedule prior to date of scheduled moonlighting activity. This needs to be submitted to the Residency Program Coordinator on the first of each month for the Program Director’s review.

The resident must log ALL internal and external moonlighting hours into New Innovations. Both internal and external moonlighting will be counted against maximum duty hours and monitored for any duty hour violations.

Non-compliance with the Internal Medicine Residency program’s Moonlighting Policy will result in disciplinary actions including dismissal from the training program.

Contact the Residency Program Coordinator for specific forms and approval for moonlighting.

## Overall Goals and Objectives of IM Resident Training

### I. Knowledge

#### Goal:

The Internal Medicine resident will be a scholar who has a breadth and depth of knowledge that facilitates the practice of internal medicine. Residents will gain competencies in the areas of patient care, medical knowledge, practice-based learning and improvement, interpersonal and communication skills and professionalism and systems based practice.

#### Objectives:

1. The resident will be familiar with fundamental aspects of all disease processes listed in the written curriculum. In most cases, this will include pathophysiology, epidemiology, diagnosis, and treatment of disease.
2. The resident will participate in the formal monthly curriculum of study sessions and examinations based on Academic Half Day.
  - a. AHD examinations are mandated for **all residents**.
  - b. Poor performance on these examinations will result in remedial study with a preceptor or faculty as delegated by the Program Director until improvement is shown.
3. The resident will be expected to attend 100% of Academic Half Days over the three- year training period. Attendance will be taken and monitored on New Innovations and only excused for approved leave. Each lecture will be placed on D2L and made available to any resident unable to attend a specific lecture.
4. Each resident will demonstrate some special achievement based on scholarly activity. This may include knowledge developed from a research project, case study or literature review. It may also include a special lecture or presentation. Residents are encouraged to present at both regional and national levels
5. Every resident will participate in a Safety and Quality Improvement project at their assigned ambulatory clinic or hospital.
6. The program will have the following composite objectives with respect to resident knowledge base:
  - a. Maintain composite In-Training scores in the first quartile over the next three years. All PGY Levels are required to take the In-Training examination.
  - b. The program strives to have a 100% ABIM Board pass rate for all graduates.

### II. History and Physical Exam Skills Goal:

Train residents to possess excellent clinical skills--including an appreciation of and skill in obtaining clues to diagnosis through patient interview. The resident should be trained to

perform a thorough physical examination with proper technique and with an ability to do a focused exam depending on particular presentation.

**Objectives:**

1. Each resident will perform a complete history and physical examination while being evaluated by a full-time faculty member during the first two years.
2. Attending physicians will evaluate the history, physical exam skills, clinical judgment, and professionalism of residents using the standard ABIM mini-CEX form.
3. Teaching rounds will be formally scheduled at least three times per week and will include instruction by the attending on bedside diagnosis.
4. Special lectures on physical diagnosis will be included in core lectures. Some of these lectures will include a literature review of the sensitivity and specificity of physical exam techniques.
5. Third year residents with excellent clinical skills will be chosen to assist in the second year medical student physical diagnosis course.

**III. Diagnostic Tests and Therapeutic Interventions Goal:**

The resident will be a wise and knowledgeable physician who recognizes the value and limitations of diagnostic tests and the indications and complications of all therapeutic options. The resident will be skilled in making therapeutic decisions both in the inpatient and outpatient setting. The resident will appreciate the role of the medical literature in reaching therapeutic decisions and the diseases and interventions for which consultation is appropriate.

**Objectives:**

1. The resident will use assigned readings and core lectures to supplement clinical experience in diagnostic and therapeutic decision making.
2. The resident's developing abilities in diagnostic and therapeutic decision making will be evaluated daily by attending physicians. CQI conferences, chart audits, clinical scenarios tested by written exam will supplement this learning experience.
3. The diagnostic and therapeutic skills necessary to develop in each specialty will be reviewed by each resident using the written curriculum that follows.
4. Core lectures will include specific knowledge about clinical decision making, technique and complications of procedures, literature review, and computer-assisted diagnosis. Residents will be expected to demonstrate a graduated level of knowledge over the course of their residency.



#### **IV. Prevention**

##### **Goal:**

The prevention of disease and disability will become an integral part of Internal Medicine's teaching. In addition to preventive medicine as a centerpiece of Primary Care, each subspecialty will emphasize the special aspects of prevention in their specialty.

##### **Objectives:**

1. The resident will be knowledgeable about all aspects of prevention as listed in the written curriculum.
2. Preventive medicine will be part of ambulatory care and continuity clinic teachings.
3. Preventive medicine will be especially emphasized in core lectures.

#### **V. Special Values and Attitudes**

##### **Goal:**

Residents will demonstrate professionalism and professional integrity. They will value the physician-patient relationship. They will demonstrate high standards of moral behavior. Residents will accept fundamental responsibility for caring for others. Residents will demonstrate compassion and empathy. Residents will work cooperatively and respectfully with other members of the health care team. They will integrate care to community health care resources.

##### **Objectives:**

1. Faculty will serve as role models in the values and attitudes that they possess.
2. Residents will develop skills in evaluating peers on these attitudes. Residents will not accept unprofessional behavior in their peer group and will know how to deal with the issue of physician impairment.
3. Residents will use principles learned in medical ethics as standards of professional behavior.
4. Residents will seek advice from program director, faculty advisor, and ethics committee when issues of professional behavior need clarification. Core lectures on professionalism, ethics, legal aspects of medicine, and patient-physician relations will supplement ward and outpatient experiences. The ABIM guidelines on professionalism and humanistic practice of medicine are included in the written curriculum.

## **Principal Educational Goals by Relevant Competency**

In the lists below, the principal educational goals for the Inpatient Floor rotations are indicated for each of the six ACGME competencies. The second column of the table indicates the most relevant principal teaching/learning activity for each goal, using the legend below.

### **1) Patient Care - Principal Educational Goals**

Learning Activities:

- Interview patients more skillfully
- Examine patients more skillfully
- Define and prioritize patients' medical problems
- Generate and prioritize differential diagnoses
- Develop rational, evidence-based management strategies

### **2) Medical Knowledge - Principal Educational Goals**

Learning Activities:

- Expand clinically applicable knowledge base of the basic and clinical sciences underlying the care of medical inpatients
- Access and critically evaluate current medical information and scientific evidence relevant to patient care

### **3) Practice-Based Learning and Improvement - Principal Educational Goals**

Learning Activities:

- Identify and acknowledge gaps in personal knowledge and skills in the care of hospitalized patients
- Develop and implement strategies for filling gaps in knowledge and skills

### **4) Professionalism - Principal Educational Goals**

Learning Activities:

- Behave professionally toward patients, families, colleagues, and all members of the health care team

### **5) Interpersonal Skills and Communication - Principal Educational Goals**

Learning Activities:

- Communicate effectively with patients and families
- Communicate effectively with physician colleagues at all levels
- Communicate effectively with all non-physician members of the health care team to assure comprehensive and timely care of hospitalized patients
- Present patient information concisely and clearly, verbally and in writing
- Teach colleagues including medical students effectively

## **6) Systems-Based Practice - Principal Educational Goals**

### **Learning Activities:**

- Understand and utilize the multidisciplinary resources necessary to care optimally for hospitalized patients
- Collaborate with other members of the health care team to assure comprehensive patient care
- Use evidence-based, cost-conscious strategies in the care of hospitalized patients

### **Evaluation Methods:**

- During floor rotations residents are formally evaluated in writing or online, ACGME six core competencies, using ABIM standard evaluation forms and parameters, by their teaching attendings, by their resident colleagues on the team, as well as by nurses and by occasional patients, thereby obtaining a true 360 ° evaluation of the resident. They are also evaluated by any medical students assigned to the team. All of these evaluations are turned in to the program office and reviewed with the resident by the Program Director at the time of their semi-annual feedback meetings. The Program Director reviews all evaluations. If an unfavorable or marginal evaluation is received on any resident, an urgent appointment with the Program Director is scheduled with that resident to review the issues raised in the evaluation. Each PGY Level is responsible for completing four Mini-CEXs per year. A total of 12 per Residency are also performed throughout each year of residency contributing to the summative evaluation.
- The Program Director meets regularly with the Clinical Competency Committee (CCC) to review resident performance in an ongoing fashion. Information from these meetings is incorporated into the feedback residents receive at their regular meetings with the Program Director. Additionally the CCC provides the Milestone review and is responsible for documenting all ACGME requirements in WebADS biannually for every resident.

## **QCOM Internal Medicine Residency**

### **RESPONSIBILITIES OF THE CLINICAL COMPETENCY COMMITTEE (CCC)**

The Clinical Competency Committee (CCC) has primary responsibility for monitoring the competence and professionalism of the internal medicine residency for the purposes of recommending promotion and certification, and for initial counseling, probation or other remedial or adverse action.

#### **Membership:**

The CCC is appointed by the chair of the department and assists the program director in these functions. Members of the Committee are chosen by the Committee Chair and may include the Key Clinical Faculty. In addition, the Program Director, Associate and Assistant Program Directors, and one Chief Medical Resident serve as members. The CCC must have at least 3 members.

#### **Responsibilities:**

The CCC will meet each fall and spring per academic year to review each resident's portfolio and generate Milestones to report to the ACGME. Two additional general meetings will be scheduled (August and February) and ad hoc meetings may be required to address pressing resident issues. The Chair or his/her designee will keep detailed minutes of all meetings. The QCOM IM Clinical Competency Committee Policy Members may also be asked to participate in semi-annual resident performance reviews in conjunction with the Program Director and Assistant Program Directors.

#### **Committee members will participate:**

- In reviewing all resident evaluations.
- Preparing and assuring the reporting of Milestones evaluations of each resident to the ACGME semi-annually.
- Making recommendations to the program director for resident progress, including promotion, remediation and dismissal.

#### **A resident may be brought up for discussion by the CCC for any of the following reasons:**

- Recommendation by the Program Director for any reason.
- Consistently low or unsatisfactory evaluation scores.
- Consistent lack of adherence to program requirements.
- A specific incident that requires review by the CCC for possible probation or dismissal.

The committee may make the following recommendations and the recommendations must follow the IM Program policies and/or the QCOM GME policies:

- No further action necessary.
- Letter of concerns with specific terms and remediation recommendations.
- Probation with specific terms and/or referral to the remediation subcommittee for specific recommendations.
- May be with or without extension of time at level of training.
- Termination.
- Delay or denial of promotion or board recommendation.

## THE INTERNAL MEDICINE MILESTONE PROJECT

A Joint Initiative of  
The Accreditation Council for Graduate Medical Education  
and  
The American Board of Internal Medicine

### MILESTONES

It is anticipated that residents will reach certain milestones in their training as remonstrated by the following General Competency Goals and Objectives for level of training.  
General Competencies Goals and Objectives for Level of Training:

#### PATIENT CARE

<b>PGY 1</b> <ul style="list-style-type: none"><li>• Monitors and Follows Up Patients</li><li>• Information Gathered Is Accurate</li><li>• Daily Notes Are Focused and Pertinent</li><li>• Begins to Perform ABIM Invasive Procedures</li><li>• Discharge Summaries are Accurate and Finished in a Timely Fashion</li><li>• Performs a Thorough History and Physical Examination</li><li>• Formulates a Reasonable Diagnostic and Therapeutic Plan</li><li>• Can Competently Use a Computerized Medical Record</li></ul>	<b>PGY 2</b> <ul style="list-style-type: none"><li>• Can Supervise Patient Care Activities of Students and PGY 1 Residents</li><li>• Interprets Diagnostic Studies Accurately</li><li>• Can Manage Multiple Problems Simultaneously</li><li>• Considers Patient Preferences When Making Health Care Decisions</li><li>• Has Performed the Majority of ABIM Invasive Procedures</li></ul>	<b>PGY 3</b> <ul style="list-style-type: none"><li>• Shows Independence to Act as an Internal Medicine Consultant</li><li>• Formulates Appropriate Plans in Ambiguous Clinical Situations</li></ul>
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## MEDICAL KNOWLEDGE

<b>PGY 1</b> <ul style="list-style-type: none"> <li>• Attends Required Conferences</li> <li>• Has Clinical and Relevant Basic Science Knowledge of Assigned Patient's Problems</li> <li>• Can Use Online Medical Data Base</li> <li>• Independently Reads and Accumulates Knowledge of Internal Medicine</li> </ul>	<b>PGY 2</b> <ul style="list-style-type: none"> <li>• Attends Weekly Internal Medicine Review Sessions</li> <li>• Takes the Monthly Internal Medicine Review Test</li> <li>• Presents at Journal Club and Morning Report</li> <li>• Is Aware Of Common Drug/Drug Interactions</li> <li>• Knows Precautions and Contraindications of Medications Used</li> <li>• Recognizes Basic ECG Abnormalities Including Common Arrhythmias</li> <li>• Teaches Students and PGY 1 Residents</li> </ul>	<b>PGY 3</b> <ul style="list-style-type: none"> <li>• Has Started a Project to Demonstrate Scholarly Activity</li> <li>• The Resident Will Likely Pass the ABIM Examination</li> </ul>
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## PATIENT-BASED LEARNING IMPROVEMENT

<b>PGY 1</b> <ul style="list-style-type: none"> <li>• Evaluates Basic Patient Preventative Medicine and Performance Measures</li> <li>• Recognizes Limitations &amp; Asks For Advice When Appropriate</li> <li>• Requests Appropriate Consultation</li> </ul>	<b>PGY 2</b> <ul style="list-style-type: none"> <li>• Develops Self-Evaluation of Clinical Performance</li> </ul>	<b>PGY 3</b> <ul style="list-style-type: none"> <li>• Develops a Portfolio of Clinical Performance Measures</li> </ul>
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## INTERPERSONAL AND COMMUNICATION SKILLS

<b>PGY 1</b> <ul style="list-style-type: none"> <li>• Fluently Speaks and Understands the English Language</li> <li>• Understands Patient's Level of Communication</li> <li>• Effectively Communicates and Updates Patients About Their Condition</li> <li>• Develops Listening Skills</li> </ul>	<b>PGY 2</b> <ul style="list-style-type: none"> <li>• Able To Discuss End of Life Care with Patients and Families</li> <li>• Counsels and Educates Patients and Families</li> <li>• Can Interact With Consultants</li> <li>• Explains Complex Diagnoses To Patients and Families</li> </ul>	
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## PROFESSIONALISM

<b>PGY 1</b> <ul style="list-style-type: none"><li>• Establishes Trust and Demonstrates Honesty with Patients and Staff</li><li>• Information Given to Colleagues and Supervisors Is Accurate and Reliable</li><li>• Respects the Opinions of Others</li><li>• Respects Differences of Culture, Gender, Race and Age</li><li>• Accepts Responsibility</li><li>• Appearance Is Neat, Clean and Professional</li><li>• Is Free From Substance Abuse or Is Undergoing Rehabilitation</li></ul>	<b>PGY 2</b> <ul style="list-style-type: none"><li>• Displays Leadership</li><li>• Appropriately Delegates Work Assignments and Authority</li><li>• Acknowledges Errors and Misjudgment and Works to Minimize Them</li></ul>	<b>PGY 3</b> <ul style="list-style-type: none"><li>• Has Clinical Knowledge and Leadership Skills to Be a Chief Resident</li></ul>
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## SYSTEMS BASED PRACTICE

<b>PGY 1</b> <ul style="list-style-type: none"><li>• Acts As a Patient Advocate</li><li>• Begins the Mastery of Global Health Care Delivery</li><li>• Begins to Understand Health Insurance Mechanisms</li></ul>	<b>PGY 2</b> <ul style="list-style-type: none"><li>• Works with Ancillary Team Members to Provide In Hospital and Post-Discharge Care</li></ul>	<b>PGY 3</b> <ul style="list-style-type: none"><li>• Understands and Can Provide Cost Effective Care</li><li>• Understands Basics of Billing and Coding Issues</li></ul>
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## **IM RESIDENCY SUPERVISION POLICY**

### **PURPOSE:**

The Internal Medicine Residency Program recognizes and supports the importance of graded and progressive responsibility in graduate medical education. This policy outlines the requirements to be followed when supervising residents. The goal is to promote assurance of safe patient care, and the resident's maximum development of the skills, knowledge, and attitudes needed to enter the unsupervised practice of medicine. There are four (4) levels of supervision recognized.

1. **Direct:** The supervising physician is physically present with the resident and the patient and is prepared to take over the provision of patient care if/as needed.
2. **Indirect supervision with direct supervision immediately available:**  
The supervising physician is present in the hospital (or other site of patient care) and is immediately available to provide Direct Supervision. The supervisor may not be engaged in any activities (such as a patient care procedure) which would delay his/her response to a resident requiring direct supervision.
3. **Indirect supervision with direct supervision available:** The supervising physician is not required to be present in the hospital or site of patient care, or may be in-house but engaged in other patient care activities, but is immediately available through telephone or other electronic modalities, and can be summoned to provide Direct Supervision.
4. **Oversight:** The supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered.

**Scope:** All Internal Medicine Residents

### **PROCEDURE:**

1. The IM Residency establishes schedules which assign qualified faculty physicians, Fellows or Senior Residents to supervise at all times and in all settings in which Internal Medicine residents provide any type of patient care. The type of supervision to be provided is delineated in the curriculum's rotation description and/or the graduate levels of responsibility.
2. The minimum amount/type of supervision required in each situation is determined by the definition of the type of supervision specified, but is tailored specifically to the demonstrated skills, knowledge, and ability of the individual resident. In all cases, the faculty member functioning as a supervising physician should delegate portions of the patient's care to the resident, based on the needs of the patient and the skills of the resident.
3. Senior residents and fellows serve in a direct or indirect supervisory role of junior residents in recognition of their progress toward independence.
4. All residents, regardless of year of training, must communicate with the appropriate



supervising faculty member transfers to intensive care and end of life decisions.

5. In every level of supervision, the supervising faculty member must review progress notes, sign procedural and operative notes and discharge summaries.
6. Faculty members must be continuously present to provide supervision in ambulatory settings, and be actively involved in the provision of care, as assigned.

## **LINES OF RESPONSIBILITY**

Ultimate supervision responsibility for patient care rests with the medical attending. The medical attending is readily available 24 hours per day for resident consultation. Medical attendings must review all resident orders, make frequent progress notes and approve all changes in the level of care, approve diagnostic studies, and sign all histories, physicals and discharge summaries. Graded responsibility for the ward team within 24 hours of admission is given to PGY-II and PGY-III supervisory residents and to the Chief Resident. They are responsible for the quality of care provided by their unit. Interns and residents are responsible for first-physician contact responsibility. When the complexity of needed services exceeds the capability of both the senior resident and the medical Chief Resident, the back-up system is activated or the appropriate qualified medical attending is contacted.

Residents are given progressive responsibility for the care of patients. The resident can act as a teaching assistant to less experienced residents. Assignment of the level of responsibility is commensurate with their acquisition of knowledge and development of judgment and skill; and is consistent with the requirements of the Accreditation Council for Graduate Medical Education and the American Board of Internal Medicine.

The determination of a resident's ability to accept responsibility for performing procedures or activities without a supervisor present and/or act as a teaching assistant is based on documented evidence of the resident's clinical experience, judgment, knowledge and technical skills. Such evidence is obtained through minutes and written evaluations completed by the medical attendings at the affiliated institutions and/or other clinical practice information.

Documentation of a resident's assigned level of responsibility is filed in the resident's record which is maintained in the office of the Program Coordinator. Documentation is also supplied to each teaching institution as well as the GME Office.

Even though the resident is acting as a teaching assistant, the medical attending remains responsible for the quality of care of the patient, providing supervision and meeting medical record documentation requirements.

All residents are responsible for assuring all medical records are completed in accordance to the Medical Staff policies of the assigned rotation facility. If medical records are not completed at the end of the rotation, residents may be asked to take annual leave for the purpose of completing discharge summaries and other paperwork. Residents are strongly encouraged to complete the records at discharge.

## **ORDER WRITING POLICY**

Residents must write all orders for patients under their care, with appropriate supervision by the attending physician. In unusual circumstances when an attending physician or subspecialty resident writes an order on a resident's patient, the attending or subspecialty resident must communicate his or her action to the resident in a timely manner.

Proficiency in usage of all participating sites Electronic Health Record is an expectation. Proper utilization of each participating sites approved Medical Staff Order Sets is required.

## **PATIENT SUPERVISION BY RESIDENTS**

On Inpatient rotations:

First-year residents:

- Must not be assigned more than five new patients per admitting day; an additional two patients may be assigned if they are in-house transfers from the medical services.
- Must not be assigned more than eight new patients in a 48-hour period.
- Must not be responsible for the ongoing care of more than ten patients.
- Should interact with second-year or third-year internal medicine residents in the care of patients.

Second-year and third-year residents:

- When supervising more than one first-year resident, the supervising resident must not be responsible for the supervision or admission of more than ten new patients and four transfer patients per admitting day or more than 16 new patients in a 48 hour period.
- When supervising one first-year resident, the supervising resident must not be responsible for the ongoing care of more than 14 patients.
- When supervising more than one first-year resident, the supervising resident must not be responsible for the ongoing care of more than 20 patients.
  - First-year residents should interact with second and third-year internal medicine residents in the care of patients.
  - Senior internal medicine residents or other appropriate supervisory physicians must be available at all times on site to supervise first-year residents.
  - Residents should have continuing responsibility for most of the patients they admit.
  - Residents from other specialties must not supervised IM residents on any IM inpatient rotation.

## **CARE OF NON-TEACHING PATIENTS**

Residents will be responsible for the care of patients on the teaching service only. If concerns or issues arise regarding care of non-teaching patients, please contact the attending and the program director.

**PGY 1 GRADUATED LEARNING RESPONSIBILITIES**  
**Internal Medicine Residency**  
**Quillen College of Medicine**

**Resident Name:**

**I. Patient Care Objectives**

*A. Interviewing:* Residents must demonstrate the importance of communication when caring for patients as they collect highly personal information.

PGY-1 residents should consistently demonstrate integrity, respect, compassion and empathy for patients and their families. They should establish trust and recognize the primary concern is the welfare of the patient. Residents at this level of training will respect personal preferences and understand patient rights. They will engage in shared decision making with their patients.

*B. History taking:* Residents must demonstrate an understanding of the importance of history in deriving a differential diagnosis.

PGY-1 residents will consistently gather essential and accurate information. The database will be organized in manner consistent with accepted medical convention and charted in a timely and efficient manner. The information will be comprehensive and include data gathered by other providers and laboratory investigations.

*C. Physical Examination:* Residents will demonstrate the importance of performing an appropriate and relevant physical exam.

PGY-1 residents will perform a comprehensive physical exam with a constant. Residents at this level will be able to identify normal from abnormal and will describe the physiological and anatomical basis for these findings. Residents will demonstrate the ability to augment their physical exam steps to elicit data not obtained with standard movements.

*D. Clinical Judgment, Medical Decision-Making and Management Plans:* Residents will progressively become more adept at assimilating information that they have gathered from the history and physical exam.

PGY-1 residents will be able to identify all the patients' problems and develop a prioritized differential diagnosis. They will understand their limitation of knowledge and seek the advice of more advanced clinicians. PGY-1 residents will begin to develop therapeutic plans that are evidenced or consensus based. Residents will establish an orderly succession of testing based on their history and exam findings. They will demonstrate wise use of diagnostic therapeutic procedures.

*E. Oral Case Presentation Skills:* Residents at all levels of training will be adept in oral presentation skills. This will be demonstrated by delivering an appropriately focused case presentation that is well organized. They will include all important aspects of the history, physical exam, and laboratory investigations. The assessment will be well developed and include an in-depth differential diagnosis and carefully executed diagnostic and therapeutic plan. Residents will become progressively more sophisticated at distilling relevant information. Pertinent materials such as x-rays and EKG's will be included and correctly interpreted.

*F. Patient /Family Education:*

PGY-1 residents will be skilled at giving patients accurate instructions regarding usage of their medications and follow-up care. They will document their counseling conversations.

*G. Use of Technology:* Residents will understand the increasing role that technological advancements bring to the bedside.

PGY-1 residents will demonstrate the usage of computer-assisted databases for diagnosis and decision-making. They will utilize the electronic medical record. They will regularly utilize drug information programs.

*H. Procedures:* Residents will understand the importance of competently performing medical procedures essential for the practice of general internal medicine.

PGY-1 residents will demonstrate knowledge of procedural indications, contraindications, necessary equipment, process for handling specimens and patient after-care. They will participate in informed consent and assist the patient with decision making through their knowledge.

Procedures will be documented by residents in New Innovations and confirmed by their preceptor.

PGY-1 residents will be supervised for all procedures. By the end of the first year, PGY I residents will successfully completed the following procedures.

Procedure	Number required	Competent
Arterial Blood Draw or Gas	5	
Venous Blood Draw	5	
Pap Smear/Endocervical Culture	5	
Venous Peripheral Catheter	5	

## **II. Medical Knowledge Specific Competency Objectives**

Residents must demonstrate knowledge about established and evolving biomedical, clinical, and cognate (e.g. epidemiological and social-behavioral) sciences and the application of this knowledge to patient care. Residents are expected to:

*A. Know and apply* the basic and clinically supportive sciences which are appropriate to their discipline  
PGY-1 residents will:

Demonstrate knowledge of common procedural indications, contraindications, necessary equipment, process for handling specimens and patient after-care.

Demonstrate knowledge of basic and clinical sciences.

Demonstrate satisfactory knowledge of common medical conditions, sufficient to manage urgent complaints with supervision. Residents must exhibit sufficient content knowledge of common conditions to provide care with minimal supervision by completion of the PGY-1 year.

*B. Demonstrate* an investigatory and analytic approach to clinical situations

PGY-1 residents will:

Exhibit utilization of the University and hospital library resources.

Exhibit self-motivation to learn.

Demonstrate sufficient analytic skills necessary to develop appropriate assessments and plans for common medical diagnoses and complaints.

Demonstrate ability to frame clinical questions and initiate literature search.

Regularly display self-initiative to stay current with new medical knowledge.  
Independently present current scientific evidence to support hypotheses.  
Prepare a scholarly work.

### **III. Practice Based Learning and Improvement Specific Competency Objectives**

The ability to utilize clinical practice and direct patient care as a venue for practice improvement and learning is a lifelong process; however it is expected that all levels of resident will satisfactorily function in the following areas:

*A. Evidence Based Medicine:* Location, appraisal, and assimilation of evidence from scientific studies related to patients' health problems. Application of knowledge of study designs and statistical methods to the appraisal of clinical studies and other information on diagnostic and therapeutic effectiveness.

*B. Information Technology:* All training levels will use information technology to manage information, access on-line medical information and support their own education.

*C. Teaching:* Facilitation of learning of students, resident colleagues, and other health care professionals  
PGY-1 residents should be able to facilitate the learning of students and other PGY-1 residents.

### **IV. Interpersonal and Communication Skills Objectives**

PGY-1 residents should:

*A. Communication:* Provide appropriately succinct oral presentations regarding patient care, using appropriate medical terminology. Develop skills in presenting at the bedside  
Provide timely thorough and complete written or electronic documentation of patient care (*e.g.*, progress or procedure notes, history and physical exams, consultant notes, discharge summaries), which are legible and use appropriate medical terminology; Demonstrate proficiency in use of language and nonverbal skills in interactions outside of the context of patient care.  
Establish rapport with patients from a variety of backgrounds; perform a medical interview that elicits both patient- and physician-centered information, as well as testing diagnostic hypotheses; and effectively communicate uncomplicated diagnostic and therapeutic plans to patients or their advocates.

*B. Ethically sound relationships:* Follow the tenets of ethics in patient care.

*C. Working within teams:* Work as team members with senior residents and attending physicians, including the communication skills outlined above and the coordination of patient care. When supervising medical students, first year residents should be able to observe students, demonstrate skills, actively involve students in patient care, and give constructive feedback. First year residents should be able to work effectively with ancillary staff to enhance patient care.

### **V. Systems Based Practice Objectives**

Residents must demonstrate an awareness of and responsiveness to the larger context and system of health care and the ability to effectively call on system resources to provide care that is of

optimal value.

Residents are expected to:

*A. Reflect* on how their patient care and other professional practices affect other health care professionals, the health care organization, and the larger society and how these elements affect their own practice.

PGY-1 residents should display ability to work well within their core clinical team, including other residents/attending physicians/directly involved nurses/respiratory therapists/other professionals involved in the care of their assigned patients.

*B. Know* how types of medical practice and delivery systems differ from one another, including methods of controlling health care costs and allocating resources.

PGY-1 residents must actively participate in discharge planning sessions and attend educational sessions relating to different types of medical practice and delivery systems.

*C. Practice* cost-effective health care and resource allocation that does not compromise quality of care.

By conclusion of the PGY-1, residents must reflect sensitivity to costs and be able to incorporate fundamental cost-effective analysis into care approaches, minimizing redundant or unnecessary care.

*D. Advocate* for quality patient care and assist patients in dealing with system complexities.

PGY-1 residents must demonstrate commitment and dedication to high quality patient care. By completion of PGY-1, residents must identify, implement, document, and monitor established local patient care plans that are consistent with nationally published clinical practice guidelines.

*E. Know* how to partner with health care managers and health care providers to assess, coordinate, and improve health care and know how these activities can affect system performance.

By completion of PGY-1, residents must demonstrate ability to regularly and effectively work with the patient care coordinators/discharge coordinator, social workers, and other health care professionals to assess, coordinate, and improve patient care.

This approved form will remain in force for a period of one year from the promotion date, or until an updated form is issued.

\_\_\_\_\_  
**Residency Program Director**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Signature of Resident**

\_\_\_\_\_  
**Date**

**cc: Resident File  
GME Office  
Teaching Institutions**

**PGY 2 GRADUATED LEARNING RESPONSIBILITIES**  
**Internal Medicine Residency**  
**Quillen College of Medicine**

**Resident Name:**

**I. Patient Care Objectives**

*A. Interviewing:* Residents must demonstrate the importance of communication when caring for patients as they collect highly personal information. All senior residents should consistently demonstrate integrity, respect, compassion and empathy for patients and their families. They should establish trust and recognize the primary concern is the welfare of the patient. Residents at this level of training will respect personal preferences and understand patient rights. They will engage in shared decision making with their patients. PGY-2 residents should demonstrate the above and aid junior peers in effective communication with patients.

*B. History taking:* Residents must demonstrate an understanding of the importance of history in deriving a differential diagnosis. All senior residents will consistently gather essential and accurate information. The database will be organized in manner consistent with accepted medical convention and charted in a timely and efficient manner. The information will be comprehensive and include data gathered by other providers and laboratory investigations. PGY-2 residents will be precise, logical, and efficient in their data collect in addition to the above. They will demonstrate progressive skills in hypothesis driven histories.

*C. Physical Examination:* Residents will demonstrate the importance of performing an appropriate and relevant physical exam. All senior residents will perform a comprehensive physical exam with a constant. Residents at this level will be able to identify normal from abnormal and will describe the physiological and anatomical basis for these findings. Residents will demonstrate the ability to augment their physical exam steps to elicit data not obtained with standard movements. PGY-2 residents, in addition to the above, will correctly detect subtle findings and understand their significance. Residents will be able to teach appropriate physical exam skills to junior peers and medical students.

*D. Clinical Judgment, Medical Decision-Making and Management Plans:* Residents will progressively become more adept at assimilating information that they have gathered from the history and physical exam. ALL residents will be able to identify all the patients' problems and develop a prioritized differential diagnosis. They will understand their limitation of knowledge and seek the advice of more advanced clinicians. PGY-1 residents will begin to develop therapeutic plans that are evidenced or consensus based. Residents will establish an orderly succession of testing based on their history and exam findings. They will demonstrate wise use of diagnostic therapeutic procedures. PGY-2 residents will demonstrate the above and in addition will regularly integrate medical facts and clinical data while weighing alternatives and keeping in mind patient preference. They will regularly incorporate consideration of costs, risks, and benefits when considering testing and therapies. They will present up-to-date scientific evidence to support their hypotheses. They will use information technology effectively to support patient care decisions and strive to provide cost effective care. They will consistently monitor and follow-up patients appropriately. They will enlist social and other out-of-

hospital clinical resources to help patients with the therapeutic plan. PGY-2 residents will assist junior trainees and medical students to become efficient managers through the appropriate use of clinical judgment and effective decision-making.

*E. Oral Case Presentation Skills:* Residents at all levels of training will be adept in oral presentation skills. This will be demonstrated by delivering an appropriately focused case presentation that is well organized. They will include all important aspects of the history, physical exam, and laboratory investigations. The assessment will be well developed and include an in-depth differential diagnosis and carefully executed diagnostic and therapeutic plan. Residents will become progressively more sophisticated at distilling relevant information. Pertinent materials such as x-rays and EKG's will be included and correctly interpreted.

*F. Patient/Family Education:* All senior residents will be skilled at giving patients accurate instructions regarding usage of their medications and follow-up care. They will document their counseling conversations.

PGY-2 residents will effectively counsel and educate patients about pertinent health issues, tests and treatments. They will be able to recommend appropriate screening exams by gender and age. Residents will consistently and thoroughly educate patients and their families, using patient education as a form of intervention and partnering.

*G. Use of Technology:* Residents will understand the increasing role that technological advancements bring to the bedside.

All senior residents will demonstrate the usage of computer-assisted databases for diagnosis and decision-making. They will utilize the electronic medical record. They will regularly utilize drug information programs.

PGY-2 residents, in addition to the above, will efficiently utilize the electronic medical record. They will utilize electronic databases for patient educational materials. They will demonstrate the ability to perform a literature search of available databases as needed to facilitate patient care and their own learning.

*H. Procedures:* All residents will understand the importance of competently performing medical procedures essential for general internal medicine.

All residents will be supervised where skill level dictates or when a sufficient number of procedures have not been completed and competency has not been ascertained. When competency has been established, they will assist their junior peers in skill acquisition.

PGY-2 residents, in addition to the above, will demonstrate extensive knowledge and be facile in the performance of procedures. By the end of the PGY-3 year residents will have successfully completed the following procedures.

Procedure	Number required	Competent
Abdominal Paracentesis	5	
Arterial Line Placement	5	
Arthrocentesis	5	
Central Venous Line-Internal Jugular	5	
Central Venous –Subclavian	5	



Incision & Drainage of Abscess	5	
Lumbar Puncture	5	
Nasogastric Tube Insertion	5	
Peripheral Venous Line Placement	5	
Thoracentesis	5	

## II. Medical Knowledge Specific Competency Objectives

Residents must demonstrate knowledge about established and evolving biomedical, clinical, and cognate (e.g. epidemiological and social-behavioral) sciences and the application of this knowledge to patient care. Residents are expected to:

*A. Know* and apply the basic and clinically supportive sciences which are appropriate to their discipline all senior residents will:

Demonstrate knowledge of common procedural indications, contraindications, necessary equipment, process for handling specimens and patient after-care.

Demonstrate knowledge of basic and clinical sciences.

Demonstrate satisfactory knowledge of common medical conditions, sufficient to manage urgent complaints with supervision. Residents must exhibit sufficient content knowledge of common conditions to provide care with minimal supervision by completion of the PGY-1 year.

PGY-2 residents will additionally:

*B. Demonstrate* a progression in content knowledge and analytical thinking in order to develop well- formulated differential diagnoses for multi-problem patients.

Demonstrate understanding and responsiveness to socio-behavioral issues.

Develop knowledge of statistical principles. Understand and appropriately use sensitivity, specificity, predictive values, likelihood ratio, number needed to treat, and odds ratios.

Take the USMLE Step 3 exam by December.

Effective for entering class 2014-2015: Pass the USMLE Step 3 exam, with documentation of passing grade provided to Residency Office. Demonstrate knowledge regarding the performance of procedures while minimizing risk and discomfort to patients.

Exhibit knowledge of effective teaching and evaluation methods.

*C. Demonstrate* an investigatory and analytic approach to clinical situations Senior residents will:

Exhibit utilization of the University and hospital library resources.

Exhibit self-motivation to learn.

Demonstrate sufficient analytic skills necessary to develop appropriate assessments and plans for common medical diagnoses and complaints.

Demonstrate ability to frame clinical questions and initiate literature search.

PGY-2 residents will additionally:

Regularly display self-initiative to stay current with new medical knowledge.

Independently present current scientific evidence to support hypotheses.

Prepare the first required scholarly work.

### **III. Practice Based Learning and Improvement Specific Competency Objectives**

The ability to utilize clinical practice and direct patient care as a venue for practice improvement and learning is a lifelong process; however it is expected that a resident will satisfactorily function in the following areas:

*A. Evidence Based Medicine:* Location, appraisal, and assimilation of evidence from scientific studies related to patients' health problems. Application of knowledge of study designs and statistical methods to the appraisal of clinical studies and other information on diagnostic and therapeutic effectiveness.

All residents should demonstrate the ability to:

Be self-motivated to acquire knowledge.

Locate scientific literature to support decision-making.

PGY-2 residents should additionally:

Be able to appraise and assimilate scientific literature.

Demonstrate understanding and use of an evidence-based approach in providing patient care.

Quickly access appropriate reference material for critically ill patients.

Voluntarily (without prompting or assignment) discuss and research relevant literature to support decision-making processes.

Acquire and use appropriate evidence-based information when acting as a consultant.

Learn and be able to research non-internal medicine patient care issues.

*B. Information Technology:* Using information technology to manage information, access on-line medical information and support their own education

All residents should be able to:

Use the EMR, web-based curricular modules, and web-based resources to access medical literature and data to support and enhance patient care.

PGY-2 residents should additionally:

Independently use Health Links and other computerized connections to primary literature to enhance patient care.

*C. Teaching:* Facilitation of learning of students, resident colleagues, and other health care professionals

All senior residents should be able to:

Facilitate the learning of students and other PGY-1 residents.

PGY-2 residents should additionally:

Facilitate education of PGY-1 residents, medical students, and other health care professionals.

Demonstrate evidence based independent research and preparation when teaching junior colleagues or peers.

Use interactions with nursing staff and other professionals as two-way educational opportunities.

### **IV. Interpersonal and Communication Skills Objectives**

All residents should:

*A. Communication:*

Provide appropriately succinct oral presentations regarding patient care, using appropriate medical terminology.

Develop skills in presenting at the bedside.

Provide timely thorough and complete written or electronic documentation of patient care (e.g., progress or procedure notes, history and physical exams, consultant notes, discharge summaries), which are legible and use appropriate medical terminology.

Demonstrate proficiency in use of language and nonverbal skills in interactions outside of the context of patient care (e.g., establish rapport with patients from a variety of backgrounds; perform a medical interview that elicits both patient- and physician-centered information, as well as testing diagnostic hypotheses; and effectively communicate uncomplicated diagnostic and therapeutic plans to patients or their advocates.

*B. Ethically sound relationships:* Follow the tenets of ethics in patient care.

*C. Working within teams:* Work as team members with senior residents and attending physicians, including the communication skills outlined above and the coordination of patient care. When supervising medical students, first year residents should be able to observe students, demonstrate skills, actively involve students in patient care, and give constructive feedback. First year residents should be able to work effectively with ancillary staff to enhance patient care.

*D. PGY-2 residents, in addition to the above, should further master the skills below:*

*Patient Communication:* PGY-2 residents should be able to engage patients in shared decision making for ambiguous or controversial scenarios, and conduct family meetings as in the setting of end of life decision making. They should be able to successfully negotiate most “difficult” patient encounters, such as the irate patient.

*Team Work:* PGY-2 residents should progressively assume a leadership role, facilitating interactions between junior residents, medical students, ancillary staff, and attending physicians. This includes establishing expectations for all members of the team, overseeing patient care, ensuring participation in academic discussions, etc. They should also be the primary team members interacting with specialists regarding consults, and notifying outpatient primary care physicians of their patients’ hospital courses.

## **V. Systems Based Practice Objectives**

Residents must demonstrate an awareness of and responsiveness to the larger context and system of health care and the ability to effectively call on system resources to provide care that is of optimal value.

Residents are expected to:

*A. Reflect* on how their patient care and other professional practices affect other health care professionals, the health care organization, and the larger society and how these elements affect their own practice.

Senior residents should display ability to work well within their core clinical team, including other residents/attending physicians/directly involved nurses/respiratory therapists/other professionals involved in the care of their assigned patients.

PGY-2 residents must also be able to work well with multidisciplinary teams, coordinating multi-specialty care and effectively working with case management and nursing in team settings such as family meetings and large team discussions. By completion of PGY-2, residents must also be able to

provide and document care in a timely and thorough manner to facilitate analysis of practice patterns and use of information by other health care professionals.

*B. Know* how types of medical practice and delivery systems differ from one another, including methods of controlling health care costs and allocating resources.

All residents must actively participate in discharge planning sessions and attend educational sessions relating to different types of medical practice and delivery systems.

By completion of the PGY-2 year, residents should demonstrate a satisfactory level of understanding regarding medical practice and delivery systems, including alternative care resources, ambulatory care resources, rehabilitation resources, and other continuing care resources. Residents should also have a satisfactory understanding of methods of controlling health care costs and appropriate allocation of resources.

*C. Practice* cost-effective health care and resource allocation that does not compromise quality of care. Prior to starting the 2<sup>nd</sup> year, residents must reflect sensitivity to costs and be able to incorporate fundamental cost-effective analysis into care approaches, minimizing redundant or unnecessary care.

*D. Advocate* for quality patient care and assist patients in dealing with system complexities.

All senior residents must demonstrate commitment and dedication to high quality patient care. By completion of PGY-1, residents must identify, implement, document, and monitor established local patient care plans that are consistent with nationally published clinical practice guidelines.

By completion of PGY-2 residents must also demonstrate ability to effectively guide patients needing assistance through the complex health care environment.

*E. Know* how to partner with health care managers and health care providers to assess, coordinate, and improve health care and know how these activities can affect system performance.

All senior residents must demonstrate ability to regularly and effectively work with the patient care coordinators/discharge coordinator, social workers, and other health care professionals to assess, coordinate, and improve patient care. The resident should reflect understanding of the benefits of such partnering activities on the operation of the health care system.

By completion of PGY-2, residents must also demonstrate ability to regularly and effectively work with case managers, utilization review personnel, physician assistants, ambulatory staff, and other providers within the larger health care system.

This approved form will remain in force for a period of one year from the promotion date, or until an updated form is issued.

\_\_\_\_\_  
**Residency Program Director**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Signature of Resident**

\_\_\_\_\_  
**Date**

cc: **Resident File**  
**GME Office**  
**Teaching Institutions**

**PGY 3 GRADUATED LEARNING RESPONSIBILITIES**  
**Internal Medicine Residency**  
**Quillen College of Medicine**

**Resident Name:**

**I. Patient Care Objectives**

*A. Interviewing:* Residents must demonstrate the importance of communication when caring for patients as they collect highly personal information.

All residents should consistently demonstrate integrity, respect, compassion and empathy for patients and their families. They should establish trust and recognize the primary concern is the welfare of the patient. Residents at this level of training will respect personal preferences and understand patient rights. They will engage in shared decision making with their patients.

PGY-3 residents should demonstrate the above and aid junior peers in effective communication with patients.

*B. History taking:* Residents must demonstrate an understanding of the importance of history in deriving a differential diagnosis.

All residents will consistently gather essential and accurate information. The database will be organized in manner consistent with accepted medical convention and charted in a timely and efficient manner.

The information will be comprehensive and include data gathered by other providers and laboratory investigations.

PGY-3 residents will be precise, logical, and efficient in their data collect in addition to the above. They will demonstrate progressive skills in hypothesis driven histories.

*C. Physical Examination:* Residents will demonstrate the importance of performing an appropriate and relevant physical exam.

All residents will perform a comprehensive physical exam with a constant. Residents at this level will be able to identify normal from abnormal and will describe the physiological and anatomical basis for these findings. Residents will demonstrate the ability to augment their physical exam steps to elicit data not obtained with standard movements. Prior to the 3<sup>rd</sup> year of training, residents will correctly detect subtle findings and understand their significance. Residents will be able to teach appropriate physical exam skills to junior peers and medical students.

PGY-3 residents additionally will to perform a focused physical exam at the level similar to a sub-specialist. PGY-3 residents will understand the sensitivity and specificity of these maneuvers.

*D. Clinical Judgment, Medical Decision-Making and Management Plans:* Residents will progressively become more adept at assimilating information that they have gathered from the history and physical exam.

All residents will be able to identify all the patients' problems and develop a prioritized differential diagnosis. They will understand their limitation of knowledge and seek the advice of more advanced clinicians. PGY-1 residents will begin to develop therapeutic plans that are evidenced or consensus

based. Residents will establish an orderly succession of testing based on their history and exam findings. They will demonstrate wise use of diagnostic therapeutic procedures. Prior to the 3<sup>rd</sup> year of training, residents will demonstrate the above and in addition will regularly integrate medical facts and clinical data while weighing alternatives and keeping in mind patient preference. They will regularly incorporate consideration of costs, risks, and benefits when considering testing and therapies. They will present up-to-date scientific evidence to support their hypotheses. They will use information technology effectively to support patient care decisions and strive to provide cost effective care. They will consistently monitor and follow-up patients appropriately. They will enlist social and other out-of-hospital clinical resources to help patients with the therapeutic plan. PGY-2 residents will assist junior trainees and medical students to become efficient managers through the appropriate use of clinical judgment and effective decision-making. PGY-3 residents will demonstrate the above and in addition, will demonstrate appropriate reasoning in ambiguous situations, while continuing to seek clarity. Residents at this level of training will not overly rely on tests and procedures. PGY-3 residents will consistently establish monitoring procedures and demonstrate the ability to change therapeutic programs for ineffectiveness or adverse side effects.

*E. Oral Case Presentation Skills:* Residents at all levels of training will be adept in oral presentation skills. This will be demonstrated by delivering an appropriately focused case presentation that is well organized. They will include all important aspects of the history, physical exam, and laboratory investigations. The assessment will be well developed and include an in-depth differential diagnosis and carefully executed diagnostic and therapeutic plan. Residents will become progressively more sophisticated at distilling relevant information. Pertinent materials such as x-rays and EKG's will be included and correctly interpreted.

*F. Patient /Family Education:* All residents will be skilled at giving patients accurate instructions regarding usage of their medications and follow-up care. They will document their counseling conversations.

PGY-3 residents will effectively counsel and educate patients about pertinent health issues, tests and treatments. They will be able to recommend appropriate screening exams by gender and age. Residents will consistently and thoroughly educate patients and their families, using patient education as a form of intervention and partnering.

*G. Use of Technology:* Residents will understand the increasing role that technological advancements bring to the bedside.

All residents will demonstrate the usage of computer-assisted databases for diagnosis and decision-making. They will utilize the electronic medical record. They will regularly utilize drug information programs. PGY-3, in addition to the above, will efficiently utilize the electronic medical record. They will utilize electronic databases for patient educational materials. They will demonstrate the ability to perform a literature search of available databases as needed to facilitate patient care and their own learning.

*H. Procedures:* All residents will understand the importance of competently performing medical procedures essential for general internal medicine.

All residents will be supervised where skill level dictates or when a sufficient number of procedures have not been completed and competency has not been ascertained. When competency has been established, they will assist their junior peers in skill acquisition. PGY-3 residents, in addition to the

above, will demonstrate extensive knowledge and be facile in the performance of procedures. By the end of the PGY-3 year residents will have successfully completed the following procedures.

Procedure	Number required	Competent
Abdominal Paracentesis	5	
Arterial Line Placement	5	
Arthrocentesis	5	
Central Venous Line-Internal Jugular	5	
Central Venous –Subclavian	5	
Incision & Drainage of Abscess	5	
Lumbar Puncture	5	
Nasogastric Tube Insertion	5	
Peripheral Venous Line Placement	5	
Thoracentesis	5	

## II. Medical Knowledge Specific Competency Objectives

Residents must demonstrate knowledge about established and evolving biomedical, clinical, and cognate (e.g. epidemiological and social-behavioral) sciences and the application of this knowledge to patient care.

Residents are expected to:

*A. Know* and apply the basic and clinically supportive sciences which are appropriate to their discipline.

All residents will demonstrate knowledge of common procedural indications, contraindications, necessary equipment, process for handling specimens and patient after-care.

Demonstrate knowledge of basic and clinical sciences.

Demonstrate satisfactory knowledge of common medical conditions, sufficient to manage urgent complaints with supervision. Residents must exhibit sufficient content knowledge of common conditions to provide care with minimal supervision by completion of the PGY-1 year.

Demonstrate a progression in content knowledge and analytical thinking in order to develop well-formulated differential diagnoses for multi-problem patients.

Demonstrate understanding and responsiveness to socio-behavioral issues.

Develop knowledge of statistical principles. Understand and appropriately use sensitivity, specificity, predictive values, likelihood ratio, number needed to treat, and odds ratio.

PGY 3 residents will additionally have taken and passed the USMLE Step 3 exam prior July 1<sup>st</sup> of their 3<sup>rd</sup> academic year.

Demonstrate growing knowledge in all areas of internal medicine. Demonstrate knowledge regarding the performance of procedures while minimizing risk and discomfort to patients.

Exhibit knowledge of effective teaching and evaluation methods.

*B. Demonstrate* an investigatory and analytic approach to clinical situations All residents will:

Exhibit utilization of the University and hospital library resources.

Exhibit self-motivation to learn.

Demonstrate sufficient analytic skills necessary to develop appropriate assessments and plans for

common medical diagnoses and complaints.

Demonstrate ability to frame clinical questions and initiate literature search.

PGY 3 residents will additionally:

Regularly display self-initiative to stay current with new medical knowledge.

Independently present current scientific evidence to support hypotheses.

Regularly demonstrate knowledge of the impact of study design on validity or applicability to individual practice.

Prepare their second scholarly work.

### **III. Practice Based Learning and Improvement Specific Competency Objectives**

The ability to utilize clinical practice and direct patient care as a venue for practice improvement and learning is a lifelong process; however it is expected that a resident will satisfactorily function in the following areas:

*A. Evidence Based Medicine:* Location, appraisal, and assimilation of evidence from scientific studies related to patients' health problems. Application of knowledge of study designs and statistical methods to the appraisal of clinical studies and other information on diagnostic and therapeutic effectiveness.

*B. Information Technology:* All training levels will use information technology to manage information, access on-line medical information and support their own education.

*C. Teaching:* Facilitation of learning of students, resident colleagues, and other health care professionals.

PGY-3 residents should additionally:

Facilitate education of PGY-1 residents, medical students, and other health care professionals.

Demonstrate evidence based independent research and preparation when teaching junior colleagues or peers.

Use interactions with nursing staff and other professionals as two-way educational opportunities.

### **IV. Interpersonal and Communication Skills Objectives**

All residents should:

*A. Communication:* Provide appropriately succinct oral presentations regarding patient care, using appropriate medical terminology. Develop skills in presenting at the bedside.

Provide timely thorough and complete written or electronic documentation of patient care (*e.g.*, progress or procedure notes, history and physical exams, consultant notes, discharge summaries), which are legible and use appropriate medical terminology; Demonstrate proficiency in use of language and nonverbal skills in interactions outside of the context of patient care.

Establish rapport with patients from a variety of backgrounds; perform a medical interview that elicits both patient- and physician-centered information, as well as testing diagnostic hypotheses; and effectively communicate uncomplicated diagnostic and therapeutic plans to patients or their advocates.

*B. Ethically sound relationships:* Follow the tenets of ethics in patient care.



*C. Working within teams:* Work as team members with senior residents and attending physicians, including the communication skills outlined above and the coordination of patient care. When supervising medical students, first year residents should be able to observe students, demonstrate skills, actively involve students in patient care, and give constructive feedback. First year residents should be able to work effectively with ancillary staff to enhance patient care.

*D. Patient Communication:* Senior Residents should be able to engage patients in shared decision making for ambiguous or controversial scenarios, and conduct family meetings as in the setting of end of life decision making. They should be able to successfully negotiate most “difficult” patient encounters, such as the irate patient. In addition to the above, PGY 3 residents should be able to successfully negotiate nearly all “difficult” patient encounters with minimal direction.

*E. Team Work:* Senior residents should progressively assume a leadership role, facilitating interactions between junior residents, medical students, ancillary staff, and attending physicians. This includes establishing expectations for all members of the team, overseeing patient care, ensuring participation in academic discussions, etc. They should also be the primary team members interacting with specialists regarding consults, and notifying outpatient primary care physicians of their patients’ hospital courses. In addition to above, PGY 3 residents should function as team leaders with decreasing reliance upon attending physicians. They should be able to function as consultants (including completion of appropriate documentation and verbal communication with the requesting physician per residency policies) whether serving as a general medicine consultant to other services or when on elective rotations.

## **V. Systems Based Practice Objectives**

Residents must demonstrate an awareness of and responsiveness to the larger context and system of health care and the ability to effectively call on system resources to provide care that is of optimal value.

Residents are expected to:

*A. Reflect* on how their patient care and other professional practices affect other health care professionals, the health care organization, and the larger society and how these elements affect their own practice.

All residents should display ability to work well within their core clinical team, including other residents/attending physicians/directly involved nurses/respiratory therapists/other professionals involved in the care of their assigned patients. PGY-2 residents must also be able to work well with multidisciplinary teams, coordinating multi-specialty care and effectively working with case management and nursing in team settings such as family meetings and large team discussions. By completion of PGY-2, residents must also be able to provide and document care in a timely and thorough manner to facilitate analysis of practice patterns and use of information by other health care professionals. By completion of the PGY-3 year, residents should demonstrate a high level of understanding regarding medical practice and delivery systems, including methods of controlling health care costs and appropriate allocation of resources.

*B. Know* how types of medical practice and delivery systems differ from one another, including methods of controlling health care costs and allocating resources.

All residents must actively participate in discharge planning sessions and attend educational sessions relating to different types of medical practice and delivery systems.

By completion of the PGY-2 year, residents should demonstrate a satisfactory level of understanding regarding medical practice and delivery systems, including alternative care resources, ambulatory care resources, rehabilitation resources, and other continuing care resources. Residents should also have a satisfactory understanding of methods of controlling health care costs and appropriate allocation of resources. By completion of PGY-3, residents should also strive to appropriately contain costs and conserve limited resources while preserving a high quality of care.

*C. Practice* cost-effective health care and resource allocation that does not compromise quality of care. Prior to starting the 3<sup>rd</sup> year of training, residents must reflect sensitivity to costs and be able to incorporate fundamental cost-effective analysis into care approaches, minimizing redundant or unnecessary care. PGY-3 residents should also be capable of acting as team leader during interdisciplinary Family Meetings regarding complex patient care needs.

*D. Advocate* for quality patient care and assist patients in dealing with system complexities.

All residents must demonstrate commitment and dedication to high quality patient care. Prior to becoming seniors residents must identify, implement, document, and monitor established local patient care plans that are consistent with nationally published clinical practice guidelines. Residents must also demonstrate ability to effectively guide patients needing assistance through the complex health care environment. PGY-3 residents should also be capable of acting as team leader during interdisciplinary Family Meetings regarding complex patient care needs.

*E. Know* how to partner with health care managers and health care providers to assess, coordinate, and improve health care and know how these activities can affect system performance.

All residents must demonstrate ability to regularly and effectively work with the patient care coordinators/discharge coordinator, social workers, and other health care professionals to assess, coordinate, and improve patient care. The resident should reflect understanding of the benefits of such partnering activities on the operation of the health care system.

In addition residents must also demonstrate ability to regularly and effectively work with case managers, utilization review personnel, physician assistants, ambulatory staff, and other providers within the larger health care system. By completion of the PGY 3 year, resident should also be able to identify and act on improvement opportunities for healthcare system through partnerships with case managers and other providers.

This approved form will remain in force for a period of one year from the promotion date, or until an updated form is issued.

\_\_\_\_\_  
Residency Program Director

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Resident

\_\_\_\_\_  
Date

cc:     **Resident File**  
         **GME Office**  
         **Teaching Institutions**

## **PROMOTION OF RESIDENTS**

Residents are promoted from one year to the next based on satisfactory performance and completion of training as determined by evaluations and performance standards as set forth by the Accreditation Council for Graduate Medical Education, ACGME, Quillen College of Medicine and the Department of Internal Medicine. Recommendations for promotion will be reviewed by the Program Director, Departmental Chair, and the Clinical Competency Committee.

After approval from the Program Evaluation Committee, a Graduated-Level of Responsibility form and a promotion form will be submitted to the Program Director for approval and signature as well as to the resident for acknowledgement. The signed form is kept in the resident's file and the GLR form updated when additional credentialing is successfully completed and confirmed. These Graduated-Levels of Responsibility forms are also sent to each teaching institution and to the GME Office for use in determining credentialing.

## **INTERNAL MEDICINE RESIDENCY EVALUATION PROCESS**

### **Purpose:**

To address the processes for conducting all ACGME required evaluations for the IM Residency Program.

### **Policy:**

The ETSU Quillen College of Medicine Internal Medicine Residency Program utilizes New Innovations™ as an electronic evaluation tool. In addition, the program may utilize paper evaluations for certain types of evaluators. In accordance with ACGME Common Program Requirements programs must follow the evaluation criteria outlined below.

**Scope:** All IM Faculty, Residents and Residency Staff

### **Procedure:**

#### **A. Resident Formative Evaluations**

1. The faculty evaluates the resident's performance in a timely manner during each rotation or similar educational assignment and documents this evaluation at completion of the assignment. New Innovations™ is utilized to meet this requirement.
2. The program provides objective assessments of the resident's competency in the 6 ACGME core competency categories: patient care, medical knowledge, practice- based learning and improvement, interpersonal and communication skills, professionalism and systems-based practice.
3. In addition to faculty, the program tracks residents' performance utilizing multiple evaluators and evaluation tools. (Peers, patients, other professional staff (nursing) and self-evaluations.)
4. Utilizing New Innovations™, the program documents, track and trends progressive resident performance appropriate to educational level. As appropriate, individualized performance improvement plans are developed for residents whose evaluations indicate the need.
5. Semiannual reviews of all internal medicine residents will be conducted by the Program Director or an Associate Program Director. These semiannual reviews will be standardized and will include at a minimum:
  - a. Monthly Rotation Evaluations ( Faculty and Peer)
  - b. Quarterly Patient and Nursing Feedback
  - c. Quarterly Mini CEXs
  - d. Self-Evaluation
  - e. In Training Exam scores
  - f. Longitudinal Board Review Scores

- g. Milestone Reports
  - h. Scholarly Activity
  - i. Resident's well-being
  - j. Future Plans
  - k. Feedback regarding the Program
6. Residents have access to their evaluations through New Innovations™ and by requesting their evaluation file located in the IM Residency Office.
  7. Residents who make satisfactory or above progress as determined by the Program Director and the Program Evaluation Committee will be promoted to the next level of residency and given increased responsibilities.

#### B. Residents Summative Evaluation

1. The Program Director must provide a summative evaluation for each resident upon completion of the program. This summative evaluation, (The Credentialing/Verification Form) becomes part of the resident's permanent record and is accessible for review by the resident and is utilized by the department as part of the credentialing process when information is requested.
2. The Credentialing/Verification Form documents the residents' performance during the final period of education. The form also verifies that the resident has demonstrated sufficient competence to enter practice without direct supervision as well as qualifies them to apply for the ABIM Board Certification.

#### C. Faculty Evaluation

The Internal Medicine Department evaluates faculty performance as it relates to the educational program at least annually. Faculty Member prepares and Academic Faculty report which is reviewed with the Chair.

1. Clinical Teaching (Medical Students and Residents)
2. CME/Scholarly Activity
3. Research/Grant Activity
4. Faculty Leadership/ Awards/Recognition
5. Clinical Knowledge/Patient Care Service
6. Administrative Service (Professionalism and Committee Responsibilities)
7. Professional Organization Membership

This is a part of the Internal Medicine's FAP, FAR, FAE process. The Residency Office generates a report that includes the residents' evaluation of faculty for this process.

#### D. Program Evaluation

The Internal Medicine Residency Program must document formal, systematic evaluation of the curriculum annually. The program must also monitor residents' performance, faculty development, graduate performance and program quality which is specifically assessed by annual confidential evaluations by residents and faculty as part of the Program Evaluation Committee, (PEC). This Committee meets at least bi-monthly with one meeting dedicated to the Annual Program Evaluation (APE).

Agenda items include:

1. Rotating calendar for review of each PGY level residents' performance. This review includes assessment of the educational effectiveness of inpatient and ambulatory teaching based outcomes, six ACGME core competencies and the goals and objectives of the rotations.
2. Faculty Development
3. In-Training Exams and Graduate Performance on the ABIM Certification Exam.
4. Review of Action Plan Progress

The Program Evaluation Committee, chaired by an Associate Program Director, is responsible for addressing any deficiencies (opportunities for improvement) identified by the program's annual assessment performed by the residents, Internal Reviews, ACGME Residents' Survey, and the annual review of the program goals and objectives. Formal Action Plans are developed to include measurable outcomes if possible.

#### Appeal of a Negative Evaluation

If a resident receives an evaluation considered unfair, the resident may put in writing why he/she feels the evaluation is unfair. The resident will meet the Program Director (PD) or Associate Program Director (APD).

The PD may call a meeting with attending physician who submitted the evaluation, the resident, and the PD for adjudication. If additional adjudication is required, the resident will meet with entire Program Evaluation Committee.

Review New Innovations™ Evaluation Module. Also see examples of evaluations included in the IM Resident Handbook.

11/2013

## **QCOM Internal Medicine Residency Responsibilities of the Program Evaluation Committee (PEC)**

The Quillen College of Medicine, Internal Medicine Residency's Program Evaluation Committee (PEC) provides a formal structure to be used in program evaluation, design and improvement. This committee is crucial in ensuring the quality of the residency program.

### **Membership:**

The QCOM IM PEC is composed of the Program Director, and the Associate Program Directors, one of which will serve as committee chair. Additionally, representatives from each level of training are appointed to a 3 year term in order to maintain continuity. Committee members will acquire an understanding in basic quality improvement principles and the relationship of quality improvement and patient safety. The PEC will meet quarterly with one meeting being devoted to the Annual Program Evaluation.

### **Responsibilities:**

The IM PEC must participate in the planning, developing, implementing, and evaluating all significant activities of the residency. This includes but is not limited to resident performance, faculty development, graduate performance and program quality.

The PEC will conduct and document a formal, systematic evaluation of the program each September. Documentation will include a written plan of action for any deficiencies identified. This plan of action will be monitored for progress as part of the standing agenda for each meeting. The Annual Program Review will include but is not limited to:

- Overall performance of residents (e.g., in-service exam results, procedure logs, summary evaluations of housestaff)
- Faculty development (e.g., CME activities, activities directed toward improving teaching abilities and professionalism, ACGME Faculty Survey)
- Graduate performance
- Confidential written Resident evaluation of the Program (e.g., ACGME Resident Survey, resident evaluation of rotations)
- Confidential written faculty evaluation of the Program (e.g. Faculty Survey)
- The previous year's improvement action plan to evaluate whether the identified improvements were achieved.

The PEC will oversee or appoint representative program personnel to develop and evaluate the competency –based curriculum goals and objective and the effectiveness with which they are achieved. The PEC will review, revise and approve IM specific policies and will ensure that both, QCOM GME policies and program policies are implemented.

The PEC will conduct the Annual Program Review during the September Committee Meeting which must include all components listed below.

1. The Annual Program Review must include a review of the following:



- Overall performance of house staff (e.g., in-service exam results, procedure logs, summary evaluations of housestaff)
  - Faculty development (e.g., CME activities, activities directed toward improving teaching abilities and professionalism)
  - Graduate performance (e.g., certification examination results, survey of graduates)
  - Confidential written housestaff evaluation of the Program
  - Confidential written faculty evaluation of the Program
  - The previous year's improvement action plan to evaluate whether the identified improvements were achieved.
2. Based on the review and evaluation, the Committee shall prepare a written improvement plan of action for the Program.
  3. The Committee must maintain written meeting minutes. These minutes must include the written improvement plan of action for the upcoming year.
  4. The improvement plan of action must be presented to and approved by the Program's faculty.

## QUILLEN COLLEGE OF MEDICINE INTERNAL MEDICINE RESIDENCY PROGRAM

### CONFIDENTIAL VERIFICATION AND REFERENCE FOR:

Name: «FirstName» «MI» «LastName», «Suffix»

This confidential document relating to a former resident is provided to you by East Tennessee State University, James H. Quillen College of Medicine, and Internal Medicine Residency Program. This document is being submitted in response to your request for verification of residency training in Internal Medicine and reference information in lieu of other forms. The original **notarized signature** of the current program director will verify its authenticity. The contents of this document are provided with the permission of the named physician and should not be released to any other party without the consent of that physician.

I. **Verification of Training:**

- ☐ Dr. «LastName» successfully completed his/her ACGME Accredited Internal Medicine residency training at East Tennessee State University, James H. Quillen College of Medicine as follows:  
**Training Start Date:** \_\_\_\_\_ **Training End Date:** \_\_\_\_\_
- ☐ See comments, Item I.

II. **Disciplinary Action:**

- ☐ During the dates of training at this institution, Dr. «LastName» was not subject to any institutional disciplinary action, such as admonition, reprimand, suspension or termination.
- ☐ See comments, Item II.

III. **Professional Liability:**

- ☐ To the best of our knowledge, Dr. «LastName» was not investigated by any governmental or other legal body and was not the defendant in any malpractice suit during residency training.
- ☐ See comments, Item III.

IV. **Ability to Practice Medicine:**

- ☐ To the best of our knowledge, no conditions exist that would impair Dr. «LastName»'s ability to practice Internal Medicine.
- ☐ See comments, Item IV.

V. **Clinical Privileges/Procedures Requested:**

- ☐ The education Dr. «LastName» received from our training program was sufficient for the practice of Internal Medicine competently and independently. Dr. «LastName» was recommended for the certifying examination administered by the American Board of Internal Medicine.
- ☐ If requested, a copy of the resident's procedure logger will be attached.

VI.

**Evaluation:** The following is derived from a composite of multiple evaluations by supervisors in this resident's rotations during **his or her** residency training. The evaluation is based upon the Accreditation Council for Graduate Medical Education (ACGME) General Competencies, which define the essential components of clinical competence. In cases where the definition of the competency could be unclear, the ACGME definition is given after the table.

	Unsatisfactory	Satisfactory	Superior	No Knowledge
Medical Knowledge				
Patient Care				
Interviewing				
Physical Examination				
Procedures				
Professionalism				
Communication and Interpersonal Skills				
Practice Based Learning and Improvement**				
Systems Based Practice ***				

\*\* Residents receiving a satisfactory evaluation in Practice Based Learning perform satisfactory investigation and evaluation of their own patient care, appraisal and assimilation of scientific evidence, and improvements in patient care.

\*\*\* Residents receiving a satisfactory evaluation in Systems Based Practice demonstrate an awareness of and responsiveness to the larger context and system of health care and the ability to effectively call on system resources to provide care that is of optimal value.

**Comments:**

**VII. Recommendation:**

Based on a composite evaluation by the East Tennessee State University, James H. Quillen College of Medicine Department of Internal Medicine, Dr. «LastName» is recommended to you as of the **30th day of June, 200** .

\_\_\_\_\_  
Internal Medicine Program Director

- VIII. ☐ I have reviewed this evaluation with the program director or designee. I understand that this form will, in most cases, be utilized as the confidential verification and reference form in lieu of other forms when requests for verification of resident training and/or reference are received by the Department of Internal Medicine.

\_\_\_\_\_  
«FirstName» «MI» «LastName»,  
«Suffix»

- IX. ☐ Resident reviewed the evaluation but chose not to sign.

\_\_\_\_\_  
Internal Medicine Program Director

- X. ☐ Resident did not review the evaluation.

\_\_\_\_\_  
Internal Medicine Program Director

\_\_\_\_\_  
Notary Signature

\_\_\_\_\_  
Term Expires

## **RESOLUTION OF RESIDENT INITIATED GRIEVANCES**

It is desirable for resident's concerns or complaints regarding the program, physical impairment, fatigue, or quality impairment, etc. to be resolved within the departmental structure. When resolution is not obtained the resident's grievance regarding the residency program should be expressed to his/her preceptor, Program Director, Department Chair, or any other faculty member or administrative officer of the College of Medicine, who will help to resolve the issue or agree on further action.

If not resolved, the problem then will be brought by the involved resident and appropriate faculty member to the attention of the resident's program director and the Executive Associate Dean for Clinical Affairs.

If there is still no resolution of the problem, the Executive Associate Dean for Clinical Affairs will convene an ad-hoc committee and proceed with the due process.

If the resident's grievance is against the Executive Associate Dean for Clinical Affairs, program director, department chair of any clinical department, or any other person who might otherwise take part in the process of resolving the problem, the above steps will be structured to exclude the involvement of that person from the judging process.

If resolution cannot be achieved using the above process, the Dean of the College of Medicine will be the final authority.

## **UNSATISFACTORY PERFORMANCE BY A RESIDENT/FELLOW**

Residents/fellows who experience a deviation from expected performance will be identified in a timely manner by the Program Director and the Program Evaluation Committee.

A resident/fellow deemed to be deficient in any aspect of his/her performance will be given verbal and written notification and, if warranted, may be placed on departmental probation. Departmental probation is utilized when it is anticipated that there will be a successful remediation on the part of the resident/fellow. The probationary period will be left to the discretion of the Program Director, but generally will be three to six months.

When such action occurs, the Program Director will inform the resident/fellow in writing of the deficiencies in academic or clinical performance which were noted. A written plan of remediation will be developed for the resident/fellow by the program director. The written plan will include the length of departmental probation. When necessary this approach will include the appointment of one or more faculty to work with the resident/fellow on a regular basis using a planned individual format. For problems appearing to involve psychiatric or substance abuse issues, efforts to obtain appropriate counseling/psychotherapy will be made. Anytime a resident/fellow is removed from his/her clinical duties the office of the Executive Associate Dean for Graduate Medical Education must be notified as soon as possible.

If the resident/fellow does not satisfactorily remediate deficiencies during the departmental probationary period or if, in the Program Director's opinion, the resident/fellow's original deficiency may result in termination, the resident/fellow will be placed on institutional probation, generally not to exceed three months. Again, the resident/fellow must be notified in writing of the deficiencies, remediation, and length of the institutional probation. The resident/fellow must also be notified in writing of the possibility that the institutional probation may lead to termination from the program. The Office of the Executive Associate Dean for Graduate Medical Education must be notified in writing by the Program Director when a resident/fellow is placed on institutional probation.

At the end of the probationary period the resident/fellow's performance will be reassessed and the resident/fellow will be notified in writing as to his/her status. The resident/fellow may be removed from probation if the stated deficiencies have been remediated, or the probation may be continued if the resident/fellow's performance has improved but deficiencies remain or new deficiencies uncovered; or the resident/fellow may be terminated. The resident/fellow is notified in writing as to the reasons for termination. The Program Director also notifies the Office of the Executive Associate Dean for Graduate Medical Education of the termination.

## **TERMINATION OF A RESIDENT/FELLOW**

Termination of a resident/fellow may occur based on two situations:

1. Unacceptable personal behavior serious enough to call for immediate temporary or permanent suspension. This action may be taken when the resident/fellow's performance endangers the health or safety of others, or, for any other reason is deemed unacceptable by the Program Director and/or the Dean; or
2. Failure to meet academic standards despite a carefully planned remediation program.

## **INSTITUTIONAL POLICY ON HOSPITAL SUSPENSION OF A RESIDENT/FELLOW**

The affiliated hospital administration may find cause to suspend a resident/fellow from clinical activities. When such a suspension occurs, the hospital administration will immediately notify the appropriate departmental chair and program director. Within five working days the program director will convene a committee of two departmental faculty selected by the program director and two representatives from the involved hospital selected by the hospital administration. This committee, chaired by the program director, will investigate the incident and recommend appropriate action to the departmental chair. Such action will also be communicated to the hospital administration representative in charge of graduate medical education. If the hospital administration is not agreeable with the committee's recommendation to the chair, the issue will be submitted to the Executive Associate Dean for Graduate Medical Education. If agreement can still not be reached with the hospital administration, the issue will be referred to the Dean of the College of Medicine and the CEO of the appropriate hospital. The ultimate decision regarding resident/fellow clinical privileges shall be made by the Hospital.

If the resident/fellow disagrees with the final recommended action, the resident/fellow has access to the grievance process outlined in the grievance policy.

## DUE PROCESS AND TERMINATION OF A RESIDENT/FELLOW

This outline of Due Process is applicable to any resident/fellow who wishes to appeal an adverse decision by his/her program director or departmental chair. Adverse actions include: non-renewal of contract; suspension from residency program; termination for residency program; imposition of limitation on resident/fellow's professional responsibilities; or imposition of disciplinary action resulting from violation of residency policy or procedure.

The house staff shall consist of resident/fellows and clinical fellows regularly appointed at the James H. Quillen College of Medicine, East Tennessee State University. Its members shall be under the supervision of the department in which they are appointed.

The members of the house staff shall abide by the rules and regulations set by the program directors, the hospitals and the Dean. Failure of a member of the house staff to perform his/her duties or to abide by the College of Medicine and the affiliated hospitals rules and regulations shall be reported to his/her departmental chair and/or program director. The department shall then institute appropriate disciplinary action.

A member of the house staff who wishes to appeal an adverse decision by his/her program director or department chair may appeal the decision of the department and request a hearing before an ad hoc committee. This committee shall consist of not less than five faculty members and two resident/fellows to be appointed by the Dean. The five faculty members will be from specialties other than those represented by the resident/fellow and will have little or no personal involvement with the resident/fellow's instruction or evaluation. One of the two resident/fellow representatives will be selected from a list supplied by the resident/fellow making the appeal and the other selected from the Chief Resident/fellows Committee. The Executive Associate Dean for Graduate Medical Education will chair the committee. In the event that the Executive Associate Dean for Graduate Medical Education is involved in the hearing, the Dean will appoint a chair. The committee shall convene a hearing at a date agreeable to all parties, but in no case more than four weeks after receiving the written request for the appeal. Committee witnesses will include those on a list provided by the resident/fellow to speak in his/her behalf. The committee will also request testimony from those in the program responsible for evaluations and decisions which led to an adverse action. The ad hoc committee may request from the department copies of all evaluations and documents leading to an adverse action. The resident/fellow making the appeal has the right to have an advocate present. The advocate cannot be an attorney. This advocate is present only to advise the resident/fellow and may not participate in the process. The resident/fellow has the right to hear all witnesses and to ask any questions under the direction of the chair of the ad hoc committee. An electronic recording of the proceedings may be made, but only for the purpose of producing a written transcript; at which time all recordings will be destroyed. This transcript and all other records related to the appeal will be available to the appellant upon request. The chair of the committee will not have a vote in the committee's decision, but will submit his/her recommendation along with the recommendations of the committee to the Dean. The decision of the Associate Dean and Dean is final.

## **CLOSER/REDUCTION POLICY**

The College of Medicine Graduate Medical Education Program recognized the need and benefits of graduate medical education and sponsors training programs which emphasize personal, clinical, and professional development. The College of Medicine residency programs are conducted in substantial institutional and program requirements of the ACGME and its individual Residency Review Committees.

In the event the College of Medicine has to reduce the number of positions in or closes a residency training program, the College of Medicine will notify the GMEC, DIO, and residents in training as soon as possible. If possible, reductions will be made over a period of time to allow all residents to complete training. In the event that an ACGME action or decreased financial or educational resources force the closure of a training program, the College of Medicine will allow the residents already in the program to complete their education or assist them in locating another ACGME accredited program in which they can continue their education.



## IM Residency Travel Policy

### Purpose:

The involvement of residents in travel related to educational activities is necessary and encouraged. Because such travel can result in absences from clinical duties and also results in numerous expenses, a number of conditions must be met before such travel will be supported. Residents submitting abstracts must notify the residency office that an abstract is being submitted. Once an oral or poster presentation is accepted by regional or national medical associations, the resident must meet with the travel coordinator in the residency office and begin the travel authorization paperwork and request education leave. Both the travel authorization and the education leave must be approved by the Program Director before any travel plans are made.

**Note: Travel Authorization must be approved for all residents even if the Department is not funding the travel.**

**Scope:** All residents

### Procedure:

1. Residents may use the annual education allotment or travel, both as a presenter and an attendee. Funding may only be used for registration, hotel, transportation and meals as outlined in the ETSU Travel Policy: [www.etsu.edu/fa/fs/finpro/fp-7\\_travel.aspx#Authorization](http://www.etsu.edu/fa/fs/finpro/fp-7_travel.aspx#Authorization)
2. Residents may also use their allotted Education Fund Money for conference attendance. Residents utilizing their individual funds for conference attendance not associated with presentations must have Education Leave approved by the Program Director and must follow the same travel authorization process.
3. Criteria for Scholarly Activity Approval:
  - A. The reason for travel is to present an oral or poster presentation.
  - B. The traveling resident will personally make the presentation.
  - C. Time away from clinical duties is minimized. Residents are encouraged to arrange their own back-up if possible and inform the chief resident, attending and fellow team members of the coverage arrangements. The back-up system may be used if necessary. Travel to the away location is a maximum of four days to include travel days, presentation day and conference attendance.
4. Criteria for Conference Attendance Approval:
  - A. Request to attend a major conference for the purpose of education and networking should be submitted with consideration to the residents' clinical duty assignment. Requests for travel during a ward month must include a proposal for coverage which

does not include the use of back-up. Residents can utilize their individual education fund money for this travel.

- B.** Education Leave must be approved by the Program Director.
- C.** Registration for the conference should only be done after the resident has met with the IM residency travel coordinator.

**5. Authorization for travel:**

- A.** A copy of your approved Educational Leave must accompany your official ETSU Travel Authorization Form.
- B.** The request will be submitted in the following order: Residency Travel Coordinator, who will then have the Program Director and Program Coordinator approve the request.

**6. Reimbursement of Travel Expenses:**

Residents will not be reimbursed if the approval of travel was not obtained thirty days prior to the date of departure. There will be no exceptions.

6/9/2014

## **Internal Medicine Resident Forum Meetings**

### **PURPOSE:**

The IM Residency Forum meetings serve as a voice for all residents to address and prioritize concerns related to the residency program.

### **POLICY:**

The Resident Forum meetings are available to all residents in the program and are facilitated by the peer elected resident representatives and the PGY IV Chief Residents. With the exception of the chief residents, there will be no program leadership in attendance unless they have been formally invited to participate. These meetings will be held every four weeks at noon during the Academic Half Day.

**SCOPE:** IM Residents

### **PROCEDURE:**

1. The Peer Elected Residency Representative and the PGY IV Chief Residents will coordinate all aspects of the Resident Forum meetings. These include but are not limited to:
  - a. Development of an agenda
  - b. Facilitation of the Meeting
  - c. Distribution of the minutes
  - d. Arranging follow-up meetings with the Program Director to share opportunities for improvement that require Program Leadership action.
2. In addition to identifying opportunities for improvement, the Resident Forum meetings allow residents to:
  - a. Recommend new policies and procedures.
  - b. Identify Quality and Patient Safety issues from all training sites.
  - c. Request guest speakers
  - d. Plan social events.

## Internal Medicine Residency Education Allotment Policy

### Purpose:

In addition to salary and benefits, the Internal Medicine Residency Program allots each resident an annual education allowance.

**Scope:** All residents and fellows

### Procedure:

1. Each resident and fellow is allowed an annual educational allotment of \$1,000.00. The Department of Internal Medicine program determines how the funds can be used based on year of training and program policies.  
No funds can be carried over from one fiscal year to the next. (July 1 – June 30)
2. The funds are allotted for the purchase of medical books, professional memberships, professional licensing fees, tablets such as an iPad (limited to one during entire training period), software, study materials and/or to offset attendance at regional or national meetings as an attendee or a presenter.  
Note: laptops and phones are not allowable purchases.
3. Residents may choose to use the educational allocation for registration fees for USMLE/COMLEX Step 3 or ABIM Board certification.
4. If funding is used for travel, the Internal Medicine Residency Travel policy must be followed as well as the guidelines set forth by the University and the Tennessee Board of Regents as outlined in Financial Procedure FP-7 which can be found at [http://www.etsu.edu/fa/fs/finpro/FP-7\\_Travel.aspx](http://www.etsu.edu/fa/fs/finpro/FP-7_Travel.aspx)
5. If funds are to be used for educational materials it is preferable for residents to contact the residency office to request and manage the purchase. The residency office will process these requests and deduct the total amount from the individual residents education allocation account.
6. If the resident does purchase education material or travels, all original receipts must be presented to the residency office. Travel must be reconciled completely with the request for reimbursement. Receipts for educational material purchased by the resident must be presented to the residency office. The office will complete the request for reimbursement and send to the GME office for processing.
7. Note: Reimbursement for computers and professional registration fees are taxable in accordance with the IRS.

## **Internal Medicine Resident Back-Up/Pay-Back Policy**

### **PURPOSE:**

QCOM Internal Medicine Residency's primary goal of the residents is to provide uninterrupted and appropriate patient care that adheres to duty hours. However, in the event of illness, family emergencies, or fatigue mitigation a back-up policy and pay-back policy must be implemented. The program recognizes that residents assigned to back-up will not be invoked without good reason. The program reserves the right to require documentation from the resident requesting back-up. The PGY-IV Chief Resident maintains careful records of the back-up system. Residents requesting back-up must call the PGY-IV chief. Only the PGY-IV chief will contact the resident on back-up.

**SCOPE:** All IM Residents, Chiefs and Attendings

### **PROCEDURE:**

1. The PGY-IV chief resident in consultation with the program director will schedule all back-up coverage duties at the beginning of each academic year.
2. Each resident will be expected to participate in the on call back-up program. PGY-1 residents will participate in two 15 day blocks annually. Senior residents will participate in one or two blocks of 15 days annually depending on the size of the program.
3. All residents assigned to back-up must be available by cell phone and/or pager 24/7 including weekends/holidays when assigned back-up call. Failure to respond to pager or return the call within 1 hour of the PGY-IV chief contacting the back-up resident will result in notification to the Program Director and can result in a formal disciplinary action for unprofessional behavior.
4. The chief residents will keep a running log of who has called requesting back up and will notify the Program Director should excessive use be suspected.
5. Payback is required for back-up call requests except in the case of personal illness. (see leave policy for requirements)
6. A schedule for payback shall be arranged with the Chief resident within 14 days of the backup.
7. When backup is called in the intern or resident who missed their clinical duties will pay back the shift to the colleague call in to cover.
8. The payback policy will be implemented for the interns or residents called in for backup and will be activated for overnight call or weekend/holiday activities (including day shifts and overnight call on weekends/holidays). If, for example, an intern or resident were called in to cover a day shift on medicine and was subsequently pulled off their ambulatory clinic for the day, this would not be an appropriate situation for payback. In general, the payback policy does not apply to situations involving an extended illness or leave of absence.
9. PGY IV chief resident is responsible for facilitating back up coverage.

## **Internal Medicine Residency Attendance and Absence Policy**

### **Purpose:**

- Provide detailed information related to program absences.
- Provide detailed information on attendance expectations required for satisfactory completion of training in the Internal Medicine Residency Program.
- Combine previous separate policies on vacation, call-back, and mandatory events.

**Scope:** All IM Residents and Attendings

### **Definitions:**

In this policy “Mandatory events” include, but are not limited to:

- Academic Half Day
- Program and Clinic Orientations
- Enhancement
- SIM sessions
- Retreats
- Semi-Annual Reviews
- Clinical Conferences
- Core Conferences

### **Procedure:**

#### **A) Attendance requirements - Program**

For satisfactory completion of training (necessary for graduation) All residents must complete, and pass, all rotations, as scheduled by the Program and in line with the agreed training curriculum unless a waiver of training has been granted. (See GME and Internal Medicine Handbooks). This requires submission of completed overall rotation in-training evaluation reports for every rotation, including elective blocks.

All residents must attend all scheduled mandatory events and activities, unless on an approved period of absence or medical leave.

All residents must attend their Semi-Annual Evaluation meetings and their EXIT interview with their Faculty Advisor and any other meetings felt to be necessary and requested by the Program Director, Faculty Adviser or Preceptor.

Resident Members of the Internal Medicine Residency Program are expected to attend all assigned Committee Meetings, unless granted an approved absence by the Program which can include any type of excused leave or expectation of duty hour violations.

#### **B) Attendance requirements - Mandatory Rotations**

For satisfactory completion of training (necessary for graduation)

Residents are expected to attend scheduled mandatory educational events unless they have an

approved absence which includes post call, night medicine and approved leave.

### **C) Attendance requirements – Electives**

For satisfactory completion of training (necessary for graduation)

Residents must attend a minimum of 75% of the length of any elective rotation after mandatory events and continuity call-back clinics have been allowed for.

Absence that is counted against this 75% “rule” includes any absence, except scheduled and agreed mandatory events.

Missing more than 25% of elective will require resident to repeat the elective.

### **D) Attendance confirmation and tracking**

All Residents are expected to sign in or swipe ETSU ID in the coding machine to track attendance as appropriate to mandatory events. If a Resident has not signed or swiped in to verify attendance, the resident is regarded as being absent from the event unless the Program has an approved absence (or resident is post-call).

Proof of attendance is required for subsequent completion of training and graduation.

Residents are required to obtain the signature of the Preceptor at the end of each week on Attendance Card during elective rotations other than Continuity Clinic, confirming resident’s attendance each day that week.

### **E) Consequences of failing to meet attendance requirements.**

Failure to attend a mandatory event, in full, without an approved absence is regarded as unprofessional. This will be reviewed with the Resident’s Program Director and will be documented in the Resident’s file.

When a resident has failed to meet any of the above requirements, the resident will be expected to meet with his/her Program Director to discuss the reasons for this and, if necessary, to plan how the Resident will make up the missing necessary attendance.

This may require extended time to allow the resident to meet the attendance requirements prior to completion of training and graduation.

Any failure to attend without an approved absence may also result in the loss of the corresponding number of Annual Leave time as well as the potential disciplinary actions described above.

## **II) Absence from Program**

### **A) Approved Reasons for Absence**

Circumstances that qualify are:

- Defined by Federal Medical Leave Act
- Sick Leave
- Vacation
- Educational leave
- Administrative days

- Named holidays

Note: A Resident who is absent from the program for any of the above reasons, is not required to attend any scheduled educational program activities including seminars, conferences, journal clubs, exam preparation sessions or academic half days but may choose to do so.

### **B) Absence – Vacation**

Residents are permitted to take up to 15 Vacation days per academic year.

It is recommended that Residents apply early for vacation and that Residents try to space out their vacation over the whole year, to improve the chances of gaining approval for requests.

All applications for vacation must be made New Innovations.

Approval of a vacation request will be notified to the Resident via New Innovations.

Approval of vacation is dependent on a number of factors including the number of other Residents on a rotation, the number of other vacation requests for the same time, call requirements, training requirements, Preceptor availability, etc. No vacation request can be guaranteed for specific time period requested.

Residents shall not be scheduled for on-call duties or shifts on one of the weekends immediate prior to or following five consecutive weekdays of vacation.

**No vacation can be taken during the last 2 weeks of June and the first week of July unless being used as terminal leave from the Program.**

**All vacation requests must be considered by the resident to ensure there is no threat to attendance described above.**

### **C) Absence - Educational Leave**

Residents, who are performing at a satisfactory academic level, are entitled to apply for educational leave to attend educational events, e.g. medical conferences.

Educational leave is not guaranteed.

Educational leave days do not have to be continuous.

All educational leave days are non-transferable to the following year.

### **D) Absence – Administrative Leave**

Residents are permitted to take up to 5 days of Administrative leave during the duration of their residency.

Residents may apply for Administrative Leave to tend to personal administrative needs, e.g. job interviews, fellowship interviews.

Administrative Leave is not guaranteed.

Administrative Leave days do not have to be continuous.

All Administrative Leave days are non-transferable.

## **III) Notification of absence and consequences of failure of notification**



Residents will familiarize themselves with the contact information of their Program Administrators/Coordinators, teaching clinics, Preceptors, or senior Residents so that timely notice is given to the appropriate people when absences are necessary or planned.

Contact information for Program Administrators/Coordinators, teaching clinics, Preceptors, or senior Residents can be found in the curriculum of each rotation in New Innovations.

Residents **must** inform their respective clinics and Preceptors directly as far ahead as possible of any planned/scheduled absences, including mandatory events, courses etc.

All unplanned/last minute absences from a clinic will require immediate notification by the Resident/Preceptor to the Program office as soon as the absence is known.

When a Resident is unable to attend a clinic or rotation at short notice, the Resident must also notify his/her clinic/rotation contact by email (or other communication deemed acceptable by Preceptor).

A Resident who fails to provide acceptable and adequate notification of scheduled absence to their clinic contacts will be reported to the Program office by the Resident's Preceptor so that this can be addressed by the Program Director or their designee.

Repeated failure to communicate absences to the clinic, which is regarded as unprofessional behavior, will result in documentation in the Resident's file and the potential for disciplinary action.

## Internal Medicine Residency Discipline Policy

### Purpose:

The purpose of this policy is to describe the process used by the program to address residents who fail to meet performance or academic standards for the Internal Medicine program. It is the policy of the program to employ procedural fairness in all matters which may lead to probation, suspension or termination.

**Scope:** All Internal Medicine Residents

### Definitions:

**Probation:** Probation shall be used for residents who are in jeopardy of not successfully completing the requirements of the program or who are not performing or behaving satisfactorily. Conditions of probation shall be communicated to residents in writing and should include: the reason(s) for probation, an individualized action plan, and the expected timeframe for the required remediation. Failure to correct the deficiency in the expected timeframe may lead to an extension of the probationary period. The probationary period should not be less than 30 days and its duration should be appropriate for the issue(s) of concern.

**Suspension:** Residents may be suspended from part or all usual and regular assignments, including clinical and/or didactic duties for failure to comply with the program's or the participating sites' policies. Suspensions are confirmed in writing, stating the reason(s) for the suspension and its expected duration. Suspensions generally do not exceed 60 calendar days and may be coupled or followed by other actions. The GME has the discretion of assigning suspension with or without pay.

**Termination:** Residents who have not satisfactorily improved in the areas discussed during the remediation and/or probation process as determined by the Clinical Competency Committee will be terminated from the program. If additional incidents or concerns arise during a period of probation or suspension and are found to be valid after review by the Clinical Competency Committee the resident will be terminated from the program at that time. The resident has the right to appeal this decision and seek due process as set forth by the GME handbook.

<http://www.etsu.edu/com/gme/resbookpol.aspx>

### Policy:

1. When evaluations suggest that a resident is not meeting the expectations of the program or is suspected of violating a policy of the College of Medicine or the participating sites, the Program Director or designated representative shall: meet with the resident to discuss the area(s) of concern, provide counseling, and identify appropriate measures of improvement or remediation. In advance of any formal disciplinary action, the program should have written documentation of the date and

nature of all previous warning and other communications given to the resident whose performance or conduct fails to meet expected standards. Verbal warnings to an individual are given in the presence of at least one other individual and the contents of the warning/concern must be documented. If an offense is so serious that it poses immediate and serious danger to patients, faculty/staff or the institutions, immediate suspension prior to procedural review is appropriate.

2. The IM Clinical Competency Committee will serve as the committee to review concerns, probation, suspension or termination. The Executive Assistant Program Director will provide the CCC with documentation of the concerns that led to the disciplinary action which will include previous meetings with the resident and prior efforts to counsel the resident. Depending of the gravity of the concern or disciplinary action, the resident may provide the CCC with a written statement explaining why they feel the concern or disciplinary action is not warranted. The CCC meets quarterly and has a standing agenda for reviews of concern. If necessary, depending of the gravity (suspension or termination), the program leadership may have a called meeting of the CCC to review disciplinary actions. The CCC may request to meet with the resident following the review of documentation. The CCC will render a decision to uphold the original action or to request an alternate action, which will include an appropriate course of remediation or a personal improvement plan. The resident will receive written notification of the CCC's decision within 10 working days. The decision of the CCC will be final unless the resident files a Due Process as outlined in the GME Due Process policy.

3. The Program leadership will inform the DIO prior to any resident being placed on probation, suspension or terminated. This notification will include a written statement describing the problem, warnings issued, deliberations of the CCC and the proposed resolution. This notification must occur prior to the program taking final action and before informing the resident of the decision.

4. The GME office and the legal department must determine whether the action is reported to State or Federal Authorities, as applicable.

5. Program Leadership must provide a specific statement to the resident as the action taken, effect on salary, benefits and training certification.

a. In cases of termination, salary and benefits shall be terminated as of the effective date, and training certification shall be granted for the period of months of acceptable service. Health insurance coverage may be maintained under COBRA options so as to provide continuous health care coverage, in which case the resident is responsible for all premiums.

b. A suspension may be imposed with or without pay, and shall result in suspension of training credit during interruption of service. In instances of suspension with pay, benefits coverage shall be continued during the period of suspension. The resident suspended without pay shall be responsible for full premiums of the benefits during the suspension period.