

CURRICULUM GOALS AND OBJECTIVES EXPECTATION OF RESIDENTS

I. Mission:

The mission of the Department of Medicine Residency Training Program is to train and produce outstanding clinicians able to accept their choice of sub-specialty fellowship or one of the broad ranges of practice opportunities afforded a general internist. This is accomplished through rigorous learner-centered education based on outstanding patient care experience, leadership development, and scholastic achievement.

II. The Educational Goals of the Program:

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

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

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

C. Practice Based Learning/Improvement: Residents are expected to constantly evaluate their own performance, incorporate feedback and external evaluation into their behavior to reflect self-improvement, use appropriate knowledge and outcome-information sources to manage their patients, track improvements in efficiency and cost of care, and maximize quality of life of patients.

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

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

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

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

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

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

III. Specific Objectives of the Program:

The program is based on the competency based Report of the Federated Council of the Internal Medicine Task Force on the Internal Medicine Residency Curriculum, 1997, and is organized into the following elaborated competency areas, all of which are explicit in our curriculum:

The Integrative Disciplines: By the completion of training, the graduate will be disciplined and fully competent in the following: Humanism, Professionalism, Medical Ethics, Lifelong Learning, The Clinical Method, Continuity of Care, The Medical Interview or History, Physical Diagnosis, Clinical Epidemiology and Quantitative Clinical Reasoning, Clinical Pharmacology, Scientific Literacy, Legal Medicine, The Management of the Quality of Health Care, Nutrition, Preventive Medicine, Home Care, Nursing Home Care, Occupational and Environmental Medicine, Physical Medicine and Rehabilitation, Care of the Dying Patient, The Management of Medical Practice, and Medical Informatics.

The Clinical Competencies: By the completion of training, the graduates will have in-depth knowledge of principles of management and indications for referral for common clinical conditions in the following organs and systems: Allergy/Immunology, Cardiovascular Illness, Dermatology, Endocrinology, Diabetes and Metabolism, Gastroenterology and Hepatology, Hematology, Infectious Diseases, HIV infection, Nephrology, Neurology, Oncology, Ophthalmology, Otolaryngology, Psychiatry, Pulmonary Medicine and Rheumatology. They will also have broad competency in principles of Genetics and competency in the following site-specific and population specific areas of Medicine: Ambulatory and Primary Care, Consultative Medicine, Hospitalist care, Critical Care Medicine, Emergency Medicine, Adolescent Medicine, Geriatrics, Substance Abuse, Women's Health, Palliative Care, and Discharge Planning.

All of the elaborated competencies are subsumed under the 6 core competencies noted above in **II. The Educational Goals of the Program.**

IV. Progressive Patient Care Responsibility of Residents

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

PGY-1 (Categorical and Preliminary) residents (interns) will attain competency in the following areas: Humanism, Professionalism, Medical Ethics, Clinical Method, Continuity of Care, Medical Interview, Physical Diagnosis, Clinical Pharmacology, Medical Informatics. They will attain in-depth knowledge of clinical conditions found in inpatients, most of whom are severely ill, with complex medical problems. They will learn the basic “rules” of medical care and apply them to their patients in an increasingly personalized manner. They will engage in supervised, meaningful care of limited numbers of patients to achieve these competencies. They will learn and be tested on key competencies of data gathering and physical examination in non-patient care settings. Categorical interns are responsible for continuity care of 75 patients.

Interns are responsible to provide pertinent and timely education to students working with them.

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

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

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

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

V. Methods Used to Achieve Program Mission, Goals, and Objectives

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

A. Supervised care of limited numbers of hospitalized patients and concurrent educational activities

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

with that patient or type of care. In general, the attending physician of record and teaching attending will be the same individual. Except where designated, such experiences will be one calendar month in length, repeated throughout the curriculum at different years. Each rotation has specific detailed curriculum located on the MCG Internal Medicine Website, to include recommended and/or required readings and scholastic requirements. Residents are expected to know and complete specific requirements of each rotation listed therein. They will provide equal emphasis on patient care and education during the time available.

Location: MCG and VA.

Teaching methods: Attending Rounds minimum 4.5 hours per week, with daily feedback and biweekly evaluation of patient care by attending (mid-term is informal, end of term uses standardized subjective competency evaluation form). The resident is expected to elicit both constructive criticism and feedback.

Self-assessment (pre- and post-rotation): Each resident will review the published goals and objectives of the rotation prior to its initiation, and complete the One45 pre-rotation assessment of personal goals for the rotation.

At the end of each rotation, the resident will complete the post-rotation evaluation of self-directed goal accomplishment as well as a critique of the attending performance and peer performance during the rotation. Rotations will not have been satisfactorily completed until evaluations are complete.

Assigned readings, core reading

Textbooks: *Harrison's Principles of Internal Medicine*, *Cecil Textbook of Medicine*, *Washington Manual*, *Parkland Manual of Inpatient Medicine*, *Up-to-Date*

Reading's pertinent to patients' needs and educational objectives of specific rotations. Residents should expect to read a major textbook of medicine such as *Harrison* or *Cecil* cover to cover and be completely familiar with its content by the middle of the PGY-3 year.

Electronic and Library resources: As pertinent to fulfill core competencies above.

Assigned writing of essays and reports:

On inpatient and ambulatory services, residents develop and maintain an appropriate patient database using a standardized admission and clinic note form. These are also assigned oral and written reports for specified rotations. These are included in the resident portfolio after appropriate critique. These are listed below under **Scholastic Requirements**.

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

1. General Medicine Wards

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

2. MICU

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

3. Cardiology and CCU

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

4. Hematology/Oncology (MCG)

Patients with sickle cell disease and other hematologic disorders, malignancy undergoing chemotherapy, and other special therapy requiring expertise of an Oncologist. Competencies relate primarily to management of acute and chronic pain, altered physiology and sepsis.

5. Nephrology (MCG)

Patients on dialysis and status post renal transplant. Competencies relate primarily to metabolic and infectious complications of renal disease and psychologic, economic, and cultural impact of renal disease.

6. Infectious Disease Consults

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

7. Gastroenterology Consults

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

8. Night Float

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

9. Consultation

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

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

MCG Medicine Ward Services

0630- Arrival at hospital

0630-0730- Independent “pre-rounding” and review of labs, discussion with nurses

0745-0800- Hand off conference

0800-0845- Morning Teaching Conference (Wed Grand Rounds 0800-0900)

0845-0900- Discharge Planning Meeting (M, Tues, Thur, or Fri)

0900-1000- Resident/Team Work Rounds

1000-1130- Teaching Rounds with Attending

1130-1200- Orders, consultations called in, final discharge instructions

1200-1300- Noon Conference

1300-1830- Admissions, work rounds, order writing, self-study, f/u consultations, re-examination and counseling of patients (if work completed, team members may leave at 1600)

1900-1915- Hand off conference to NF

1915- Departure if no late admissions

2000- Departure if admissions after 1800

Teams post-call from overnight call

0630- Teaching rounds (new cases) (finish by 0900)

0730- Hand off conference (one member)- not official on the weekend, but need to sign out to your colleague what happened with their patients overnight.

0900-1100- Patient care duties

1100- Departure all residents after sign out to on-call team

MICU/CCU

0630- Arrival to hospital (on most days)

0700- Residents need to be in-house by 0700 in the units; call in the MICU/CCU is from 0700-0700

0700- Unit-Unit or Card-Card handoffs (one member)- hand off the code pager

0630-0900- Pre-round/ Resident/Fellow Team work rounds

0900-1100- (1130) Teaching Rounds with Attending

1100-1200- Charting, call in consultations, and patient care

1200- Post-call resident must be clocked out and on way home or at home

1200-1300- Noon conference

1300-1700 Admissions, work rounds, order writing, self-study, f/u consultations, re-examination and counseling of patients; may not leave the units earlier than 1700, except on the weekends (assuming all the work for the day has been completed)

*When a HS officer is post-call in the units, they should have their work completed by 1200.

Residents will conduct their continuity clinics at times scheduled and will be excused from the above schedule when in their clinics. Attending clinic schedules may require movement of teaching rounds to the afternoon 1400-1530. Post call day does not count as a "day off." Teams will distribute work and coverage to allow each member one day off in seven.

B. Supervised care of limited numbers of ambulatory patients

All patient care will be supervised by a designated attending physician who is responsible not only for the outcome of the patient, but along with the resident, attainment of the educational competencies associated with that patient or type of care. Except where designated such experiences will be one calendar month in length, not repeated throughout the curriculum.

Location: MCG or VA

Teaching methods: Seminars in clinic minimum 4.5 hours per week, daily feedback and semimonthly evaluation of patient care.

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

1. Continuity Care Clinic: All years

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

2. Subspecialty Continuity Clinic: PGY 3 in subspecialty track

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

3. Emergency Medicine: One month as PGY-3 (VA and MCG ED)

Residents will care for patients with acute medical problems and needs requiring immediate attention or felt by the patient to require such attention. Competencies relate primarily to integrative disciplines, cardiac, pulmonary, drug abuse, psychiatric, and metabolic diseases listed above. Residents will develop competencies in decision making, triage and rapid evaluation and management of acutely ill patients. They will all serve as consultants in internal medicine to the emergency department during this rotation.

4. Patient Centered Care and Value Based Medicine (VA Educational Innovation Project, at Uptown VA, all three years, didactic and experiential components)

Part of the PGY-2 Didactic Experience will be at the Atlanta HQ of BlueCross BlueShield. Vision, Goals, Objectives, and Hypothesis/AIMS of the Augusta VA/MCG EIP

a. Vision: To develop leaders who will implement a chronic care model that is patient-centered and value-based and results in enhanced health for the population.

b. Goals:

- 1) To provide effective didactic and experiential education in patient-centered and palliative care
- 2) To improve patient biological, psychological, and social outcomes in a population with chronic illness in a cost-efficient manner.
- 3) To develop leadership skills, attitudes, and behaviors to the extent that resident graduates of this program will demonstrate competency in patient-centered and value-based care during the remainder of their residency.
- 4) To develop leadership skills, attitudes, and behaviors to the extent that resident graduates will make scholarly and leadership contributions in patient-centered and value-based care in near and long-term practice.

c. Objectives

1) PGY-1: By the end of the PGY-1 didactic and experiential rotations, residents will be able to accomplish the following within the competency level of *proficient*:

- a) Explore both disease and illness while conducting patient interviews
- b) Explore understanding of the whole person, including military, occupational, social support, psychological, sexual, and spiritual issues
- c) Use interviewing techniques to find common ground with the patient
- d) Incorporate prevention and health promotion in management planning
- e) Enhance the patient-physician relationship through communication and management skills
- f) Conduct comprehensive multi-disciplinary evaluations using a variety of tools
- g) Assess, manage, and alleviate common symptoms, including pain.
- h) Prognosticate anticipated morbidity, adverse drug reactions, and mortality to assist patients in goal setting and health care planning.
- i) Conduct outcomes evaluation of provided patient-centered care.

2) PGY-2: By the end of the PGY-2 didactic and experiential rotations, residents will be able to accomplish the following within the competency level of *proficient*:

- a) Evaluate and apply current methods of quality of life measurement
- b) Apply patient values and preferences in health care with respect to their chronic illness or disability

- c) Apply concepts of value-based medicine to the longitudinal care of two patients with chronic, disabling or progressive illness.
 - d) Conduct cost-utility analyses of health care utilization from the patient and payer perspective.
 - e) Describe the current systems of health care financing and their impact on efficacy, efficiency, safety, and patient satisfaction with health care provided.
- 3) PGY-3: By the end of the PGY-3 didactic and experiential rotations, residents will be able to accomplish the following within the competency level of *competent*:
- a) Teach in PGY-1 and PGY-2 didactic sessions on patient-centered and value-based care.
 - b) Conduct case discussions on patient-centered and value-based care with medical residents and students.
 - c) Complete a publishable paper on or within the scope of patient-centered and/or value-based care.
 - d) Assist the OEF/OIF Program Director in managing the weekly patient review meeting, and fostering team development.
 - e) Participate in the OEF/OIF Program semi-annual outcomes report.

5. Women's Health / Adolescent Medicine (Richmond County Health Department) PGY-3; 2-weeks required, but may elect 4 weeks. Residents will care for patients with sexually transmitted diseases, women's health screening, adolescent evaluation and health care pertinent to women's health issues. Residents will develop competencies in women's health and adolescent medicine.

6. Geriatrics (MCG Center for Senior Health): PGY-3; 4 weeks simultaneous rotation with patient-centered care. Residents will manage geriatric patients in conjunction with faculty at the Center. Competencies include Geriatrics, Clinical Method, Continuity of Care, Home Care, Nursing Home Care, and the Dying patient.

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

Specific Objectives:

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

Location: Christ Community Health Services, Augusta, Georgia

Duration: 2-week or 4-week elective, or second continuity clinic.

8. Neurology PGY-3: 2-weeks required

Residents manage patients with neurologic diseases and symptoms (one half clinic, one half consultative). Primary competencies are in Neurology, to include physical diagnosis and management of acute and chronic neurological disease expected of a general internal medicine practice.

9. MTW Foreign Ambulatory Internal Medicine (Dr. Ted Kuhn and other faculty): 2-week supervised elective experience in ambulatory and community medicine in a developing country under supervision of Dr. Ted Kuhn and other faculty, designed to develop appreciation of systems-based practice and physical exam skills in resource-poor environments. Requires 3-month prior approval.

10. Albany Georgia Internal Medicine (Dr. Joseph Stubbs): 2-week elective opportunity for exposure to a premier internal medicine practice to develop skills in communication, patient care, practice-based learning, and system-based practice.

C. Ambulatory and Consultative Rotations: Required and Elective

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

Patients seen typify patients with acute and chronic illnesses in the named specialties. Unless specified, rotations are at the VA or both VA and MCG. Application for specific non-ward rotations will be approved by advisors contingent upon track of resident, performance on in-service exam subspecialty components, and availability of teaching space on the rotation for the month desired. Residents should plan their non-ward rotations early in the academic year.

Core Rotations

1. Gastroenterology Consults/Clinics
2. Cardiology Consults/Clinics
3. Cardiology CHF inpatient service- don't think we have this anymore
4. Rheumatology Consults/Clinics
5. Pulmonary Consults/Clinics
6. Endocrine Consults/Clinics
7. Nephrology Consults/Clinics
8. Infectious Disease Consults/HIV Clinic

Other Electives-Track specific

9. General Medicine Practice (Albany Medical Clinic, Albany Georgia): 2 or 4 weeks, PGY-2/3 required for generalist track.
10. Women's Health (Athens, Georgia, VA or as special arrangement)
11. Sports Med/Orthopedics/Rheum (Musculoskeletal)
12. Allergy-Immunology
13. Rehabilitation-(VA Spinal Cord Unit)
14. WIC (walk-in clinic) VA or MCG
15. Inpatient Hospitalist (MCG)
16. Advanced Procedural Skills (Echo, Sigmoidoscopy, Treadmill Stress Testing, EKG, others as individually arranged); PGY-3
17. Anesthesia/Pain Clinic- can't do this anymore!
18. Dermatology Clinic/Consults
19. Ophthalmology/ENT
20. Adolescent Medicine
21. Research Month (needs defined and approved research protocol and mentor, completion of clinical Trials Competency 4 module training prior)
22. Off-Campus Elective (maximum one month at US ACGME approved program, see policy for approval)
23. Community Medicine
24. MTW Short term Foreign Ambulatory Internal Medicine

Non-ward rotations will be approved according to the following track distribution requirements over 2 years of PGY2-3:

Primary Care Track

3 months Core Rotations

4 months required: Select from: Sports Medicine/Ortho, WIC, Geriatrics, Women's Health, Allergy-Immunology, Dermatology, MTW, Community Medicine, Albany Georgia Ambulatory Medicine

3 Electives

Hospitalist Track

4 months Core Rotations

3 months required: Hospitalist rotation plus 2 others: Radiology, Rehabilitation, VA spinal cord unit, Doctor's Burn unit

3 Electives

Sub-Specialty Track

4 months Core Rotations

3 months required: month of consult in chosen subspecialty area, month of clinic/procedures/ancillary studies in subspecialty area, month research in subspecialty area

3 Electives

Note: Core requirement is for total time; must be done in at least 2 week blocks

Vacation can be only taken in elective rotations

Non-ward rotations taken in PGY1 count toward requirements

Changes in track choice will be handled individually through the advisor system.

D. Procedures

Residents are expected to learn the indications for, complications of, and demonstrate the skills of the following ABIM recommended internal medicine procedures:

Abdominal paracentesis (3)

Arterial puncture for blood gas analysis (5)

Arthrocentesis of knee joint (3)

Central Venous line placement (5)

Lumbar Puncture (5)

Nasogastric Intubation (3)

Thoracentesis (5)

Breast examination (5)

Rectal Examination (5)

Pelvic examination with PAP smear including wet mount (5)

Venapuncture (10)

Peripheral IV insertion (10)

Residents must have documented successful performance of their procedures in their One45 portfolio and log book with annotation by a supervising physician that the procedure was appropriately considered and accomplished. In order to complete the PGY-1 year at least 2 of each procedure listed above except arthrocentesis should be documented. In order to complete the PGY-2 year, the complete number of procedures must be successfully completed and documented.

Advanced procedural skills may be acquired during the special procedures elective noted above.

E. Didactic Curriculum

Didactics are designed to integrate, supplement, and broaden experience and knowledge in the rapidly developing fields encompassed by internal medicine. Students learn from their mentors and peers, through literature review, and by study and analysis in preparing timely topics. The

didactic curriculum does not replace patient care. The didactic curriculum is designed as a three year educational experience, with educational repetition of approximately one-fourth of the topics. Topics include information from the basic medical sciences, psychosocial, economic, and cultural aspects of health and illness, as well as population dynamics, health care quality and management, and personal, family, community, and national/international aspects of health and disease.

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

Attendance is taken at all conferences. It is the responsibility of the resident to make certain attendance is tabulated. Failure to achieve attendance goals will result in failure to graduate from the PGY year unless the RPEC accepts hour-per-hour alternative education such as Hopkin Modules, assigned self-study, or tested video/computer study.

The following are the key didactic and patient care conferences:

1. Morning Hand-off Conference: Night Float or Night call team transfers care (using PAMPER Handoff form) to receiving physicians (typically on-call team and hospitalist service) through discussion of cases. (0745-0800)
2. Morning Report Conference and bedside rounds as appropriate (0800-0830 or 0845, daily M-F). This is also a daily teaching conference for the Night Float team.
3. Night/Unit Float Follow-Up Conference: Mondays 0800-0830 Hospitalist and teams give feedback to Night/Unit Float Team on outcomes of cases admitted to various teams during previous week
4. Clinical Pharmacology/Adverse Drug Reaction Conference (every other Tuesday) 0800-0830). All interns/residents at MCG to report and discuss adverse outcomes with representative of department QI, Allergy Program, and PharmD/Clinical Pharmacology Programs. Mini-lecture on ADE topic.
5. Medicine Grand Rounds: Wednesday 0800-0900 Small Auditorium. Topics of current general interest to internists.
6. Resident Case Management Conference (am report) 0800 M, T, and some Thursdays. Scheduled presentation by residents of case management issues, graded by protocol format with attending and resident discussion.
7. Hematology Case Unknown and Review, Dr. Paul Dainer, every other Thurs (0800-0830)
8. Resident Problem/Didactic Conference (PGY 2 and 3). (Friday 0800-0830 from August-April). Evidence-based discussion of current medical topic by resident. Must use evidence-based format outlined by program director to achieve competency scores in practice-based learning, medical knowledge and communication. (See attached)
9. Acute Care Lecture Series (Noon T,W,Th,F) July-August : Acute Medical Problems
10. Physical Diagnosis Course and Simulator Training/Testing (Noon last week July and first week August, PGY -1 only)
11. Noon Conference (Noon Tues, Thur, Fri): Key management topics pertinent to the practice of general and subspecialty internal medicine and preparation for the ABIM. The schedule of lectures and discussions (with pre and post MKSAP questions) is based on about 160 high-yield topics and repeated every 18 months. Some conferences will be given by residents.
12. 12.Research Conference (1st Thursday of every month at noon) Departmental and resident research presentations
13. 13 Interdisciplinary Conference: (Wed Noon): Medical Ethics, Practice Management,
14. Health Care Evaluation, Information Mastery, Interdisciplinary Medicine)
15. Basic Science and Medicine Series (Statistics Lipidomics, Glycomics, Genetics (3rd Monday of every month at noon)
15. Clinical Pathologic Conference (2nd Monday every month at noon)
16. Housestaff Administrative Meeting and Periodic Examinations (Last Friday at noon)
17. Morbidity/Mortality/TQI Conference (4th Monday at noon)
18. Medicine-Surgery Interdisciplinary Conference: as scheduled
19. Medicine-Emergency Medicine Interdisciplinary Conference: 3rd Thursday 0800 every other month.
20. PGY-2 Leadership Seminar (Before beginning PGY-2 year): Discussion and role play of major issues of leadership, teaching, time management, feedback and evaluation.

21. X-ray rounds (as scheduled by Radiology). Review and teaching on current cases managed by ward teams at MCG and VA.
22. Board Review Course: Based on MKSAP, for PGY 2 and PGY 3 residents, Fridays March-June, time varies.
23. Journal Club: Wednesday Evenings monthly at selected restaurants: Required for PGY2 & 3 (60% attendance) partial attendance expected for PGY 1.
24. Subspecialty conferences: Residents electing a specific subspecialty track are encouraged and expected to attend subspecialty conferences held outside of core conferences noted above.

F. Special Educational Experiences

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

Required:

1. Journal Club: Monthly evidenced based medicine review of key journal article and current article answering a clinical question. (Required for PGY3 to present, required for PGY2 to attend, partial attendance requirement for PGY1).
2. Clinical Evaluation Exercise (CEX): Bedside evaluation of diagnostic and decision making skills of the resident. Four of these mini-CEX are to be performed in the PGY-1 year.
3. Annual ACP Inservice Examination: held for each categorical resident each October.
4. Procedure accreditation-residents are expected to log the successful performance of all procedures in One45. Every effort should be made to complete all procedures by the end of the PGY-1 year (minimum requirement of at least 2 of each procedure except arthrocentesis).
5. Resident Research: All residents are required to have completed a scholarly paper or abstract in publishable format by the end of the PGY-3 year. Guidelines, expectations, and timelines for this requirement are listed in the document: "Resident and Fellow Research Program" dated 16 October 2001.
6. Hopkins Ambulatory Care Web-based Curriculum: All residents are expected to fully complete at least 6 of ambulatory care modules each year. This activity is found at www.hopkinsilc.org

G. Scholastic Requirements

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

1. All residents, all rotations: All residents are encouraged to submit reports of adverse drug reactions, quality improvement initiatives, near miss reports and other QI events promptly to the program director on the "near miss form." Residents will be measured and achieve competency in Practice based learning and Systems Based Practice based on reports submitted and activities accomplished. In addition, all residents will participate on subcommittees of the Residency Program Patient Care Quality Improvement Committee, as well as selected residents (designated future Chief Residents) on the Residency Program Improvement Committee.
2. Resident Reflection and Self-Evaluation: Each resident will complete the One45 pre and post rotation self-evaluations before and after each rotation. This includes setting goals and objectives for the rotation with the attending and monitoring whether goals have been achieved.
3. Practice Profile: Residents will participate in performance monitoring of their continuity clinic patients with semi-annual report on the following performance measures: Number of patients followed, number of visits, % patients with controlled hypertension, diabetes, completion of preventive care tasks, and assessment of individual patient and system interventions to improve performance.
4. Outside and Special Rotations: Each resident will complete assigned essays by the completion of the rotation in order to achieve credit for the month. These rotations will be incorporated into the resident's portfolio.

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

1. PGY-2: Completion of at least one Friday Morning Evidence-based Medicine Conference according to prescribed format with grading and entry into portfolio.
2. PGY-3:
 - d. Preparation of at least 1 noon conference on assigned topics for PGY1 or PGY2/3 curricula with grading according to written criteria and entry into portfolio.
 - e. Preparation of at least one journal club presentation according to CAT methodology with grading and entry into portfolio.
 - f. Completion of at least one Friday Morning Evidence-based Medicine Conference presentation according to prescribed format with grading and entry into portfolio.
3. All years: Each resident will prepare a case vignette each year for submission to the annual ACP state competition.

H. Optional Activities

1. Resident paper/poster competition for ACP state meeting.
2. Hospital and MCG committees (especially Risk Management, GME, Drug Reaction)
3. Community service
4. Resident organization
5. Moonlighting-Moonlighting is limited to PGY2/3 only, must be prior approved according to department policy, and must be reported monthly to the Program Director.
6. Social Activities-Department parties and activities
7. Christian Medical and Dental Society
8. Religious Organizations (Churches, etc.)
9. Personal recreation and fitness

I. Resident Program Tracks

The program will offers 3 tracks to categorical medicine residents. This allows residents opportunity to pursue their personal academic goals while satisfying the requirements of the American Board of Internal Medicine. PGY-1 residents will declare their chosen track by 31 December.

1. Subspecialty Track

The subspecialty track allows participation in desired subspecialty inpatient, outpatient, and consultative subspecialty experiences in the first 2 years of residency to prepare the resident for application to a competitive fellowship program. Residents will initiate and participate in subspecialty related scholastic and research activities in their desired subspecialty.

2. Hospitalist Track

The hospitalist track allows enhanced participation in inpatient care on general medicine. This is coupled with training in managed care administration, quality improvement, hospital epidemiology, drug utilization review, medical error prevention, and medical outcomes research.

3. General Medicine Track

The general medicine track prepare resident for a career as a general internist working primarily in an outpatient primary care or multi-specialty setting. Residents receive special training in practice organization, psycho-social aspects of primary care, communication skills, and small group leadership.

VI. Administrative Requirements

A. Performance of Duty: Residents are expected to be prompt and dutiful in assumption of all patient care and administrative duties. Residents are expected to know, understand and abide by the Department Policy on Professionalism. Residents on wards are expected to arrive in time to conduct personal “pre-rounds” on their patients (PGY-1 on all patients, PGY2/3 on selected ill patients), to be completed by

0745. At 0845 each team is expected to begin work rounds as a team, visiting each patient expeditiously, and discharging all appropriate patients in order to clear beds by 1000.

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

C. Incomplete and Delinquent Records: Residents are expected to their inboxes weekly to verify they have no dictations or signatures to complete. Delinquent records will result in disciplinary action, including but not limited to formal citation in portfolio.

D. Attendance: 60% attendance is required for each conference, as measured on a quarterly basis. This percentage takes into account leave and off-site rotations.

E. UMSLE step 3 Examination: Residents will successfully complete UMSLE step 3 within 6 months of date of eligibility.

F. Evaluation Forms Completion: It is the responsibility of the resident that all scholastic requirements be accomplished and that all evaluation methods be completed and annotated in his or her personal record no later than June 10.

VII. Resident Evaluation, Promotion, Probation, and Dismissal

A. Resident competency will be evaluated and documented according to the methods outlined in the policy paper "Resident Competency Program" dated 6 June 2002. Residents are expected to be familiar with this policy and program, key components of which are outlined below:

B. Advisor Program: Each resident is assigned a faculty advisor who will be his or her primary mentor and advisor for the length of the residency. Advisors will meet the resident at least 3 times per year and assist the resident in completing all requirements including rotations, procedures, completion of required scholastic papers, research paper and administrative and professional requirements. The advisor will also complete chart reviews and assist in preparation and supervision of learning agreements.

C. Competency Evaluation Tools

1. Monthly One 45 Summary Evaluation: Residents are expected to discuss their evaluation with their attending physician at mid-month informally and at the end of the rotation before leaving the service. The attending should discuss and show the completed evaluation to the resident who should sign it. It is the responsibility of the resident as well as the attending that this be accomplished. (All competences)
2. Clinical Evaluation Exercise: A mini-CEX is to be accomplished by interns while on each General Medicine, Cardiology, Renal, or Hem-Onc Rotations (Patient care, communication, professionalism competencies).
3. Direct Observation by attendings, program director, chief residents at morning report, conferences, and in working on wards (Patient care, communication, PBL, SBP)
4. 360 degree evaluation by nurses, students, others performed at least semiannually by nurses, monthly on One 45 by residents (patient care, professionalism, Institute of Medicine quality aims, Practice Based Learning)
5. Formal written examinations: EKG, Palliative Care, Microscopy, ACP Inservice, and ad hoc exams as determined by the program director (Medical Knowledge)

6. Chart Reviews: Admission notes, progress notes, and dictations are formally reviewed and graded by the program director (inpatient) and three times yearly by advisors (outpatient). Residents review such evaluations and correct deficiencies.(Patient Care, PBL, Communication)
7. Patient satisfaction surveys/Complaints (Professionalism) are performed in continuity clinics and wards and placed in portfolio after review by the program director.
8. Procedure Documentation log (Patient care, PBL). Residents are expected to complete approximately 50% of ABIM recommended internal medicine procedures by the end of PGY-1 and all of recommended procedures by the end of PGY-2 year in order to advance. These procedures will be documented in One45 and the ABIM procedure log book provided each resident.
9. Self-assessment instrument will be completed thrice yearly by residents and discussed with advisors (All competencies and IOM quality aims).
10. Validated reflective thinking on case vignettes (Morning case conferences, Morbidity and Mortality conference) (Medical Knowledge, PBL)
11. Critique of written and oral communication by peers and faculty, particularly of noon conference presentation. (Medical Knowledge, Communication)
12. Semi-annual resident continuity report (Systems-based practice).

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

D. Criteria for Advancement of Residents

1. Residents are evaluated continuously by advisors, the program directors, and the Resident Evaluation and Promotion Committee (RPEC) according to standards listed in the policy Statement Criteria for Advancement of Residents (Appendix 1, linked)

2. Residents are evaluated biannually by the Residency Evaluation and Promotion Committee with written report from the Program Director with due input from attendings and others as appropriate, and are promoted and graduated by committee vote.

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

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

5. Residents are evaluated annually by the RPEC based on completion of duty and quality of performance as measured using the evaluation tools listed above, as well as meeting of milestones listed in the Criteria for Advancement of Residents. The RPEC vote determines promotion of each resident. The program director completes an annual report on competency and progress to the American Board of Internal Medicine, documenting satisfactory completion of the academic year. After the PGY-3 year, the program director also recommends to the ABIM the suitability of the resident to sit for the ABIM certifying examination.

E. Academic Remediation, Probation, and Dismissal from the Program

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

Residents will be counseled promptly for perceived deficiency in any of the 6 core competencies. Such counseling will be performed by attending, advisor, chief resident, or program director as appropriate, and documented in the academic record of the resident. The program director may write specific letters of counseling, censure, or reprimand as he or she deems appropriated. Such letters will be reviewed by the RPEC, which may vote to remove or sustain such information in the permanent academic record of the resident.

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

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

VIII. Program Evaluation

The Program is evaluated in the following methods:

- A. Resident written evaluation of attendings and program as a whole.
- B. Post-graduate written inquiry (letter to graduates 9 months after)
- C. ABIM Pass/Scores
- D. In-service Training Scores
- E. Yearly Internal Review (by faculty and residents using formal questionnaire)
- F. Biannual External Review
- G. RRC Review
- H. Weekly informal housestaff/Chief Resident/Program Director Meeting
- I. Resident formal and informal input into this curriculum.

IX. Action to Improve the Program

The Program is improved in the following manner, using results of evaluations noted above in VIII.

- A. Curricular change: Modification of rotation content, location, length, scope
Modification of didactic schedule, content, teachers
Modification of available electives
Modification of available research
- B. Personnel change: Modification of ineffective teachers
Faculty Development
- C. Equipment change: Purchase of Literature as needed
Purchase of Computer, AV or other equipment as needed
- D. Systems change: Modification or re-engineering of systems of care, teaching, or research as needed to improve program accomplishment
- E. Reassessment: After modifications are made, the changed are assessed to determine that improvement has been accomplished.

X. Responsibility

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

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

ADVISOR MEETING WITH ADVISEE

Expectations for the meeting

1. Get to know your new advisee (s) at a personal level
2. Review evaluation of rotations with advisee
3. Fill out the quarterly evaluation form: Residency Feedback Form
4. Fill out the appropriate information on the Resident Performance Summary (The areas in black are the responsibility of the advisor, the areas in blue are the housestaff, and the red one is the program directors.)

Please make sure that you review:

- a. Certified procedures
 - b. Record reviews
 - c. Attendance to lectures
5. Keep track and review the attendance to lectures
- Regarding the attendance to lectures these are the expectations:
 - Every housestaff is **expected to have a minimum of 60% attendance** to the required conferences.
 - If the houseofficer (HO) has LESS than 60% of the expected attendance at your first meeting with them, this is considered the **first offense** and a formal citation will be placed in the HO's file. Document that you warned them and inform them of future consequences if violation of the expectation. The **second offense** of not meeting attendance expectation will result in a permanent citation placed in the HO's file and they will be brought up in RPEC. **The third offense** will result in the HO being evaluated for possible dismissal from the program.

It is important that you inform your advisees of these issues in your first meeting and document this in his/her file. Remember tracking data is extremely important and would avoid concerns with future problems.

6. Have the residents sign the forms, evaluations, and the summary of your encounter with them.

If you notice that the evaluations of the advisee are sub-optimal (score less than 4 in the ABIM evaluation form done by faculty supervising the HO) or if you notice that there are some active problems with the advisee that concern you, contact Dr. Thornton, Dr. Merchen, or Dr. Haburchak at your earliest convenience. Help will be provided for the houseofficer as soon as possible. We will help you in putting your advisee on the right track immediately. You must take leadership in helping your advisee and facilitate the process for remediation of probation. You must develop a plan and you must notify Dr. Haburchak, Dr. Thornton, and Dr. Merchen of your plan. If you deem necessary, please document the issue in the resident's file. It is the responsibility of the advisor to identify active issues on the advisee that need attention and/or remediation.

BACK-UP POLICY

1. The back-up resident or intern will only be utilized for appropriate coverage.
2. The back-up resident or intern is not to be used for planned or known absences and are only to be called in the event of an emergency, or excessive workload of inpatient services.
3. If a house officer cannot perform his or her duties due to illness or an emergency, he/she must call the housestaff office no later than 7:30 am on the morning of the absence and leave a voicemail indicating the following: name, rotation, attending, clinic day, and a phone number where you can be reached.
4. The house officer should then call the Chief Medical Resident (CMR) and inform him/her of their absence.
5. The CMR will then arrange coverage for clinical duties if needed. The 1st back-up intern or resident will be called first, followed by the 2nd back-up intern or resident. In a crisis situation where the 1st and 2nd back-up intern/resident have already been pulled, then available elective rotators will be pulled.
6. If the back-up house officer is pulled to cover someone on a call day or any rotation requiring them to be in the hospital overnight (i.e. unit float or night float) the house officer who is not able to fulfill his/her duties must repay the coverage by covering a call day or NF/UF shift for the back-up house officer at a later date. If you are hospitalized or have a note from a physician indicating your illness, then you will be excused from having to repay coverage to the back-up house officer.
5. Failure to be available when you are either 1st or 2nd back-up will result in either additional back-up days or extra call duty. It is your responsibility to know when you are on back-up.

CONSULT RESIDENT

The consult resident is responsible for all general internal medicine consults at MCG and the VA Monday-Friday 7:30 am-5:00 pm, as well as follow-up as needed on consults from evening and weekends. They are expected to be at MCG morning report at 7:45 am.

The consult resident will facilitate general medicine admissions during resident clinics and in the mornings as needed. However, admissions are the primarily the responsibility of the long-call team. The long-call team should make every effort to see new admissions as they come in and write their own admission orders. During resident clinics, it is appropriate for the long-call interns to see new admissions on their own, with the understanding that the consult resident is available for questions or concerns until the long-call resident finishes clinic. The consult resident is not at any time obligated to write admission notes on new patients.

In addition to medicine consults and backing up call teams, the consult resident will maintain their continuity clinic during the consult month.

During the consult rotation, outpatient experience in ophthalmology, non-surgical orthopedics/rehab medicine, and otolaryngology will be provided in the form of 1-2 half days of clinic in each specialty during the month. A schedule of available clinics will be provided at the beginning of each month. Attendance in these clinics will be documented by attending physician signature on the day of clinic. The evaluation for the month will still be performed by the consult attending.

The consult rotation will be in month long blocks, with 1-2 residents rotating each month.

CLINIC POLICY

Continuity Clinic

All categorical residents will have ½ day of clinic on an assigned day throughout their three years of training (**either 8-12 am or 1-5 pm**). They are expected to attend clinic every week except vacation, holidays, and while on MICU/cardiology rotations. For nightfloat rotations, clinic will be reassigned to Friday morning.

Each clinic will begin with a 15-20 minute case-based didactic session with the attending physician on a topic in ambulatory general internal medicine. The first patient appointment will be scheduled at 8:20 and 1:20 for morning and afternoon clinics, respectively, to allow time for the clinic conference. **Residents are expected to arrive in clinic on time for the clinic conference.**

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

Residents are expected to arrive promptly to begin patient care. The nursing staff will obtain vital signs and place patients in assigned rooms. Residents are expected to evaluate the patient with a full H&P if are seeing them for the first time, even if they are previously a patient in the clinic. Follow-up patients require a progress note, including a review of their medication list.

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

If you miss continuity clinic for ANY reason, you are required to make that clinic up at a later time. This is a requirement by the Internal Medicine ACGME guidelines, and there will be no exceptions. If the absence is planned, you are responsible for your own coverage. Forms for coverage are available in the housestaff office.

MCG clinic only:

Lab and other test results and patient phone messages will be sent to your Powerchart Office Inbox. It is required to review the inbox and address any messages or test results every 24-48 hours. When on vacation, you are required to assign one of your colleagues as “proxy,” (instructions will be given by the attending physician.) You are required to notify the covering resident, attending physician, and housestaff office via email of your plans for coverage.

Failure to address Inbox messages and test results in a timely manner will be considered a violation. The 1st violation will result in a verbal warning. The 2nd violation will result in a written citation and review by the RPEC committee. The 3rd violation will be considered grounds for dismissal from the program.

Walk-In Clinic (VA) and Acute Care Clinic (MCG):

All preliminary interns will have ½ day of clinic on an assigned day for the duration of their intern year (**8-12 am**). They are expected to attend clinic every week except vacation, holidays, and while on MICU/cardiology rotations.

Each clinic will begin with a 15-20 minute case-based didactic session with the continuity clinic attending physician on a topic in ambulatory general internal medicine. Acute care interns are encouraged to attend. The first patient appointment will be scheduled at 8:00 am. Often a student or off service rotator

will be available to see the first patient to enable clinic conference. **Residents are expected to arrive in clinic on time.**

The patient panel will consist of continuity clinic patients requiring care for acute issues when their primary care physician is not available. At times, single-visit hospital follow-up patients will also receive care in this setting.

CONFERENCE ATTENDANCE POLICY

Attendance should be 60% or greater for each of the following individual forums:

- Grand Rounds
- Morning Report
- Noon Conference
- Journal Club (PGY-2/3 only)

Attendance is calculated based on the total number of available conferences during the year. Though it is understandable that average attendance will be decreased by night float, days off and vacation, the difference may be made up by more frequent attendance during elective and inpatient months (including MICU and cardiology) throughout the year.

The housestaff office will calculate conference attendance monthly, and percent attendance for that month and the year to date for each individual conference type will be provided via email. Cumulative attendance to date will be reviewed at each advisor meeting, and if below 60% at that time, a formal citation will be placed in the advisor evaluation for that month.

On December 1 of each year, the cumulative attendance for the first 5 months will be reviewed. Housestaff below 60% will each have an additional 3 days back-up call assigned in the ensuing 6 months.

On June 1 of each year, PGY-2 and categorical PGY-1 attendance for the previous 6 months will be reviewed. Housestaff below 60% will each have an additional 3 days back-up call assigned in the ensuing 6 months.

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

DICTATIONS AND MEDICAL RECORDS

Proper discharge planning, including the timely completion of dictations, is a crucial step in attaining our goals for quality patient care. Dictated narrative summaries should be timely, accurate, and concise. They should have the following outline: a) reason for hospitalization, b) historical, physical, and lab findings supporting diagnosis and outcome, c) thorough, accurate discharge diagnosis based on ICD code, d) listing of procedures performed, e) description of status and prognosis at discharge (i.e.: discharge weight, peak flow, functional and mental status, life expectancy especially if 6 months or less, etc.), f) listing of discharge instructions and follow-up care which includes medications, diet, activity, scheduled outpatient appointments, home care (i.e.: home health, PT, OT), discharge location (i.e.: home, hospice, nursing home, etc.), g) name and address of patient's primary care physician (a copy of the dictation should be sent to this physician).

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

In order to help all of us achieve these goals, the following policies and procedures are effective as of July 1, 2008:

Procedure:

1. The House Officer who discharges/transfers a patient is responsible for the discharge dictation. This may either be a PGY1, PGY2, or PGY3, although dictations are typically the responsibility of the PGY1. These dictations should ideally be done at the time of discharge. If the summary is not immediately dictated, then it is expected that the dictation will be performed within 72 hours. During high volume rotations/months PGY2 & 3 residents will assist the interns with dictations so that they are completed in a timely manner. Residents, use common courtesy- if a patient is being discharged on your intern’s day off, please dictate the discharge summary if possible. Students are **NOT** allowed to dictate discharge or death summaries.
2. Patients who are being discharged from the MICU or CCU or expire in the MICU or CCU must be dictated by the resident (not intern) for the months of July and August only. Beginning September 1, interns may dictate all charts. As a team leader, the residents are responsible for delegating dictations to the interns but must ensure that they meet standards and timeliness.
3. Death dictations should be completed by the intern primarily taking care of the patient. If a patient expires overnight or on the weekend when either the NF intern or cross-cover on-call intern is temporarily taking care of the patient, the death dictation will be the responsibility of the intern primarily taking care of the patient. The dictation should be completed the following morning when the primary intern arrives at work. Death dictations are not the responsibility of the NF or cross-cover intern. However, the NF or cross-cover intern is responsible for the death packet paperwork. Deaths that occur under the initial care of the NF resident prior to the primary team accepting the patient will be the responsibility of the NF resident who admitted the patient since this is the only resident who has evaluated the patient.
4. Patients who are being discharged to nursing homes or assisted care facilities usually require a STAT discharge summary to be faxed prior to transfer. Please consider doing this the day prior to discharge, and then adding an addendum on the day of discharge to facilitate a timely transfer.
5. Except in emergency situations, summaries should be dictated before the patient leaves the ward.
6. All patients that leave AMA (against medical advice) must be dictated regardless of their hospital length of stay.
7. By the 15th of every month, the Chief Medical Resident (CMR) will be notified by both the MCG and VA medical records department of any outstanding dictations. The CMR will then email each house officer on the list and let them know of their delinquencies. The House Officer then has 72 hours to complete the dictations. If dictations are not completed by the end of the month, disciplinary actions will be taken (see #10 below).

8. Certain patient accounts are designated by MCG as “**high-dollar accounts**” and cannot be billed if the Discharge Summaries have not been dictated. These particular dictations must receive top priority and MUST be completed within 72 working hours after the house officer receives notification. If they are not, disciplinary actions will be taken (see #10 below).
9. Complicated patients extending over the end of a calendar month or transferred to another unit or service should have an interim narrative dictated (usually 2-3 pages in length).
10. Delay in dictations will have the following consequences:

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

- A. First failure to fulfill the requirements: three extra days of back-up call duty and a warning letter added to your personnel file
- B. Second failure to fulfill the requirements: three extra days of back-up call duty, a letter of reprimand added to your personnel file permanently, and withholding of paycheck
- C. Third failure to fulfill the requirements: probation for unprofessional behavior
- D. Fourth failure: consideration for non-renewal of contract

In addition to providing exemplary patient care, the payoffs for investing a minimal amount of time needed to following these procedures will be a well-coordinated and efficient Team and a reduction in time-draining administrative headaches. You will develop self-discipline, hone your leadership skills, and earn the respect of both your mentors and your peers.

DISCHARGE/DEATH NARRATIVE SUMMARY OUTLINE EXAMPLE

1. **Primary Care Physician and Address:** If unknown, state unknown
2. **Source of Admission:** (e.g. MCG ER, direct admit from another, specified ER, HemOnc Clinic, etc).
3. **Reason for Admission:** (Age, Gender, admitted for evaluation/management of Altered mental status, vomiting, abdominal pain, dyspnea, wheezing, mass, etc)
4. **History of Illness:** (When did disease causing illness start? What is current stage? If previously admitted state condition at last discharge, including appropriate clinical parameter such as PFT, ABG, Weight, CD4, Mental Status. Describe patient’s course leading to admission, emphasizing clinical symptoms and signs with full description of functional status, what medicines were used as outpatient for this illness, and how compliant patient was with therapy)
5. **Past History:** (List key continuing medical diagnoses, to include stage; surgeries, psychiatric diagnoses, allergies, advanced directives). Do not include all medicines, family, genetic, social history or review of systems in discharge narrative unless pertinent to the course of the admission.
6. **Physical Exam:** (Admission vital signs, weight, general appearance, mental status exam, and findings, negative and positive to reason for admission and outcome)

7. **Pertinent Laboratory:** (Key laboratory only pertinent to discharge diagnoses)
 (List all x-ray tests performed chronologically, with results)
 (List all positive microbiology results by date)
 (List all pathology/cytology/genomic results by date)
 All lab test results pending at discharge should be stated as such-along with who is to follow up these tests)
8. **Procedures:**(List all procedures in chronological order)
9. **Immunizations Administered:** (pneumococcus, influenza, immune globulin, others)
10. **Consultations:** (List chronologically, name of consultant, service)
11. **Hospital Course:** (Summarize briefly each of the following:
 - a. Location and categories of care given: (e.g ward 5W acute diagnostic and therapeutic, MICU intensive/resuscitative care, 6S palliative care)
 - b. Diagnostic Interventions
 - c. Therapeutic Interventions
 - d. Complications and Medical Errors
 - e. Outcome and condition at discharge (Include objective and subjective measures, such as discharge peak flow, ABG, weight, ADI, MMSE, et.)
 - f. Time and manner of death: State if and when patient made DNR, palliative or terminal care given, ACLS performed, autopsy/organ donation request and family reasons if not accepting).
12. **Discharge Diagnoses:** (Use ICD-9 Code with physiological status as appropriate, with first diagnosis being the diagnosis prompting admission; all diagnoses bearing on course and outcome should be listed, especially psychiatric diagnoses such as personality disorders, depression, etc)
13. **Prognosis:** (Life expectancy, functional prognosis, etc)
14. **Disposition:**
 - a. Where discharged to such as home, nursing home, home health, hospice, rehabilitation center, community psychiatry, morgue;
 - b. Who (by name) is responsible for care such as self, specific family member, primary care physician, rehab center, nursing home
 - c. When patient is to be followed up by primary care physician (by name); other specialty appointments, referrals
 - d. What patient or family is to do if they have problems
15. **Discharge Instructions:**
 - a. Medicines
 - b. Diet
 - c. Activity (include smoking, drinking, exercise)
16. **Who should get this narrative:** (primary physician, referring physician, consultants to be following patient, nursing home, home health agency, etc.)

Dictated by: _____

Resident responsible for patient at disposition: (Usually same as one dictating)

Attending approving: _____

Test Form: Not part of Medical Record
Inpatient Medicine Work Sheet

Patient:

Date of Admission:

Team (Color/type) caring for patient

Primary Care Physician and Address:

Reason for Admission:

Pertinent Laboratory this admission (annotate tests performed/results/pending)

X-Ray Studies

Results Positive Microbiology

Pathologic/Genomic Tests

- | | | |
|----|----|----|
| 1. | 1. | 1. |
| 2. | 2. | 2. |
| 3. | 3. | 3. |
| 4. | 4. | 4. |
| 5. | 5. | 5. |

Other tests (unusual chemistry, endocrine, serological, etc.) ordered/results

- 1.
- 2.
- 3.
- 4.

Procedures/Surgeries (date):

- 1.
- 2.
- 3.
- 4.

Immunizations Performed (Date)

1. Pneumococcus
2. Influenza
3. Other

Consultations (Date, service, consultant)

- 1.
- 2.
- 3.

Complications and Medical Errors (Include drug toxicity):

- 1.
- 2.

Problem List (Template for Discharge Diagnoses)

1. Problem/Diagnosis for which admitted:
- 2.
- 3.
- 4.
- 5.

DISCHARGE POLICY

1. Purpose: To outline policy and procedures to provide highest quality discharge planning implementation to the patients managed by the residents of this program.
2. Applicability: All Medicine wards and services, including ICU at the Medical College of Georgia.
3. Policies:
 - a. Patients are to be discharged only after optimal hospital benefit has been achieved in terms of safety, efficacy, and efficiency of management of the medical problem requiring hospitalization.
 - b. Patients are to be discharged only after patients and their families demonstrate to the discharging nurse and physician their understanding of the reasons for the hospitalization and the discharge plans which have been accomplished to ameliorate or prevent the processes leading to re-hospitalization.
 - c. Patients should be discharged only after their primary care physician has been notified of the patient's hospitalization and a follow-up appointment has been scheduled. **This is the responsibility of the house officer caring for the patient and should be dictated into the narrative summary.**
 - d. Patients are to be discharged only after they receive proper education and understand the reason for their hospitalization. They should also understand the immunizations that are offered or were received, discharge medications and diet, updated advanced directives and/or POLST (Physician Orders for Life-Sustaining Treatment), activity instructions, follow up appointments, and what to do for annotated likely problems.
 - e. Patients are to be discharged only after they or their surrogate decision maker/care-giver have received a copy of the documentation noted in d. above. They should be instructed to give this material to their primary care physician at their next follow-up appointment.
 - f. Patients transferred to other hospitals or nursing homes will have dictated summaries which include discharge plans accompany them during transfer. **Residents should anticipate at least 2 hours for completion of a STAT dictation.** For routine patients, dictated narrative summaries should be dictated within 24 hours of discharge, but must be dictated by 72 hours. A copy of the hospital dictation should always be forwarded to the patient's primary care physician.
 - g. **Discharges should be completed by noon to maximize nursing assistance, transportation, and final family conferences. Precipitous or evening discharges are not desirable.**
4. Procedures
 - a. **Upon admission, the resident will include in his evaluation include risk assessment, discharge planning needs and anticipated date of discharge.**
 - b. Patients determined to be high risk will be discussed with the discharge planning team within 24 hours of admission or the next weekday.

- c. All patients will be discussed with the discharge planning team at least once weekly at the discharge planning meeting held in the team room (exact day of the week to be determined by the team members).
 - d. Residents are encouraged to arrange and conduct family meetings that include the discharge planning team and appropriate consultants when enhanced palliative care, hospice, or transfer to other facilities is anticipated.
 - e. Residents will notify nursing staff, patients and families of pending discharge at 48 and at 24 hours prior to anticipated discharge, in order for them to make transportation and other arrangements.
 - f. Decision as to the timeliness of discharge should be made predominantly on clinical rather than laboratory criteria. If you are planning to discharge a patient the following morning, think about if you really need labs on the morning of discharge, as this may delay your discharge plans.
 - g. **Nearly all patients should be discharged or transferred by noon. This should be accomplished by writing discharge orders specifying time of discharge and dictating the summary the afternoon before discharge.**
 - h. Family members should be encouraged to arrive to pick up the patient at 1000. Those patients unable to be retrieved at that time will be moved to 8W.
 - i. **Nursing home and hospital transfer patients should also be moved by noon.**
 - j. Residents and attendings will give final instructions on the morning of discharge when the family is present and all instruction sheets are available.
5. Quality Improvement
- a. The Discharge Planning and Palliative Care Subcommittee of the Resident Patient Care Quality Improvement Committee will train residents to implement these policies and procedures.
 - b. The same subcommittee will conduct outcome studies of the quality of procedural implementation, quality of dictated summaries, satisfaction of patients and primary care physicians, length of stay, and return hospitalization.
 - c. The results of the outcome studies will be used to modify the policies and procedures noted above.

DISCIPLINARY ACTIONS

References:

1. Professionalism in Medicine, Policy 13 June 2003
2. Curriculum Goals and Objectives-Expectations of Residents, Internal Medicine Residency Program Synopsis 2003/2004 1 May 2003
3. MCG Policy HS 13.0 Resident Evaluation & Disciplinary Procedures 14 Jan 2000
4. MCG Policy M.4.0 Housestaff Delinquent Records 15 May 2001

I. Introduction

Responsibility: The timely and proper completion of patient care, scholastic, and administrative requirements of this program is solely the responsibility of the resident. Residents are expected to be reliable, punctual, and diligent adult professionals in conduct of their duties in all spheres as outlined in the documents noted above.

Discipline: The purpose of the program is to set, instruct and enforce standards of resident competency in Medical Care, Medical Knowledge, Practice Based Learning/Improvement, Interpersonal and Communication Skills, Professionalism and Systems-Based Learning.

1. In order for residents to become competent and meet requirements of this program, they must cultivate self-disciplined behavior, what Osler called “A Way of Life.”
2. If self-discipline is lacking, the program must enforce its standards through consequences that improve behavior or dismiss the resident as failing responsibilities.

II. Graded Disciplinary Measures

Letters of Counseling and Reprimand: Letters of counseling and/or reprimand will be the initial discipline for negligent participation and insufficient performance of scholastic requirements and the 6 residency competencies noted above. These letters will be part of the permanent resident file.

Assignment of Additional Back-up Call: When after appropriate investigation and due process, residents have been determined to have willfully or negligently failed to perform patient care and/or administrative duties, they will be subject to 3 days additional back-up call per event. This penalty will be instituted for willful failure to respond to pagers, failure to attend clinic, failure to inform the housestaff office of illness or emergency request for leave from duty, etc. Second and further episodes will provoke recommendations by the program director for further discipline.

Probation, Remediation, and Dismissal: Repeated or egregious failures will result in a recommendation to the Resident Promotion and Evaluation Committee (RPEC) to consider a period of probation no longer than 3 months with defined remediation actions and measurable outcome. Determination by the RPEC that the problem has not been solved will result in dismissal from the program or determination that the resident has not satisfactorily completed all requirements for that year and must repeat.

Adverse Letters of Reference: All disciplinary actions will be noted in response to reference requests from potential state licensing boards, American Board of Internal Medicine and employers.

III. Resident Due Process:

Residents are entitled to due process and appeal under the provisions of MCG and Departmental Policies.

INPATIENT COMPETENCY EVALUATION

Using the Housestaff Clinical Performance Evaluation tool, houseofficers will be measured on the required six competencies each month by their attending physician.

The six competencies are:

1. Patient Care
2. Medical Knowledge
3. Practice-Based Learning and Improvement
4. Professionalism
5. Interpersonal & Communication Skills
6. Systems-Based Learning

I FACULTY REQUIREMENTS

1. FEEDBACK:

The attending physicians are required to meet with their houseofficer/s at the mid-point of each rotation to give feedback to the houseofficer as appropriate. Appropriate feedback will enable the

houseofficer to address any areas of concern that the attending physician may have and make changes in their behavior. Failure to meet and give feedback may result in an evaluation being deemed null by the Residency Promotion and Evaluation Committee (RPEC). The Department Chairman will also receive notification of attending physician failure to meet performance standards.

Note: It is imperative that a houseofficer receive appropriate mid-point and end of rotation feedback. The mid-point feedback is crucial to houseofficer development and progress. If performance is not meeting expectations, the mid-point feedback session will provide the houseofficer with the opportunity to correct behavior and address shortcomings before the end of the rotation. This process will ensure that the houseofficer is given the chance to successfully complete all rotations and mature as a competent physician. Specific form for mid-rotation feedback will be provided to all houseofficers at the beginning of their inpatient rotations. This form must be filled by that attending providing feedback to the houseofficer. The houseofficer will forward the form to the housestaff office.

2. EVALUATION DONE ON A TIMELY FASHION:

All faculty members working with houseofficers in the inpatient setting will have a grace period of 15 days after the termination of the rotation to complete the evaluation on the One45 system.

II EVALUATION SCORING

Evaluation scoring is based on the 6 core competencies of practice, as outlined by the ACGME.

1. Patient care
2. Medical Knowledge
3. Practice-Based Learning and Improvement
4. Professionalism
5. Interpersonal & Communication Skills
6. Systems-Based Learning

III ACADEMIC REMEDIATION

- Competency remediation guidelines have been specifically outlined by the program directors. If any houseofficer receives 3 or more unsatisfactory marks overall, then this will be grounds for remediation. The advisor for the houseofficer will be instrumental in helping the houseofficer through the process of academic remediation. The guidelines for academic remediation will be given to the houseofficer by the residency program specialist who monitors the One45 system.
- All cases of remediation will be presented to the RPEC.
- Once a houseofficer enters academic remediation, s/he will not be given credit for the rotation until all remediation criteria has been met.
- All remediation requirements must be completed no more than 30 days after remediation notification.

WHO ENTERS ACADEMIC REMEDIATION?

- Any houseofficer who receives 3 or more unsatisfactory marks overall on their evaluation will be placed on academic remediation.

If all academic remediation requirements are met within 30 days of the initiation of the academic remediation, the houseofficer will be removed from academic remediation status and will receive passing credit for the rotation with the approval of the attending physician, advisor, and the RPEC.

If academic remediation requirements are not successfully completed within 30 days of the initiation of the academic remediation the houseofficer automatically fails that rotation and it needs to be repeated. The houseofficer's case will be reviewed by the RPEC Committee. RPEC has the sole discretionary power to make decisions concerning the disposition of any and all cases.

RPEC can place a houseofficer on probation, dismiss the houseofficer from the program or have the resident reenter academic remediation. Terms of probation, dismissal and/or reentering academic remediation will be set by RPEC. If a houseofficer fails to meet terms of probation, s/he can be dismissed from the program or have the contract not renewed for the following academic year.

IV. FAILING THE ROTATION

RPEC has the sole responsibility of deciding whether a rotation must be repeated on the basis of the evaluation criteria as described.

Failure of the rotation will occur in the following conditions:

1. If a houseofficer receives 3 or more unsatisfactory marks overall, this constitutes grounds for repeating the rotation. The houseofficer will be automatically one month behind his graduating time.
2. If a houseofficer fails to successfully accomplish his/her academic remediation within 30 days.

V. PEARLS:

- Please check your e-mail daily
- Be alert when the message comes from:
Support@one45.com
This is the e-mail address for the internal medicine resident's end of the month evaluation.
- It is strongly recommended that you do your evaluation jointly with the houseofficer at the end of the rotation.
- You will receive a total of 4 reminders to comply with the houseofficer's evaluation:
 1. Four days prior to the ending of the rotation
 2. The last day of the rotation
 3. Five days after the termination of the rotation
 4. On the 15th day after the termination of the rotation. This is the attending's deadline to comply with the evaluation requirement.

RESIDENT SUPERVISION

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

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

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

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

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

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

MCG MEDICINE WARD / UNIT DAYS OFF POLICY

- Every M.D. should get 4 days off per month (1 day / week)
- The resident cannot take off on any call or clinic day. Residents are encouraged to take off weekend days.
- Interns cannot take off on call or clinic days.
- Taking off 2 days in a row should be cleared by the attending on service and the chief resident in advance.
- Interns may not take off the last two days of the rotation without prior approval from the resident taking over the service and the chief resident.
- Call is q3! If call falls on Sunday-Thursday, then it is from 0730-1900. If call falls on a Friday or Saturday, then call is from 0730-0730 (24 hours).
- The on-call team will accept two patients admitted by the night float service from the previous night.
- If your team has less than 7 patients at the start of the day (0730), you will receive additional patients (up to a max of 3) that were admitted by the night float service the previous night.
- Leave / Sick Days: no later than 7:30 am on the morning of the absence, the resident is to call the housestaff office (721-2423) and leave a voicemail indicating the following: name, rotation, attending, clinic day, and a phone number where you can be reached. The chief resident should also be notified of your absence as soon as possible so they can arrange coverage. A note from your physician must accompany leave beyond 48 hours due to illness. On the weekend, you should notify the Chief Resident as soon as possible! Please see Leave/Sick Policy and Back-up policy for further details.
- No one should work more than 80 hours a week (7 day period) averaged over a 4-week period.
- No one should work more than 30 hours at a time (24 hours for admissions and 6 hours to follow up patients).
- In a week where you have an overnight call (Friday or Saturday) and one day off, you should average no more than 12 hours per day on the other four days.
- Time is kept in One45 and you should log your time at least weekly. If anyone on any of the teams is in danger of breaking any of the above hour rules, the chief resident must be notified immediately.
- Off-service rotators should report their time to the housestaff office each week. See Diana Duva, Kimberly Bass, or Sharon Willis in BI-5070 or call 721-2423. If you are in danger of going over the work hour limits, you must report it immediately so that you can be relieved of duties and coverage can be contacted.

I. Special Circumstances

- Please fill out Death Certificates as completely as possible. Cardio-pulmonary arrest is NOT a cause of death. Only address the highlighted areas on the death certificates.
- DNR orders must be signed by the attending within 24 hours.
- Please write a procedure note for every procedure, even if the procedure was not successful. Proper supervision is required on all procedures performed.
- Procedures are documented in the One45 system.
- TPN orders must be renewed daily by noon.
- Restraint orders must be renewed daily, please sign the stamp on the doctor's order sheet and document reason for restraints. This should be done by noon everyday.
- Physicians are responsible for obtaining consent for all procedures and transfusions. If there is a chance that a patient may require a transfusion after hours, then the primary team should obtain consent- this is not the night float intern's responsibility.
- Labwork should be ordered daily instead of qam to minimize unnecessary labs.
- Renew IVF orders daily as they will continue as written on admission until changed or discontinued.

Bouncebacks

- Once the resident takes over the team, any patient that the resident admits will be a bounce back until the resident leaves that service.
- For patients inherited by the resident from the previous team, if the current resident discharges the patient within the first 5 days of taking over the service, the patient does not count as a bounce back. Inherited patients discharged after the first 5 days of the resident taking over the service count as bounce backs to that resident/service.

II. Code 99 Coverage

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

Check out:

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

III. Transfers from the MICU

- When a patient is ready to be transferred out of the MICU, the intern or resident from the MICU team will contact the on-call medicine resident who will be accepting the patient.
- The MICU intern or resident is responsible for the transfer note and orders. A daily progress note is not sufficient as a transfer note.
- If a patient needs to be transferred out of the MICU at night, the night float resident will accept the patient and check out the patient to the appropriate team in the morning.
- The hospitalist service will accept up to two MICU patients that are transferred out of the unit until 2 pm.

RESIDENT STRESS AND FATIGUE POLICY

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

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

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

MOONLIGHTING PROCEDURES

I. Purpose:

The In-house Moonlighting Program (referred hereafter as “moonlighting”) was created in 2004 in response to the increased demands placed upon the program to consistently meet the 30hr/80hr work mandates set forth by the American College of Graduate Medical Education. This program created a compensated position, staffed by a PGYII or PGYIII resident or fellow, to support and assist the Critical Care Resident on call, specifically by aiding the concurrent Critical Care Intern with admissions, procedures, or emergent patient issues.

II. Qualifications:

Housestaff wishing to participate in the moonlighting program (hence referred to as moonlighter) must:

1. Be a PGYII or PGY III resident in good standing within the Department of Internal Medicine
2. Have successfully completed a Cardiac Care Unit (CCU) and a Medical Intensive Care Unit (MICU) rotation at the Medical College of Georgia or the Veteran Affairs Medical Center, Augusta, GA
3. Be competent in required critical care procedures as mandated by the American College of Physicians and have appropriate documentation of the following:
 - a. Central venous catheter placement
 - b. Arterial line placement
 - c. Thoracentesis (preferred but not required)
 - d. Paracentesis (preferred but not required)
 - e. Lumbar Puncture (preferred but not required)
4. Or, be a Fellow training in an Internal Medicine Subspecialty

Candidates wishing to participate in moonlighting must have the approval of the Program Director of the Department of Internal Medicine and the Associate Dean of Graduate Medical Education prior to commencement of moonlighting activity.

Candidates must adhere to all local, state, and national laws governing such activities deemed necessary by The Medical College of Georgia (MCG) Office of Graduate Medical Education (GME).

The MCG Department of Internal Medicine and Office of Graduate Medical Education reserves the right to refuse or suspend moonlighting privileges as they deem necessary.

III. Scheduling

Housestaff wishing to participate may only register for shifts during elective rotations. Moonlighting shifts cannot be taken during time where overnight calls are required or potentially present such as during required Back-up calls.

Shifts are selected by PGYII and PGYIII residents and Sub-specialty Fellows on a first-come, first-serve basis the month prior.

Available shifts are as follows:

Friday 5p – 12a, 12a – 7a; Saturday 11a – 5p, 5p-12a, 12a – 7a; Sunday 11a – 7p

Procedure:

1. Residents will acknowledge receipt and understanding of the moonlighting policy on a separate document semi-annually to be placed in their academic folder.
2. Externally moonlighting residents will inform the program of their moonlighting on this same form when changes occur or semi-annually.
3. Internally moonlighting residents will sign up for moonlighting 2 months prior when notified by the housestaff office. After the schedule is set, it will be maintained by the assistant program administrator, who will notify residents of open shifts and attempt to fill all shifts by the 15th day of the preceding month.
4. Once a resident has signed for a shift, it is their responsibility to complete the work, cancel, or find a replacement by the 25th of the preceding month. Any changes after the 25th, require coverage and must be arranged at least a week prior to the date of work. These non-emergent changes will be arranged through the assistant program administrator via email with a copy sent to the covering resident. Emergency changes must be approved by the Chief Resident with confirmation by email to the housestaff office. The covering person should sign in clearly so the housestaff office can verify the shift coverage.
5. In order to be paid for internal moonlighting, residents must sign-in to be paid for each shift. All sign-ins will be verified and matched to calendar schedule prior to authorization of payment, with final resident signatures for request of payment only after full verification.
6. On the first of each month, the moonlighting schedule will be sent to the Pulmonary/Critical Care Department.

IV. Expectations

The Moonlighter acts in the capacity of a resident in the Intensive Care Unit or Cardiac Care Unit but is truly an extension of the Unit Float which is available Sunday - Thursday nights. Thus, while the primary role is to assist the Critical Care intern with the management of their respective unit throughout the duration of the moonlighting shift, they are also expected to assist the General Floor Resident as needed. This includes:

1. Conducting admissions to the respective unit, including proper disposition and treatment plan
2. Communicating with the appropriate Critical Care Fellow regarding
 - a. Admissions
 - b. Acute change in status in a patient
 - c. Emergent Transfers to/from the Unit
 - d. Other circumstances requiring direction from the Fellow
3. Facilitating the completion of procedures with the interns, educating interns as appropriate
4. Performing necessary procedures required for appropriate patient care
5. Assisting the intern with emergent patient issues
6. Any other task mandated by the Critical Care Fellow or Attending Physician.
7. Provide assistance with floor admissions and cross cover floor issues General Medicine Resident as outlined in the night float policy.
8. Moonlighters must inform one member of the MICU and CCU team upon arrival (intern, resident, fellow, or attending).

V. Compensation

Compensation will be \$40/hour.

VI. Reprimand

Moonlighting in this capacity is a privilege, not a right. In adherence to the policies and procedures stated above will not be tolerated. The first incident will result in reprimand and forfeiture of monetary compensation for the shift in question. The second incident will result in forfeiture of monetary compensation and revocation of moonlighting privileges.

MORNING REPORT POLICY - MCG

Monday, Tuesday, Thursday:

0745-0800 Checkout: will include Program Director, Chief Resident, Hospitalist physician, night float resident and intern, unit float resident, and medicine resident that is on-call. Admitting house staff from overnight will quickly review each case that came in and what was done for the patient, as well as, what important issues are pending for these patients. Night float interns will relay important overnight events, transfers to MICU, etc.

0800-0845 Morning report: residents, interns, and medical students are all expected to attend. The topic will vary from day to day, but include inpatient case presentations by the various medicine teams, Dainer's unknown, adverse drug reaction conference, EKG review, Xray review, Medical Jeopardy, etc.

Wednesday:

0745-0800 Checkout: same as above

0800-0900 Grand Rounds: mandatory for all interns, residents, and students

Friday:

0745-0800 Checkout: same as above

0800-0845 Resident Report- mandatory for all residents (inpatient and outpatient both at the VA and MCG); a pre-selected resident chooses an interesting case that inspires clinically relevant questions. This conference should be a presentation of evidence based medicine.

Saturday:

0730-0745 Checkout: same as above except overflow overnight admissions will be distributed by the chief resident if needed.

Sunday:

0730-0745 Checkout: same as above except overflow overnight admissions will be distributed by the chief resident if needed.

NIGHT FLOAT TEAM POLICY

The night float team consists of the Night float resident, the Unit float resident (or moonlighter on Friday and Saturday; MCG only), and the Night float intern. They are to use a team approach to the management of hospital inpatients and admissions during the night. Specific duties for each team member are as follows:

Night float intern

1. Arrive at 7:00 pm Sunday through Thursday. Meet in on call team room to accept checkout on medicine inpatients for the coming night.
2. First call for all floor issues on hospital inpatients from 7:00 pm-7:30 am.
3. Respond to all Code 99 in house from 7:00 pm-7:30 am.
4. Checkout overnight events to day teams by 7:30 am.
5. Attend morning checkout for overnight patients at 7:45 am.
6. Attend morning report from 8:00-8:30 am Monday, Tuesday, and Thursday.
7. Continuity Clinic (or Acute Care Clinic as appropriate) will be rescheduled to Friday morning starting at 8:00 am.
8. Contact the Night float resident or Unit float resident for support for routine clinical questions and assistance with decompensating or unstable patients.
9. Night float interns are **NOT** responsible for general medicine admissions or consults.

Night float resident

1. Arrive at 7:00 pm Sunday through Thursday. Meet in on-call team room to assume responsibility for any late admissions (called from ER after 6:30 pm). Claim on-call pager from on call resident (MCG only).
2. Primary resident for all general medicine admissions and consults.
3. Assist Unit float (or moonlighter on Friday and Saturday) with pending MICU/cardiology admissions when all general medicine admissions/consults are complete. (VA Night float resident will be responsible for MICU/cardiology admissions 3 out of 4 nights with assistance of appropriate intern.)
4. Respond to all Code 99 in house from 7:00 pm-7:30 am.
5. Support and teach Night float intern on routine clinical questions as well as with decompensating or unstable patients.
6. Give morning checkout to daytime teams for overnight patients at 7:45 am.
7. Attend morning report from 8:00-8:30 am Monday, Tuesday, and Thursday. The Night float resident will be responsible for one case presentation during the 2-week block.
8. Continuity Clinic (or Acute Care Clinic as appropriate) will be rescheduled to Friday morning starting at 8:00 am.

Unit float resident (or moonlighter on Friday and Saturday)

1. Arrive at 7:00 pm Sunday through Thursday (or at start of shift for moonlighter.) Contact the on call cardiology or MICU intern as appropriate to identify critical patients and assist with active problems.
2. Primary resident for all cardiology or MICU admissions on alternating nights with the help of the appropriate intern.
3. Assist Night float with pending general medicine admissions/consults after all MICU/cardiology admissions are complete (including any necessary procedures.)
4. Respond to all Code 99 in house from 7:00 pm-7:30 am.
5. Support and teach MICU/cardiology intern on admissions, routine clinical questions, and with decompensating or unstable patients.
6. Assist VA Night float resident on occasions when VA workload is excessive.
7. Give morning checkout to daytime MICU/cardiology residents or fellows at 7:00am (since this is when the ICU/Cardiology resident start call).
8. Attend morning checkout at 7:45am and morning report from 8:00-8:30 am Monday, Tuesday, and Thursday.
9. Continuity Clinic (or Acute Care Clinic as appropriate) will be rescheduled to Friday morning starting at 8:00 am.

PAGER POLICY

Overall:

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

Inpatient interns:

Your pager should be on and not forwarded every weekday from 7:30 to 5pm unless you are off. If interns are off, the pager should be forwarded to the resident covering the patients during the day. At 5pm on weekdays or when the interns are checking out, the pager must be forwarded to the intern receiving checkout. At 7pm, anyone checking out should forward their pager to the night float intern. PLEASE ensure that your pager is either on and can be answered by you or is forwarded to the appropriate person to facilitate nurses being able to contact the covering physician. You **must** unforward your pager **on arrival** to the hospital each morning (0730 at the latest).

Inpatient residents:

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

Outpatient interns/residents:

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

Vacation interns/residents:

Residents and interns on vacation should change their pager status to reachable at 721-2423, which will route the caller to the housestaff office.

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

Basic paging instructions:

To page: call 721-7243, you will be prompted to enter the 4 digit pager ID followed by #, you will then be prompted to enter the call back number followed by #. If at MCG, enter 1-then the 4 digit extension where you want to be called, then * then your 4 digit pager ID to tag the page then #. If at the VA, enter 0188-then the 4 digit extension where you want to be called, then * then your 4 digit pager ID to tag the page then #.

To forward or change your page status: call 721-7243, then your 4 digit pager ID then #, then *1# to change page status, then 1 again to change page status, you will then have a menu of options:

Press 1 to unforward pager

Press 6 to forward pager to phone number (721-8400 for nights and weekends on outpatient rotation, 721-2423 if on vacation)

Press 7 to forward pager to another pager, then enter 4 digit covering pager ID followed by #

PROFESSIONALISM IN MEDICINE

I. Definition:

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

Overall, professionalism comprises the attitudes, behavior, and interpersonal skills defined as essential in relating to patients and educating them, their families, and other health care professionals. Professionalism includes the ability and willingness to communicate effectively, to accept responsibility, to write comprehensive notes, and maintain timely and legible medical records, to be available as a

consultant to other physicians when needed, and to evaluate critically the new medical and scientific information relevant to the practice of medicine.

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

- a. **Focus on fostering positive attributes of professionalism**
- b. **Demonstrate concerns for learners, individually and as a group**
- c. **Facilitate faculty role modeling**
- d. **Measure professional attitudes and behaviors among learners**
- e. **Stay up to date with the ABIM Project Professionalism, AAMC MSOP and ACGME Outcomes Project.**

II. Examples of Unprofessional Attitudes:

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

III. Examples of Unprofessional Behavior:

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

IV. How important is professionalism?

Medicine is a *profession*. It can not be practiced nor exist without professionalism. Medicine is under attack precisely at the level of its existence as a profession. Economic forces conspire to make medicine into a *health care industry* with attributes of excellence, efficiency, and profit, often at the expense of true professional relationships. As long as organized medicine and its professionals have control of the practice and training of physicians, there must be professional standards set and upheld by the profession itself. As the threat to professionalism increases, the profession will and must ever tighten and defend its own professional attitudes and behaviors. This is why the American Board of Internal Medicine, licensure boards, accrediting agencies, hospitals, and other groups of physicians place increasingly scrupulous emphasis on professionalism of current and potential practitioners. The profession must police itself to justify itself as a profession, and it is increasingly able and desirous to do so.

IV. What are the consequences of unprofessional attitude and behavior for residents?

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

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

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

VI. Documentation and Due Process for alleged unprofessional attitude and behavior

- 1) All persons observing unprofessional attitudes and behaviors of residents are encouraged to document these in writing and send it to the Program Director(s). Anonymous letters will be accepted, but will not carry the weight of signed observations. Hearsay will not be accepted.
- 2) Monthly attending evaluations of “3” or less (out of 9) on professionalism will have documentation specific to the rating given, and carry the same weight as item (1) above.
- 3) All accusations of unprofessional attitude and behavior will result in the following:
 - a) Prompt presentation of the documentation to the accused by the Program Director or His/Her designate.
 - b) Counseling of the accused housestaff
 - c) Documentation of counseling if attitude or behavior is substantiated.
 - d) Further investigation of this or other instances involving the resident as determined necessary by the Program Director.
 - e) Placement of Counseling and Investigative Reports into the Permanent Resident File, as deemed appropriate by the Program Director(s).
 - f) Appropriate disciplinary action by the Program Director(s).
This could include one or more of the following:
 - 1) Verbal and written counseling.
 - 2) Letter of reprimand.
 - 3) Forfeiture of vacation time.
 - 4) Temporary suspension from duty.These actions will become part of the permanent record of the trainee.
- 4) Repeated or egregious unprofessional attitude or behavior will additionally result in the following:
 - a) Discussion of the resident at called meeting of the Residency Promotion and Evaluation Committee (RPEC).
 - b) The resident may represent himself or herself at this meeting, according to MCG Policy.
 - c) The RPEC may institute one or more of the following disciplinary actions:

- 1) Probation for up to 3 months.
- 2) Dismissal from the program.
- d) The resident has right of appeal according to MCG Policy.

SOME FACTS ABOUT PROFESSIONALISM

It is your responsibility to be available on pager during working clinical hours and during on call duties. (see pager policy). If you need to leave your assigned clinical responsibilities for whatever reason during working clinical hours, please notify the housestaff office (ext 1-2423). **DO NOT TURN YOUR PAGER OFF**, be available on pager.

If a clinic you were assigned to attend has been canceled for whatever reason, please notify the housestaff office about this issue. You can use your time for reading. Be available on pager, we might need to contact you for any reason.

If you need to be absent from a clinical responsibility that was assigned to you, and the absence is not cleared by the Program Director or the Associate Program Directors, this violation will be grounds for unprofessional behavior. You are expected to attend your assigned clinical responsibilities on a timely and professional manner at all times.

Remember in order to be eligible for board certification, you are required to have **33 MONTHS** of meaningful patient experience (Mandated by the ABIM). If you are sick longer than the time allocated annually, you have visa problems, accidents, acts of war, pregnancy, need to be out of the country for non clinical assignments, etc., once you come back, you need to pay back day by day the time you took to take care of your personal matters. This time will be given back to the institution without extra pay. This rule will have no exceptions. This delay will make the termination of your training later than June 30 of the specific year it was planned for your graduating class. By the ABIM rules and regulations you cannot pay back your absence with vacation days.

VII. Summary

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

References: American Board of Internal Medicine. *Residents: Evaluating Your Clinical Competence in Internal Medicine*. 1995.

RESIDENT WORK HOURS AND WORK HOUR MONITORING

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

- A maximum of 80 hours per week averaged over four weeks, inclusive of all in-house activities
- Ten-hour period of rest and personal activities must be provided between all daily duty periods and after in-house call

- Houseofficers will be provided with one day in seven free from all educational and clinical responsibilities, averaged over a four-week period, inclusive of call. One day is defined as a continuous 24 hour period free from all clinical, educational and administrative duties
- Twenty-four hours maximum continuous on-site duty with up to six additional hours permitted for patient transfer and other activities.
- No new patients after 24 hours of continuous duty
- Houseofficer's time spent in the hospital during at-home call is to be counted toward the 80 hour maximum
- In-house moonlighting to be counted toward the maximum 80 hours

Adequate back-up through resident physicians or supervising staff physicians will be available and utilized as needed to assure that patient care is not jeopardized by resident stress or fatigue.

Resident training is a full-time responsibility. It encompasses the formal curriculum, the individual learning opportunity through independent study time, and clinical exposure including the service component of patient care. It is MCG institutional policy (HS 16.0) that the program director must be informed and approve of activities outside the educational program (i.e., [moonlighting](#)). Written permission for moonlighting must be obtained by the house officer from his/her program director with official notification of the GME Office of the moonlighting activity. Outside activities must not interfere with the resident's performance in the educational process defined in the agreement between the institution and the resident.

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

Procedure:

1. Residents will annotate time in, time out, and hours in the hospital each day on One 45. Records will be kept of hours worked at both VA and MCG. If any time is spent elsewhere, it will be so indicated. In-house moonlight will be included, but not moonlighting out of either MCG or the VA.
2. Hours should be logged at least weekly.
3. Residents will receive oral and written counseling regarding violations of the 80 hour, 24+6, one day off in 7, ten hour rule or any other rules instituted by the RRC, OSHA, state, federal, or other credible authorities.
4. Residents with repeated violations of work hour rules will be prosecuted by the RPEC committee, with due consideration of programmatic, patient-care, and faculty contributions to the excess hours.

RESIDENT RESEARCH CURRICULUM AND REQUIREMENTS

I. Requirements of the Accreditation Council for Graduate Medical Education, Internal Medicine Residency Review Committee, 2007

A. Residents' Scholarly Activities

1. The curriculum must advance residents' knowledge of the basic principles of research, including how research is conducted, evaluated, explained to patients, and applied to patient care.
2. Residents should participate in scholarly activities.
The program must provide an opportunity for residents to participate in research or other scholarly activities such as: original research, comprehensive case reports, or review of assigned clinical and research topics.

B. Practice-based Learning and Improvement

Residents must demonstrate the ability to investigate and evaluate the care of patients, to appraise and assimilate scientific evidence, and to continuously improve patient care based on constant self-evaluation and life-long learning.

II Research Goals and Objectives for Trainees

A. Goals: Participation in research and scholarly activity benefits residents in three ways:

1. Scholarly accomplishments distinguish trainees from their peers. This raises the status of the individual and prepares him or her for future training, career development, and positions of research, teaching, and clinical responsibility.
2. Scholarship enhances the quality and reputation of the training program. Quality attracts quality and excellence promotes excellence, both in current and future trainees.
3. Most importantly, scholarly and research activities promote and encourage the skills, attitudes and behaviors necessary for the competency of practice-based learning and a disciplined professional career.

B. Objectives: by avidly participating in four or more components of this program, each resident, by its completion is expected to demonstrate the following:

1. Search the literature.
2. Assess the literature and current state of knowledge.
3. Establish the evidence supporting claims in the literature.
4. Describe the ethical and legal constraints upon biomedical research.
5. Effectively present written and oral communication of scholarly and research activity to peers and mentors.

III. Components of the Research and PBL Program

A. Journal Club Presentation: Each graduate will have presented a journal club presentation using the prescribed format and achieved a PBL competency grade of at least 18 of 24 possible points.

B. EBM Problem Review (Friday AM Resident Report): Each resident will present one EBM Problem Review according to the prescribed format in both PGY-2 and PGY-3 years and must achieve a PBL competency grade of at least 50 of 60 possible points on both presentations.

C. Noon Conference: Each resident will present one review of a clinical medical topic at a noon conference during the PGY-3 year and achieve a PBL competency grade of at least 3 of 5 possible points.

D. Completion of a research or scholarly product with subsequent publication submission or presentation before a regional or national meeting or presentation before the hospital performance improvement committee: All categorical residents will select one or more of the following options to research, formulate, complete, and present finished work for publication in a peer reviewed journal, regional or national meeting, or before the hospital performance improvement committee. Residents must chose one of the following options by 31 August of the PGY-2 year, keep on progress for completion of the activity, and have a paper ready for submission by April 15th of the PGY-3 year. With approval from the program director, up to one month elective may be used to accomplish work needed for this requirement.

1. **Basic Science Research:** The Institute of Molecular Medicine, an integral component of the Department of Medicine, has available opportunities for basic and translational research in the following areas: Cell Signaling, Gene Regulation, Molecular Immunology, Developmental Biology, and Neurobiology. Clinical areas include cancer, cardiovascular disease, diabetes/obesity, infection/inflammation, and neurological disease. Interested residents should contact Dr. Mellor or faculty participating in the IMMAG.
2. **Clinical Investigation or Clinical Trials:** Prerequisite to this track is completion of the Web-based Clinical Research Program that includes certification by the Human Assurance Committee. Topics and mentors for this track may be procured through contact with faculty participating in such research as published on the Department website.
3. **Health Services Evaluation/Research:** This includes work performed with the Center for Health Care Improvement, UHC, Blue Cross, and other databases, the MPH program in medical informatics, and MCGHS utilization review. Residents may elect to modify their residency schedule to obtain a Masters in Public Health within this option. Interested residents should contact Dr. Goggans.
4. **Performance Improvement:** Residents will successfully develop, complete, and present a quality improvement project approved by the Department Performance Improvement Committee, with presentation to that Committee, the Hospital Committee, and submission to appropriate electronic or print publication. Interested residents should contact Dr. Haburchak.
5. **Infection Control and Epidemiological Evaluation:** Residents will successfully develop, complete, and present an epidemiological evaluation of infection, antibiotic use or infection control procedure to the Hospital Infection Control Committee, and submission to an appropriate periodical. Interested residents should contact Dr. Rissing.
6. **Medical Education Research:** Residents will develop a research question regarding medical or health education with a testable hypothesis, test the hypothesis, and determine outcome and future direction. Topics may be related to patient, public, health care worker, student/trainee education and behavior change. Resources of the MCG Center for Educational Excellence, as well as Educational Simulator Laboratory are available for resident use. Interested residents should contact Dr. Albritton.
7. **ACP Clinical Vignette Presentation:** Residents will develop an effective case study and literature review of a case or cases they have managed that have particular educational merit. A case abstract will be prepared by deadline for submission to regional ACP competition. Abstracts selected and presented at state or national meetings and subsequently submitted to a peer-reviewed journal will fulfill this requirement. Department contact: Dr. Moore.
8. **Outside Research Collaboration:** Residents who have had previous experience in basic, clinical, or collaborative research at some previous location may elect to officially re-establish that research relationship during their residency. Residents must be listed as co-investigators on institutionally approved protocols, participate in the conduct of the protocol, and be co-author on a paper submitted before the completion of the residency. The major portion

of the work must be completed during the residency. Residents may elect up to one month off campus at their own expense for the completion of this research. Approval for this track will require a letter from the sponsoring investigator attesting that the above stipulation will be fulfilled. Approval by Dr. Haburchak.

IV. Implementation Time Line

- A. PGY-1 Year:** Residents anticipating Clinical Investigation, Case Report, Outside, and Basic Science Research Options must complete the Web-based clinical trials education program before conducting literature review or developing their protocol. This should be done as soon as possible, no later than 31 December. Residents will contact research mentors of their choosing as soon as possible in the PGY-1 year using contact personnel noted above.
- B. PGY-2 Year:** By 31 August, the resident will have selected a provisional research option among the 8 choices, and determined as specifically as possible the research topic and approach to be used. This will be documented on the Resident Research Progress Report, to be maintained on One45 for use by the resident, advisor, and program directors. Progress on the project will be updated quarterly on One45 as above.
- C. PGY-3 Year:** All residents will continue their research progress reports, with the project completion date and submission for publication no later than 15 April.

V. Administrative Support and Funding for Presentations

- A. Administrative Support:** Residents will receive administrative support for their projects such as typing, editing, etc. from the subspecialty section of the faculty mentor.
- B. Funding Support:** Residents will be supported for travel expenses according to availability of funds from the residency program, foundation support, and sponsoring sections according to current funding policy.

Resident Research Progress Report

Resident:

Date of Report:

Research Mentor:

Type of Project (Circle): Basic Science Clinical Trial Health Services Evaluation
Performance Improvement Infection Control
Clinical Vignette Medical Education Outside Research

Completed Web Clinical Investigation Training (date):

Title of Proposal:

Research Question:

Hypothesis:

Objective:

Background and Literature Review:

Human or animal Use:

Study Plan:

Progress:

1. Protocol completed
2. Submitted to IRB
3. IRB approval
4. Progress
5. Completion of work
6. Completion of Paper
7. Submission of Paper
8. Presentation of Paper
9. Publication of Paper

VA MORNING REPORT POLICY

Purpose

The purpose of morning report is to discuss cases and/or clinical scenarios in a collegial atmosphere to promote discussion and further education on the topic of Internal Medicine. This is accomplished through case presentations, small-group discussion, and brief instruction on the subject matter. Furthermore, morning report is utilized to hand over patients admitted overnight to their respective teams and discuss any issues that occurred with the current inpatient census.

Schedule

Morning report occurs Monday through Friday, beginning at 7:45AM, typically lasting an hour. The first 15 minutes is spent discussing patients admitted overnight by the Night Float Resident, and transferring patient care from the Night Float Intern to the Ward Interns. The Chief Medical Resident will attend this session. Short-call and long-call residents and interns are expected to be at this meeting. Students are not required. Beginning at 8:00 AM, the remaining time will be spent either in case presentation or formal conference depending on the day of the week. All VA inpatient residents, interns, and students are required to attend.

Monday, Tuesday, and alternating Thursdays: Team presentations

Wednesday: Grand Rounds (MCG)

Alternating Thursdays: "Dainer's Unknown" (MCG)

Friday: Resident Report (MCG)

Saturday and Sunday: No formal report

The Chief Medical Resident will distribute a schedule of conferences at the beginning of the month, demonstrating when teams are scheduled to present. Teams are required to notify the chief resident of the planned case 24-48 hours in advance to enable the chief to facilitate teaching points.

Format

Team Report: Members of the respective ward team (residents and interns, not students) present a case that was admitted to their service during the month. Case presentation should flow like a detailed IM History and Physical, and include all pertinent information contained in such. The final diagnosis should be known to facilitate discussion at the end of the session. A literature search should also be utilized to further lend to discussion. A faculty member typically attends to this conference. The Chief Medical Resident will moderate as needed. Location: 4D Conference room

Grand Rounds: A formal conference presented at MCG every Wednesday morning, usually given by an invited speaker. Attendance is mandatory. Location: Small or large Auditorium at MCG

“Dainer’s Unknown”: Dr Paul Dainer, Oncology Attending, presents a case scenario, asks a series of questions, then provides an in-depth lecture on the case presented. These lectures center on Hematology and/or Oncology subjects, and are occasionally presented by guest lecturers (Heme/Onc fellows, Chief Residents, etc). These lectures are high-yield, well-presented, and interesting. Location: Internal Medicine Library, MCG 5th floor.

Resident Report: A formal presentation by an upper-level Medicine Resident. This conference centers on a specific clinical scenario which prompts a clinical question. The presenting resident attempts to answer these questions via a literature search presenting their findings. This conference is specific to residents, but all are welcome to attend. Location: Internal Medicine Library, MCG 5th floor.

Weekends: There is no formal report. The post-call teams should expect to hand patients back to their managing services at 7:30AM.

Attendance

Attendance, in general, is mandatory for the above conferences. This is the primary mode which the night team communicates with the ward teams, and this is a chance for collegial discussion and education. It is in your best interest to attend these conferences on a regular basis. These conferences can be missed with a valid, reasonable excuse which outweighs the importance of the conference. These reasons being:

- Concurrent outpatient clinic
- Scheduled day off
- Attending to a Code 99 on the floors or otherwise unstable patient

Any other reason should be discussed with the Chief Medical Resident, preferably in advance.

Questions/Issues

Please direct all further questions to the Chief Medical Resident at VA ext. 2135

VA WARDS / MICU / CCU

WARDS

1. Three ward teams
2. Short call – accepts overnight admissions, up to 3 admissions per call. If there are more than 3 admissions at night, these patients get admitted to the long call team. There is no short call on Saturday, Sunday or holidays.
3. Long call Mon –Thu 7:30AM-7:00PM, Fri-Sat 7:30AM-7:30AM, Sun 7:30AM-7PM – cap is 10 patients. If over the cap, resident admits to the next team taking admissions.
4. Back-up resident is available every night when needed, but the unit float or moonlighting resident should be called first.
5. Back-up intern is available if an intern is sick and one is absolutely necessary for the team to survive a night call.
6. 10 patient cap per intern, sub-interns are allowed to have up to 4 patients.
7. Interns MUST write an H/P on every new patient. Use the generic H/P template in CPRS. Charts will be reviewed.
8. Resident MUST enter a note for every new patient that they admit – focus on HPI, DDx, assessment and plan. Resident must write a full H&P on all sub-I admissions.

9. Interns should also write a daily progress note. When an intern is off, the resident will write daily progress notes on this intern's patients. Don't let COPY AND PASTE propagate inaccurate documentation. Resident will write daily progress note on sub-I patients daily. When resident is off, interns will assume responsibility for sub-I patients including daily notes.
10. BOUNCE BACKS – If inherited patients are discharged within the first FIVE days from which the resident takes over the team, and these patients return to the hospital, they are admitted to on-call team (NO BOUNCE BACK). If the resident admits the patient (or the patient got admitted to this resident's team by the night float), this patient bounces back to the resident for the entire month provided they return.
11. Bounce backs are extra admissions and they do not count towards the cap.
12. Discharge summaries are required at the time of discharge. Resident – if your intern is off, then you are responsible for the discharge summary.
13. Off-service notes are required on every patient at the end of the month. If the patient has been in the hospital more than 5 days, dictate an interim discharge summary.
14. Count your work hours. Do not work more than an 80 hr/week (average), but DO NOT check out when a patient is unstable and may require a transfer to ICU.
15. There are no residents in CCU and one resident in MICU, therefore one in four nights either the long call resident (Mon-Thu 5PM-7PM, Fri 5PM-7:30AM, Sat 7:30AM-7:30AM, Sun 7:30AM-7PM) or the night float resident (Sun-Thu 7:00Pm-7:30AM) will admit to all services. Interns covering CCU/MICU will be asked to help the resident to admit patients that are going to their service.
16. Remember to check out your patients to a covering intern. Residents check out for interns when they are off. Include allergies, detailed medication list, and code status on all checkout sheets. Remember to forward your pager to a covering person (after 5 PM on weekdays).
17. Do NOT leave until all of your patients are stable.
18. Do NOT check out critical radiographic data. You may give the radiologist your beeper number and go home, but only if it is a non-emergent procedure.
19. Do NOT check out patients who are undergoing procedures (endoscopy, bronchoscopy, etc.). You must be available to discuss results and complications with patients and families.
20. Consults are called only by interns or residents. Call as early as possible, and order them in CPRS.
21. Remember 24+6 rule and be out of hospital by 1PM on a post call day. Remind your attending to round early on a post call day.
22. Even if you have completed your daily routine early, do not check out before 2PM on a weekday. Spend your free time on teaching. Do not forward beepers until 5PM.
23. A resident must be present in-house at all times to cover Code 99. This is the responsibility of the long-call resident unless they specifically make arrangements with MICU resident or other residents for coverage.
24. Residents pre-round with their team prior to rounding with an attending physician.
25. Rounds with attending are to be 9-11AM on Monday – Friday.
26. It is one of our primary responsibilities to teach medical students and other residents. Set a goal to teach them at least 5-10 minutes a day.

MORNING REPORT

1. MON-FRI at 7:45AM – night float check-out – the chief resident, the night float resident, the night float intern and the short call resident and interns will discuss patients admitted to the hospital in the night prior. If night admitted more than 3 patients, then the long call resident should be present too. Students are not required to be at checkout.
2. MONDAY and TUESDAY 8:00AM – residents, interns, and students attend. See schedule for your presentation day. The presentation should be done by the resident or intern. Students are not to present cases.
3. WEDNESDAY 8:00AM – Grand Rounds
4. THURSDAY 8:00AM – same as Monday and Tuesday. Every other week Dr. Dainer will be presenting a hem/onc case with a didactic review at MCG.

5. FRIDAY 9:00AM (at MCG) – Resident Report – Attendance is mandatory and it will be strictly enforced. Interns and students are welcome but not required. I will be taking attendance and will take your clinics into account.
6. Morning report should be a case-based presentation. The presenting resident or intern must involve other residents in establishing diagnosis, proposing a differential diagnosis, suggesting appropriate labs and treatment.
7. BE ON TIME!!! This is a reflection of your professionalism and time management.

MICU

1. The MICU team consists of one intern, one resident, one fellow and one attending physician, and possibly sub-interns.
2. The team is responsible for admissions until 5PM on weekdays. After that you check out to the MICU/CCU intern or resident on call.
3. Remember 80hr week and 24+6 rule. Leave the hospital by 1:00PM on your post call day.
4. Noon conference is required on MICU rotations.

CARDIOLOGY/CCU

1. The cardiology/CCU team consists of two interns, one fellow and one attending physician.
2. The team is responsible for admissions until 5PM on weekdays..
3. Interns are welcome at intern morning report.

CONSULTS

1. We have a consult resident (the same one for MCG and VA) on weekdays between 7:30AM and 5PM.
2. Either long call or night float resident will cover the hours from 5PM to 7:30AM on weekdays and all of Saturday, Sunday and holidays. Long call attending will serve as a consult attending during these hours. On the next day the consult will be passed to the consult resident or the long call resident (on Sat and Sun).

TRANSFERS

1. All transfers from one service to another within our VA (i.e. from ENT to medicine or from medicine to surgery) should be done between two attending physicians. The chief resident does NOT decide this matter.
2. The chief resident will be responsible for transfers from outside facilities on Mon-Fri between 7:30AM and 5PM. There should be NO transfers outside of these hours, unless there is a transfer from the outside ER to the VA ER. If you have any questions, call the chief resident or your attending.
3. Transfers from outside ER's will be handled by the LSU OD. Please see the handout for our policy.

DAYS OFF

1. Every resident should get 4 days off a month (1 day per week).
2. The resident may not take off on any long or short call day. Residents are encouraged to take weekend days off.
3. Interns may not take long call days off.
4. Taking off two days in a row should be cleared by the chief resident and the attending.
5. Interns may not take off the last two days of the rotation without prior approval from the resident taking over the service.

VACATION / SICK LEAVE / CME DAYS OFF POLICY

1. Vacation Leave
 - a. Each housestaff officer is given 20 days off per academic year.
 - b. If you need to change your vacation for personal reasons (coordination with family members, out of town plans, etc) and its <60 days from the date of your previously scheduled vacation, then there will be no clinic cancellation and the house officer is responsible for finding their own clinic coverage. If the change is requested >60 days in advance from the date of your previously scheduled vacation, then the house officer should submit dates of change in email or writing to the housestaff office. The paperwork will then be processed and clinics canceled accordingly.
2. Sick Leave
 - a. Per the GME, each houseofficer is granted 14 calendar days for medical leave according to their contracts each academic year. A house officer may accrue a maximum of 21 calendar days of medical leave by carrying over only 7 days of unused medical leave from the previous year.
 - b. Time taken as leave will be accounted for in the following sequence:
 - i. Medical leave with full stipend and all benefits until exhausted, then
 - ii. Annual leaves until exhausted, then
 - iii. Leave of absence without stipend or benefits (LWOP)
 - iv. The GME office must be notified in writing of medical leave, FMLA, or LWOP at least 2 weeks prior to house officer's leave
 - c. If a house officer is not able to perform his/her duties due to illness or an emergency, he/she must call the housestaff office no later than 7:30 am on the morning of the absence and leave a voicemail indicating the following: name, rotation, attending, clinic day, and a phone number where you can be reached. The chief resident should then be notified so that clinical coverage can be arranged for as needed.
 - d. Sick leave for more than 48 hours must be accompanied by a physician's note.
 - e. It is never appropriate to send text pages via cell phone or pager to request sick leave or to report that you will be out on sick leave.
 - f. Unexcused absences will result in a warning letter placed in the resident's file and loss of a vacation day. If you are out of vacation days, you will be required to make up unexcused absences at the end of your residency training without pay. Unexcused absences are in violation of the Professionalism policy and are subject to disciplinary action, which may include forfeiture of vacation time, repetition of a rotation, and/or probation (see Professionalism policy for details).
 - g. Trainees may take up to 1 month (30 days) per year of training for vacation, parental or family leave, CME, or illness (including pregnancy-related disabilities) combined. Training must be extended to make up any absences exceeding 1 month (30 days) per year of training. Vacation leave is essential and cannot be forfeited.
3. Maternity and Extended Leave (from GME policy HS 4.0)
 - a. The department is responsible for informing the GME office in writing if the house officer will be on leave for longer than 2 weeks or if the house officer has exhausted annual and/or medical leave and needs to be placed on leave without pay (LWOP). A copy of written statement from the house officer's physician must be on file in the GME office.
4. Emergency Family Leave
 - a. If there is an unanticipated absence due to family emergency, the housestaff office must be notified immediately with the information above in 2b.

5. CME leave

- a. Educational leave is not a right, but a privilege which may be granted contingent upon the house officer's standing in their program and the ability to benefit from the extramural educational opportunity.
- b. 1st year house officers should not expect educational leave, but there may be special circumstances, such as presentation of their own work at a scientific meeting.
- c. 2nd and more senior house officers may be allowed educational leave not to exceed 5 days per academic year, subject to confirmation by their Program Director that their progress in training is sufficiently satisfactory to permit the absence(s).
- d. Every request for off campus activities **MUST** receive prior approval. The initial request should be made through the housestaff office secretary who handles scheduling. You need to show evidence of the CME you are attending or invitation letter for your job interview. You will receive a written request (CME/Interview off campus form) that must be processed prior to approval of the off campus time.
 - i. First you need to have the time approved by the director of the clinic or service where you are rotating. Time off will not be approved if it interferes with any coverage of wards, units, or call for either MCG or VA. If the time off interferes with your clinical responsibilities, you **must** coordinate finding the appropriate coverage. It is your responsibility to ensure that your clinical responsibilities are covered appropriately by one of your colleagues or that your continuity care clinics are re-scheduled. You will need written approval from either Dr. Shilpa Brown (if you have MCG clinic) or Dr. Luis Montalvo (if you have VA clinic). **REMEMBER!** You are responsible for the coverage of your clinical responsibilities while you are off campus.
 - ii. Second, take the written request to the housestaff office. The secretary who coordinates scheduling will then contact the Program Director for final approval of the request.
 - iii. Failure to follow these procedures is considered to be "unprofessional behavior."

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

