

WILLIAM BEAUMONT ARMY MEDICAL CENTER

DEPARTMENT OF MEDICINE HOUSESTAFF HANDBOOK

July 2004

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Table of Contents

Topic	Page
Introduction and Philosophy	3
Organizational Structure	4
Resident Training and Education	5
Faculty Responsibility and Supervision of Residents	7
Ambulatory Internal Medicine Continuity Clinic	8
Elective Subspecialty Rotations	10
Admission Policies	10
Consults	12
Resident Responsibilities	
Inpatient Intern	13
Inpatient Resident	14
Night Resident and On-Call Intern	15
MOD/AMOD	16
Sign Outs	16
General Policies	
Military Readiness and Licensure	17
Dress Code, Mailboxes, Call Rooms, Food	18
Leave, Pass, TDY, Permissive TDY	19
Pregnancy	19
Illness and Emergency Leave	20
Fatigue	20
Moonlighting Policy	21
Medical Records	21
Performance Evaluations	23
Scholarly Activities Requirement	24
Procedure Tracking	25
Resident Grievance and DUE Process	25
Resident Performance Standards	26
Resident Performance Checklist	27
Major Program and RRC Requirements	29
2004-2005 Calendar of Events	29
Websites	31
Appendix	
Policy on Resident Supervision	32
General Competencies	39
Attachments	
Competency Based Milestones by Year group	40
Subspecialty Lecture Schedule	
Organizational Structure Chart	
Medical Professionalism: A Physician Charter	
Army Values/Soldier's Code	
Statement of Understanding	

Introduction and Philosophy

William Beaumont Army Medical Center (WBAMC) provides health care support for an area that includes several southwestern states. WBAMC serves as the tertiary referral center for the Department of Defense medical facilities in its region, as well as a center for the urgent care of civilian emergencies. WBAMC serves as a community hospital for the active duty soldiers and their dependents stationed at Fort Bliss, as well as the local retiree population. WBAMC also provides consultation and inpatient services for Veterans Administration beneficiaries. WBAMC sponsors residency training programs in Internal Medicine, General Surgery and Orthopedic Surgery, and sponsors a Transitional Internship training program. WBAMC has formal teaching affiliations with the University of Uniformed Services University of Health Sciences and the Texas Tech Medical School. In addition, WBAMC sponsors medical student rotations from a variety of other and osteopathic medical schools primarily through the Health Professional Scholarship Program.

The WBAMC Internal Medicine Residency is a three-year training program leading to eligibility for board certification in Internal Medicine. A typical residency class consists of 4-5 Army residents and 2-3 civilian (US citizen) residents sponsored by the Veteran's Administration for a total of 20-24 total residents training during any given training year. First year residents are often referred to as interns. Alternatively residents may be referred to by their year of training – Post Graduate Year 1 (PGY-1), Post-Graduate Year 2 (PGY-2), and Post-Graduate Year 3 (PGY-3). To confuse things further, sometimes the residents are also referred to as R1, R2, or R3 to again designate their years of training and a fully trained physician in internal medicine is called an "internist".

Internal Medicine residents have the opportunity to train in a variety of primary and subspecialty care areas. Departmental inpatient facilities consist of a 70 bed combined medicine and surgical ward and one ICU with total of 22 beds shared with the surgical services. Outpatient services consist of the Prime Adult Medical Clinic (PAMC) and 12 specialty medicine clinic services with approximately 32 attending staff physicians. There are also rotations offered in WBAMC non-medicine specialties. All Internal Medicine residency training occurs at WBAMC with the exception of Geriatric Medicine (4 weeks in Tucson, AZ in the PGY3 year) or specially arranged rotations at other facilities that are approved on a case-by-case basis. The academic program is in full compliance with the Accreditation Council for Graduate Medical Education (ACGME) guidelines and the Residency Review Committee – Internal Medicine (RRC-IM). Any guidelines or criteria not addressed in this handbook will default to the policies of the ACGME and the RRC-IM (www.acgme.org). In particular, the WBAMC Internal Medicine Residency training program is fully committed to adherence to all ACGME and RRC-IM work-hour, work-load, and duty limitations. **Resident safety, resident supervision, and patient-centered care are paramount.**

The WBAMC curriculum is dynamic and updated annually to ensure full compliance with the ACGME and RRC-IM guidelines. More importantly, the curriculum outlines what we hope residents in our Internal Medicine residency program will learn over their three years or training and where they will learn it. Input to the curriculum comes from many sources to include the annual resident retreat, anonymous annual resident surveys, faculty feedback, subject scores on the annual American College of Physicians In-Training-Examination (ITE) and American Board of Internal Medicine (ABIM) certification examination, guidance from educational organizations, meetings and websites (Association of Program Directors in Internal Medicine, ACGME, Tuft's Institute of Education) and guidance from the Internal Medicine Residency curriculum committee (that includes resident and staff members). The formal written curriculum is reviewed annually and revised every 2 years. Due to the need to incorporate the six newly defined areas of competency introduced by the ACGME in July 2001 and the delineation of training year milestones the curriculum this year will be partially re-written, starting with the inpatient rotations (Ward, ICU, Cardiology) and selective outpatient rotations, with the goal of converting to an entirely competency based, milestone based curriculum by the July 2005-2006 academic year.

The Internal Medicine residency program adheres to the vision statement of WBAMC – "Together providing the best in Federal Health Care and the Army Values (Loyalty, Duty, Respect, Selfless-Service, Honor, Integrity, and Personal Courage. The Internal Medicine resident and faculty retreat April 21, 2004 focused on Professionalism and Leadership. This retreat through a series of dynamic group exercises and discussions identified similar goals that are eloquently delineated in the American College of Chest Physicians Patient-Focused Care Pledge.

I will strive to provide patient-focused care wherever and whenever I have the privilege of caring for patients. I will also work to ensure that all health-care systems in which I provide care are patient-focused. Patient-focused care is compassionate, is sensitive to the everyday and special needs of patients and their families, and is based on the best available evidence. It is interdisciplinary, safe, and monitored. To ensure the provision of patient-focused care in my professional environments, I shall willingly embrace the concepts of lifelong learning and continuous quality improvement.

Organizational Structure and Management of the Program

1. The Chief of the Department of Medicine is ultimately responsible for all patient care, teaching, and administrative functions throughout the department. The Chief of Medicine is COL Homer J. LeMar. Dr. LeMar is board-certified in endocrinology and internal medicine. He has been at WBAMC for 7 years and Chief of Medicine for 6 years. The Assistant Chief of Medicine is LTC Wayne T. Frank. Dr. Frank is board certified in Allergy, Immunology and Internal Medicine.

2. The Program Director is a senior WBAMC internist. He/she is appointed by the Surgeon General of the U.S. Army for an average duration of three years and is responsible for the day-to-day administrative management of the training program. RRC-IM criteria for the Program Director include.....- time commitment. The Program Director chairs the monthly Resident Evaluation Review Committee and the Education Committee. LTC Lisa L. Zacher is board certified in Pulmonary, Critical Care, and Internal Medicine. The 2004-2005 academic year will be her fourth year as Program Director.

3. The Associate Program Director is a WBAMC internist appointed by the Chief of the Department of Medicine and the Program Director who assists in the day-to-day management of the residency program and enhances his/her knowledge of medical education through attendance at special courses and through special educational readings. The Associate Program Director chairs the Curriculum Committee. Per RRC-IM guidelines the Associate Program Director must devote at least 20 hours per week toward program related functions. The Associate Program Director for 2004-2005 is MAJ Michael Abel – board certified in Rheumatology and Internal Medicine. This will be Dr. Abel's second year in this position.

4. The Chief Medical Resident is a member of the Department of Medicine staff. He/she acts as the direct liaison between the housestaff and the other medical staff. He/she is responsible for the academic and administrative management directly related to the housestaff to include coordinating/implementing the department's academic curriculum and scheduling rotations for house officers. The Chief Resident's primary duties are teaching and mentorship. All efforts will be made by the Program Director to minimize non-program related duties. MAJ Mark G. Carmichael is the Chief Resident for this academic year. Dr. Carmichael is a Uniformed Services University of Health Sciences (USUHS) medical school graduate. He is well qualified for this position, having been selected by his peers and teaching staff as WBAMC's Most Outstanding Intern, Most Outstanding 2nd Year Resident, and Most Outstanding Senior Resident.

5. The Resident Research Coordinator is a staff member with research expertise, dedicated to coordinating and optimizing research output by the Internal Medicine residents. He or she provides expertise and mentorship in project concept, design, statistical analysis, presentation, and publications. The coordinator helps in preparation of abstracts and presentations for the Army American College of Physicians (ACP), Far Northwest Texas ACP Clinical Vignette competition, Texas ACP, and WBAMC Research Day. He or she also promotes publications to include the *El Paso Physician*, *Military Medicine*, and other peer reviewed journals. The Resident Research Coordinator for the 2003-2004 academic year was MAJ Sue Baum, board-certified in Infectious Disease and Internal Medicine. She was recently promoted to Chief, Department of Clinical Investigation and will continue to help facilitate resident research in her new position. A new Resident Research Coordinator will be named.

6. The Education Technician supports the administrative needs of the residents, Chief Resident and the Program Director. Ms. Linda Palomarez has been a WBAMC civil servant for the past 12 years and is in her 3rd year at this position. She is extremely supportive, resident friendly, and is a valuable GME asset.

7. The Director of Medical Education (DME) provides institutional oversight to all the residency programs at WBAMC. The DME chairs the monthly Graduate Medical Education Committee. The Program Director, Chief Medical Resident, Chief of Medicine, and a peer-selected Internal Medicine resident represent the Internal Medicine Residency program and are voting members. The DME also oversees the other training programs at WBAMC to include General Surgery, Orthopedic Surgery, and the Transitional Internship.

8. The ombudsman is a designated non-biased institutional representative who is available to also serve as a resident advocate. CDR Richard Mondragon, pathologist is the GME designated ombudsman.

Resident Training and Education

The art and science of Internal Medicine at WBAMC is taught through a variety of teaching modalities. These include formal didactic lectures, bedside teaching rounds, case presentations with discussion, and one-on-one clinical teaching from staff to housestaff, or resident to intern during inpatient and ambulatory rotations. Residents are also expected to participate in Journal Clubs, Morbidity & Mortality conferences, Clinical Pathology Conferences, Tumor Board, and Grand Rounds presentations. Opportunities to participate in community educational seminars and academic forums are available. Residents are encouraged to submit research or case reports for presentation at local, regional, national or international meetings. Each resident has a staff advisor to assist in this process.

A. Basic Internal Medicine Curriculum

Residents are expected to read about individual problems pertaining to the patients under their care. They are expected to do additional reading in preparation for case presentations, journal clubs, and any other departmental learning function. The specified textbook for the 2004 academic year is Cecil's Internal Medicine. All residents have access to *UpToDate* and MDConsult. Residents are strongly encouraged to become associate members in the American College of Physicians. Along with its accompanying benefits such as the Annals of Internal Medicine, the residency program will purchase the Medical Knowledge Self-Assessment Program (MKSAP) for residents who apply for membership. A separate resident handbook outlines the curriculum of each inpatient and outpatient rotation.

B. Teaching Conferences and Attendance Expectations

Clinical teaching occurs at a variety of conferences that deal with the presentation, evaluation, management, and follow-up of patients. These conferences provide a "real life" adjunct to basic reading and allow for the development of critical thinking, differential diagnoses development, decision making, and problem solving through structured discussion of actual cases. Attendance is recorded at all formal teaching conferences with feedback provided to the Program Director, Associate Program Director, Chief Resident and residents after each rotation. Residents are expected to attend 70% of all formal teaching conferences. Since the ICU and Cardiology rotations often make attendance difficult, residents must ensure nearly 100% attendance during all other rotations to ensure an adequate overall attendance rate above 70%. Absences and chronic tardiness will result in formal counseling and may result in other disciplinary actions to include additional reading assignments, call duties, remediation, probation, extension of training or failure of professionalism reported to the ABIM. Good attendance will also be noted with favorable actions to include preference in attendance at additional training opportunities, or other favorable special requests.

1. Morning Report

The Morning Report is the most important daily teaching conference, providing excellent education in the methods of diagnosis and care of Internal Medicine patients. Report begins promptly at 07:45 and is completed by 0830. All housestaff except those rotating in the Intensive Care Unit are expected to attend, and at least one staff member from each specialty will be in attendance. The Chief Medical Resident will choose cases for presentation from the general medicine ward, the intensive care unit, emergency department, or outpatient clinic setting.

The intern or medical student who initially evaluated the patient will present the history and physical exam findings regarding the case for discussion. The presenter is responsible to provide all pertinent data including x-rays, laboratory results, etc. The presenter may refer to notes, but under no circumstances should the presenter read a copy of the H&P. Communication skills will be evaluated, since an accurate but concise and appropriate relay of information is a critical part of working within a medical system.

The presenter's immediate supervising resident should be prepared to further discuss the case and answer questions regarding pertinent data, history, physical examination findings, laboratory tests, and other diagnostic studies. Key competencies that the resident will be expected to display in addition to medical knowledge are a) practice based learning, through a review and summary of current medical literature, and b) professionalism as evidenced by the preparation (mentorship and teaching) provided to the presenter.

A discussion follows by staff and housestaff, moderated by the Chief Medical Resident. Emphasis is directed to generation of problem lists, differential diagnosis, and management plans. Specialty staff feedback is solicited and provided regarding the differential diagnoses and treatment plans, while providing constructive education to the housestaff. All subspecialists and general internists are encouraged to provide their point of view during the discussion.

The usual format for inpatient presentations will utilize one primary case from the previous admission period, and a second, shorter case or teaching point. When appropriate, follow-up of previously presented cases is provided. The AM teaching conference is augmented with additional teaching opportunities and tools to include Medical Jeopardy, "EKG of the Week", the Audience Response System, and short inservices. Morbidity and Mortality, Clinical Pathology, Patient Safety (Near Miss), Ethics, Medical Informatics, Managed Care and Journal Club Conferences are also scheduled throughout the year and may be substituted for the AM teaching conferences. Some of these special conferences will be further delineated below.

On holidays or weekends, admissions are discussed each morning with the admitting Ward, Cardiology, or ICU attending physician.

2. Educational Lectures

Didactic lectures geared to the housestaff, based on a core curriculum, ITE specialty area results, and weighted in accordance with the ABIM blueprint for the board examination are given from 1200-1300 on Monday, Tuesday, and Thursday of each week. Board-type questions with general and subspecialty staff will be reviewed with residents on the first 3 Wednesdays of the month, after AM report. Journal Club is scheduled for the 4th Wed of each 4-week rotation. On Fridays there is no lecture after Morning Report to facilitate attendance at Grand Rounds. Check your mailboxes for a monthly detailed schedule of lectures and conferences.

Each PGY-2 and PGY-3 resident will give a lecture annually on a selected core or subspecialty topic in Internal Medicine. These lectures will start in October 2003 and be spaced throughout the rest of the academic year in place of an AM lecture. Housestaff are required to provide a handout at the time of their lecture. This handout is not to be a simple reproduction of slides used in the presentation. It should be written similar to a textbook chapter and should contain ten or more references. This is part of the scholarly activity required by the ACGME and it is described more fully later in this handbook.

3. Grand Rounds

The Department of Medicine sponsors Grand Rounds every Friday at 11:00 in the Clinic Assembly Room. This conference is open to all WBAMC personnel as well as Veteran's Administration and community civilian physicians. The topics for this conference reflect a broader view of Internal Medicine and are given by many visiting speakers as well as Department of Medicine staff. Speakers are expected to present biased-free, state-of-the-art, evidenced-based information in keeping with the professionalism goals laid out by the Medical Professionalism Project and referenced in the appendix.

4. Staff Teaching Rounds

Attending staff physicians are responsible for ward teaching rounds with his/her ward or unit team. Housestaff and students assigned to that service are expected to attend. Basic pathophysiology, diagnosis, and management issues are incorporated in the discussions. The duration, frequency and specific constitution of these rounds are at the discretion of the attending. ACGME guidelines mandate a minimum of 4½ hours of teaching rounds per week. The teaching rounds may be incorporated into work rounds as long as teaching is taking place. Bedside teaching is strongly encouraged. Chief of Medicine rounds, Program Director Rounds, or Chief Resident Rounds will be scheduled monthly with the teaching teams.

5. Journal Club

A *noon journal club (4th Wednesday of the rotation)* will be held to permit discussion of recent medical literature. Articles are selected by the Chief Medical Resident or by a specialist on a rotating schedule. One resident and staff will be assigned to critically review each article and discuss the pertinent points of its content, merit, and clinical applicability. All housestaff are expected to have read the article(s) prior to the conference and to participate in the discussion. Evidence-based medicine and a systematic critical review of medical literature is emphasized and helps fulfill attainment of the competencies of practice-based learning and systems based practice.

6. Morbidity and Mortality Conference/ Clinical Pathology Conference/Autopsies/Tumor Board

The department through its Risk Management Committee reviews deaths or complications occurring on the Medicine services monthly. Some cases are referred to the Program Director or Chief Resident to present at a Morbidity and Mortality Conference (M&M). Not all M&M cases imply that a mistake has been made by an individual practitioner. In fact, most cases identify systems based errors. Free discussion in a non-confrontational, multi-disciplinary conference is key to improving patient care and imparting the competency of

systems based practice to the residents. Pathology, radiology, nuclear medicine, general surgery, emergency medicine, nursing, and various other services often participate.

Clinical pathologic conferences provide additional opportunities to involve multiple services in the discussion and findings of particularly interesting cases. The admitting ward team, usually the resident, will be responsible for the case presentation with the Chief Medical Resident moderating the discussion. Pathology will present pertinent photos, slides, and microscopic specimens. Subspecialists will present pertinent teaching points. This conference is an ideal opportunity to correlate clinical and pathological findings.

The pathologist will contact the Chief Resident and attending staff when the autopsy is being performed. Residents are encouraged to attend the autopsy but maximal attendance is expected at the post-autopsy. Residents will be given a "heads-up" at AM report with the tentative time and then contacted via beeper when the autopsy is being performed. All autopsy findings are available to residents via CHCS. Residents are strongly encouraged to review all autopsy cases involving patients under their care.

Tumor Board is a multi-disciplinary teaching conference held every Wednesday at 1300 in the Surgical Conference Room (2nd floor). Each intern and resident should attend a minimum of 5 Tumor Boards per year. Make sure that you sign in with the Tumor Registrar when you attend to ensure that you receive the appropriate credit. To enhance the learning experience, the resident is encouraged to attend when their patient will be presented – and better yet, the resident is encouraged to be the presenter.

7. Chief's Rounds, Program Director Rounds and/or Chief Resident Rounds

Chief's Rounds, Program Director Rounds, and/or Chief Medical Resident Rounds will be scheduled once monthly with each Ward team and occur on 9E. These rounds will involve the inpatient ward teams and will include any combination of the Chief of Medicine, the Program Director, Associate Program Director, Chief Medical Resident, or other designated staff. Ward residents/interns should be prepared to present patients. These rounds supplement the ward experience with an emphasis on the learning value of individual cases, bedside teaching, and subspecialty diagnostic evaluation skills and help fulfill the ABIM requirement for 4 ½ hours of teaching rounds (in addition to work rounds).

Faculty Responsibility and Supervision of Residents

The WBAMC Department of Medicine emphasizes primary resident responsibility for patient care under the close supervision of the attending staff.

The attending staff is ultimately responsible for the delivery of safe, quality care for all patients seen, treated, and/or managed by residents in the department. The Chief Medical Resident serves as the primary liaison between staff and housestaff to maintain acceptable patient care standards. In the outpatient clinics, residents are responsible for writing appropriately thorough notes. Housestaff who do not have medical licenses are required to staff and submit each outpatient encounter and note to a supervising staff provider for review. Housestaff who have medical licenses are required to submit all encounters to the attending staff for review. Unless specifically given permission to do so, unlicensed residents should not release patients from the clinic area until the staff supervisor has reviewed the resident's note. Of note, these represent minimum standards and will defer to the PAMC guidelines if there is a discrepancy.

The inpatient attending has the responsibility to interact daily with the inpatient ward team to conduct work rounds, assuring that proper diagnostic and treatment plans are in effect. The designated attending will be available to assist, advise, and supervise the residents on all aspects of patient evaluation and management, day or night. The intern and/or resident directly responsible for each patient's care are responsible for writing the orders regarding that patient. Staff attendings are discouraged from writing orders on inpatients, and have been instructed to inform the patient's resident and/or intern whenever they do so. Staff attendings may need to assume patient care duties if their team meets admission or ongoing care patient "caps" and to assure that residents and interns are released within 6 hours of performing 24 hours of continuous duty (24/6 rule).

Duty hours are closely followed by the Program Director and the Graduate Medical Education Committee (GMEC). Work hours and violations of the 24/6 rule are reported at the monthly GMEC meeting. Violations are handled initially at the program level with an interview of the involved resident and staff. System problems (to include faculty) will be immediately addressed. Recurrent violations by faculty will result in suspension of teaching staff status; violations attributed to inefficiency by residents will be addressed with remediation attempts.

The attending staff is additionally responsible for providing or ensuring at least 4½ hours per week of educational experiences to the inpatient team during teaching rounds. How and when the teaching rounds are conducted will be determined by each attending, and is likely to be variable. Some will choose to teach every day, some will teach for 1½ hours three times per week, and obviously other options are possible. Teaching

rounds may focus on problems presented by patients currently on the service or may pertain to an area of expertise for the attending staff.

All H&Ps need to be reviewed, edited, and co-signed by the attending staff. In addition, all medical student H&Ps or clinical notes need to not only be co-signed but key elements of the H&P need to be independently performed by the attending staff. Attending staff should ensure that allergies are properly entered in CHCS on all inpatients, that the Multi-Disciplinary and Education forms are filled out appropriately, that pain is accessed and re-accessed in daily notes, that restraint documentation and orders are entered and updated every 24 hours, and that ongoing inpatient record review (2 charts per resident and staff per month) is performed.

For further guidelines on resident supervision, see the attached Resident Supervision Policy in the appendix. It is key that the attending staff realizes that every resident or medical student procedure is either directly or indirectly supervised in accordance with the WBAMC Internal Medicine Residency Supervision policy.

Lines of Responsibility for Housestaff

All ward and ICU residents have the responsibility of providing the attending staff with continuous feedback on each patient's progress. Interns should assume responsibility for being the direct point of contact for provision of information and plans to patients and their families. It is the intern's responsibility to insure that orders are written, tests are scheduled, procedures are done, consults are delivered, and that the overall diagnostic and treatment plan is being expeditiously carried out. The intern's resident has the responsibility to insure that the intern is capable of accomplishing these duties. The resident should provide guidance, instruction, and direct assistance to his or her intern so as to avoid undo workload, insure good patient care, and advance the medical education and professional capabilities of the intern. Medical students may be assigned to work with interns, but the resident needs to provide direct supervision. Ultimate supervision is provided by the attending staff. For further guidance please see the Residency Supervision Policy

Ambulatory Internal Medicine Resident Continuity Clinic

Each resident will carry a panel of continuity patients during their 3-year residency. All housestaff will be assigned one half-day of continuity clinic per week during which they will see outpatient internal medicine patients. Continuity clinics will be made up of a diverse population of patients with a variety of medical problems. Patients will be directly impaneled to the resident, with the resident assuming the role of the patient's primary care physician. In this capacity, the resident will provide continuity of care, preventive medicine, medication refills, and respond in a timely manner to telephone consultations. Residents are encouraged to interact with their outpatients whenever they require admission. To fully appreciate continuity of care, residents should closely follow the inpatient course of each of their patients, whether or not they are on an inpatient rotation when the patient is admitted. Continuity clinic will take place during all rotations with the exception of night float rotations or off-site rotations and be held in the Prime Adult Medicine Clinic (PAMC).

The VA residents will see a mixture of VA beneficiaries and PAMC patients, while the military residents will see a majority of PAMC patients. On average, residents will need to participate in 36 weekly continuity clinics per year to achieve the RRC-IM minimum standard of 108 weeks of continuity clinic. Continuity clinic experience will not be interrupted by greater than 4 weeks (exceptions include an additive of 2 weeks of vacation time that precede or follow a no clinic rotation). The number of continuity clinics will be maintained by the Education Technician and residents will receive updates of their progress on a quarterly basis. Patient loads on average will consist of 3-5 patients for PGY1 residents, 4-6 patients for PGY2 residents, and > 4 patients for PGY3 residents.

All patients seen in continuity clinic will be staffed with internal medicine teaching staff. Under no circumstance will teaching staff supervise more than 5 residents or students during a clinic session. In the majority of cases the teaching staff supervises 3-4 residents. Residents are also expected to answer telephone consults and follow-up on abnormal labs or studies in a timely manner.

All residents will also rotate a minimum of one month per year in the PAMC to fulfill their Internal Medicine Ambulatory Care requirement. This rotation will enhance skills in new patient evaluations, acute care management, pre-operative consultation, use of clinical guidelines, and health maintenance evaluations to include immunizations, and gender specific health care.

Inpatient Medicine Rotations

1. Ward Medicine Teams

The Department of Medicine's inpatient general medicine service usually consists of three teams (GM1, GM2, GM3) taking admissions on an every 3rd day basis.

a. GM1 and GM2 teams will consist of one internal medicine resident, one to two interns, and one to two medical students. The GM3 team will be made up of teaching staff with or without a medicine resident.

b. Each GM team is on call every third day and takes all admissions from 07:00 till 07:00 the next day. Each intern takes overnight call on average every sixth night. Resident call will be with their respective teams on about every sixth night with night call supplemented by a hospitalist. Close monitoring of duty hours and “days off” will take place and if work hour limits are exceeded the ward coverage system will need to be revised to ensure full compliance with all RRC-IM requirements.

c. The interns not scheduled to take in-house call will remain on the ward until their resident determines that they may leave

d. On the days following the “on call” day, the team takes no new admissions, but may be required to resume care of “bounce-back” patients.

e. As a requirement of the ACGME, all housestaff are to have “on average one day in seven free of patient care responsibilities”. The “off duty” days for each member of the inpatient team should be scheduled after review of the call schedule and continuity clinic schedule with the staff attending. A resident on each inpatient team will provide a schedule of the planned “days off” to the Department of Medicine Education Technician (Ms. Linda Palomarez) within 5 days of starting each rotation. These days should not be saved up with the idea of taking 3-4 days in a row within the rotation. (Note: C4 counts as one day off). The ACGME also limits work to no more than 80 hours per week. After 24 hours of continuous duty, residents cannot initiate new patient evaluations and have 6 hours to finish work-ups and be relieved of duty. Residents and interns should notify the Chief Medical Resident or the Program Director if any of these ACGME requirements is not being met.

2. **Cap Rules:** An intern must not be responsible for more than 5 new patients per admitting day (plus 2 bouncebacks or ICU transfers). An intern must not be assigned more than 8 new patients in a 48-hour period (plus 4 bouncebacks or ICU transfers). An intern must not be responsible for the ongoing care of more than 12 patients. When supervising more than one intern, the PGY2 or PGY3 must not be responsible for the ongoing care of more than 24 patients. The R-2 or R-3 must not be responsible for admitting more than a total of 10 new patients per admitting day (plus no more than 4 bouncebacks or ICU transfers) or more than 16 new patients (plus 8 bouncebacks or ICU transfers) in a 48 hour period, which includes the first-year resident being supervised. The attending staff remains primarily responsible for ensuring at no time are these cap limits violated. The resident will be the first backup when an intern exceeds the cap and the staff is the first backup when the resident cap is surpassed. Teams approaching or exceeding these levels should contact the Chief Medical Resident for possible redistribution of patients or utilization of the accessory MOD (AMOD).

Medical Intensive Care Unit (MICU) Team

The Medical Intensive Care Unit (MICU) service is made up of one to two internal medicine residents, one to two interns, and occasionally medical students. Outside resident rotators may also be present, but under no circumstances will a non-internal medicine resident supervise a medicine intern or serve as MOD. The MICU team is 100% staffed with board-certified or board-eligible critical care staff physicians. Specific ICU policies are outlined in a specific handout you may obtain from Ms. Palomarez or your attending staff at the time of your ICU rotation.

a. The interns will usually be either from the Internal Medicine residency or the Transitional Internship, but may include interns from other programs or departments

b. The ICU interns will be on overnight call on average every 4th night and cover both the MICU and Cardiology team patients. Interns on medicine elective may be pulled to help cover the ICU rotation.

c. The ICU night resident will provide coverage from 1900 to 0700 hours. In most cases, two residents will be assigned to the MICU team with one serving as the “day” resident and the other as the “night” resident. This arrangement improves resident familiarity with patients and facilitates staff evaluation of their performance.

Cumulative night float call will not be greater than 6 weeks per academic year or 12 weeks for the total residency. Night float assignments will be separated by at least 10 hours of non-patient care duties and one day off on average every 7 days will be ensured. Night float will take place in one to two week blocks and when averaged over the 4-week elective period, the 80-hour workweek policy will not be exceeded.

d. The ICU will accept critically ill admissions on a daily basis, unless “closed” by the Deputy Commander for Clinical Services (DCCS).

Cardiology Inpatient Team

The Inpatient Cardiology service is made up of one internal medicine residents, one to two interns, and occasionally medical students. Outside resident rotators may also be present, but under no circumstances will a non-internal medicine resident supervise a medicine intern or serve as MOD. The MICU team is 100% staffed with board-certified or board-eligible cardiologists.

Elective Subspecialty Rotations

1. The Department of Medicine has elective subspecialty rotations available in the following areas: allergy and immunology, adolescent medicine, cardiology, hematology/oncology, dermatology, endocrinology, gastroenterology, geriatrics, gynecology, infectious diseases, nephrology, neurology, nuclear medicine, ophthalmology, outpatient orthopaedics, otorhinolaryngology, physical and rehabilitation medicine, pulmonary medicine, and rheumatology. Electives in other areas or even at other institutions can often be arranged with proper foresight, planning and an approved curriculum. Most rotations last four weeks; some can be established for only two weeks. The resident sees patients in both the inpatient and outpatient settings. Board eligible or board certified subspecialists in the appropriate area carry out formal supervision. Residents are encouraged to read and study extensively in the area under the direction and tutelage of the staff physicians. The number of periods available to each resident for elective rotations varies depending on the PGY level.

2. Rotations on subspecialty services in the Department of Medicine are available to transitional interns, local civilian residents, and medical students on a space available basis. Department of Medicine personnel receive first priority in this regard. All housestaff rotating through a subspecialty clinic should sign up through the chief medical resident who coordinates the number of housestaff on a given service.

3. Each subspecialty clinic is encouraged to administer a pre- and post-rotation examination or some other type of objective measurement to objectively quantify the intern's/resident's medical knowledge and to provide an assessment of the effectiveness of that clinic's teaching program.

4. Each subspecialty service has a written curriculum for housestaff training. This outlines the responsibilities of the housestaff and clarifies goals and objectives. In addition each service is encouraged to have a written syllabus that outlines the basic knowledge that a general internist should have in the subspecialty areas. The curriculums will be rewritten throughout this academic year to reflect core competency based learning objectives and objectives delineated by PGY milestones. Please default to the published curriculum unless a new one is provided at the time of your rotation.

5. The curriculum for each outpatient and inpatient rotation is available to residents via many avenues. Each resident will be given a written copy of the curriculum. The curriculum is also available on the Intranet. The curriculum for each resident rotation will be E-mailed via Outlook to the resident at the time of the initial rotation (e.g. Ward curriculums will not be forwarded with each Ward rotation). It is still expected that 100% of the time that the resident will meet with the staff preceptor in the first few days of the rotation to review learning objectives and performance goals.

ADMISSION POLICIES

Ward admissions are directed to one team from 07:00 – 07:00. The ICU team will manage ICU admissions. The Chief Medical Resident will monitor numbers of patients assigned to each of the inpatient teams and has the authority to alter admission distribution to achieve an equitable workload between teams.

Admissions to the Department of Medicine are coordinated through the Medical Officer of the Day (MOD) at pager #5210. Physicians requesting admission for a patient begin the process through the MOD. If the patient is admitted from the medicine clinics, the clinic physician should call the ward resident to discuss reason for admission, plans for the patient, etc. Admissions may also need to be screened through the nursing supervisor to ensure bed availability. Generally, elective admissions should be admitted before 1200 hours Monday through Thursday. Cap limits will strictly be enforced. Please see cap limits for interns (PGY1) and residents (PGY2 and 3) noted under Ward admissions. Keep in mind 5 (new admissions) + 2 (bouncebacks) for interns; 10 + 4 for PGY 2 and PGY3 residents in a 24 hour period. In a 48 hour period: Interns 10 + 4; residents 16 + 8. A resident can not be responsible for greater than 24 patients. When cap rules are surpassed, first the resident, then the staff must absorb the additional workload. Additional back-up is available via the AMOD or by redistribution of patients.

Remember: When active duty soldiers are admitted to WBAMC, you must notify his/her Commander ASAP. An acceptable alternative is to contact the Ft. Bliss Staff Duty office at 568-1501.

Air Evacuation Admissions

The air evacuation clerk in the Patient Administration Division notifies the MOD of anticipated patients and their estimated time of arrival. The MOD will assign patients to a ward team at the time of their arrival. Ward team residents will notify and/or consult the accepting clinic physician or service upon arrival of the patient.

Transfer of Patients from Other Departments

1. The resident will often be asked to evaluate patients for consideration of transfer from other services. The decision to accept a patient in transfer will be made in conjunction with a medicine staff physician.

2. Transferred patients will be assigned to the on-call ward team. Transfers from other services after 18:00 or on weekends are discouraged unless necessary for appropriate medical management of the patient.

3. No transfer patient should be accepted without a completed history and physical, resident admission note, and staff note on the chart unless special circumstances supervene. Dictations for the entire hospital stay become the responsibility of the discharging physicians, except in complicated cases or extended hospitalizations, in which the transferring team should dictate an interim summary. This must be approved through the supervisor in medical records.

Transfers of Patients from Other Facilities

1. Calls regarding patient transfer from another facility during duty hours should be referred to the Chief Medical Resident (Dr. Carmichael, beeper #3002). After duty hours, the decision to accept a patient in transfer will be made by the on-call resident in consultation with a medicine staff physician. The accepting physician should generally be the attending for the accepting service or a subspecialist with expertise in the area of concern. Coordination of patient transfers by residents should be reviewed with an attending physician prior to acceptance. It is the responsibility of the sending physician to assure that the patient is stable for transport.

2. Medicine always accepts active duty personnel. It is the responsibility of the sending physician to assure that the patient is stable for transport.

3. Medicine also accepts eligible patients from other facilities as indicated for appropriate level of care for that patient. All transfers from civilian hospitals should be cleared through Patient Administration Division (PAD) to ensure eligibility. The Chief Resident or MOD is responsible for checking with PAD.

4. The following scenarios should provide useful guidelines:

From other facility wards-- Patients ideally will proceed directly to the appropriate WBAMC ward as previously arranged by the accepting physician. At the discretion of the accepting team and after contacting the ER physician, transfers from other facilities may "pass through the ER". The ER staff will not be expected to evaluate patients beyond ABCs, vital signs, and an EKG or ABG if appropriate.

From other facility ER's-- The CMR or MOD will not accept a patient's transfer from another facility's ER to a Ward setting if there is any concern about appropriate triage. If the WBAMC ED staff physician accepts this transfer the MOD should be notified when the appropriate initial work-up is initiated and if admission to the internal medicine seems likely.

From other facility's ICU-- Patients will proceed directly to the appropriate WBAMC ICU as previously arranged by the WBAMC ICU Attending. Patients will not be accepted from another facility's ICU to WBAMC wards. An exception may be Coronary Monitoring Units at other hospitals to our telemetry monitoring on the general medicine ward.

Admission of VA Patients

The referring El Paso VA physician should contact the MOD to notify him/her of a planned or needed admission. Transfers of VA patients from other facilities during work hours should be referred to the Chief Resident. Verification of VA eligibility must be assured before acceptance. It is WBAMC's obligation as a federal institution to accept VABs in transfer. However, after duty hours, if verification of eligibility cannot be confirmed these transfers can be deferred until verification can take place. After duty hours, as a minimum, the transferring facility should FAX a copy of the front and back of the veteran's benefits card.

Readmission Policy (Admission Credits)

1. Residents have "ownership" of discharged patients, and will resume care of any patients re-admitted while the resident is still on the ward rotation (includes "back-to-back" rotations on the wards).

2. For patients re-admitted:

a. The resident will write an interim note that documents the brief prior history and updates the current presentation and working problem list.

b. If the patient is re-admitted after 18:00 hours or after the "owning team" has left the hospital for the day, the on-call team will write a holding note and admission orders. Transfer of care and responsibility goes back to the original team on the next working day. The receiving team will write an acceptance note to assume care of the patient.

c. "Bounce-backs" who come in on a weekend or holiday will be handled on an individual basis among the involved residents.

d. The MOD writing consults sending patients home from the ED will be the admitting resident if the patient needs to be admitted for the same problem within 72 hours (this includes patients that left AMA).

Criteria for Restriction of Inpatient Services by Department of Medicine

1. Based upon bed space availability, nurse staffing, and/or housestaff workload, restrictions or closure will occur at a staff level after discussion with nursing staff. Restriction in one area of service does not imply restriction in other areas.
2. Adjustments for teams missing an intern due to leave, illness, etc., will be handled on an individual basis by the Chief Medical Resident.
3. General Medicine Ward Teams
 - a. An intern must not be responsible for more than 5 new patients per admitting day. An intern must not be assigned more than 8 new patients in a 48-hour period. An intern must not be responsible for the ongoing care of more than 12 patients. When supervising more than one intern, the PGY2 or PGY3 resident must not be responsible for the ongoing care of more than 24 patients. The PGY2 or PGY3 resident must not be responsible for admitting more than a total of 10 new patients per admitting day or more than 16 new patients in a 48 hour period, which includes the first-year resident being supervised. Teams approaching or exceeding these levels should contact the Chief Medical Resident for possible redistribution of patients or utilization of the accessory MOD (AMOD). Capped teams may still take "bounce-backs" and patients returning from the intensive care unit if the bounceback limits noted under the Inpatient Ward Team sections are not exceeded.
 - b. If all teams exceed the upper limits, only active duty patients will continue to be admitted. The Chief, Department of Medicine, or his designee will make ER notification to this effect. Closure of ward services will only occur as directed by the Chief, Department of Medicine or Chief, Department of Nursing. At times of ward closure, suspension of EMS services may be appropriate.
 - c. During periods of closure, clinic admissions, which can be deferred to a later date, will be tracked on a "waiting list" by the MOD. These admissions will be accommodated as space becomes available on a first-come, first-served basis. In these rare circumstances when Ward are closed, specific guidance will be issued by the Chief of Medicine and/or Chief of Nursing.
4. Intensive Care Units

There must be one ICU bed available at all times for emergent transfers from other wards within the hospital. Bed census in the Intensive Care Units is a coordinated effort among the Nursing Supervisor (as a primary participant), ICU Attendings, the MOD, and the Surgical Officer of the Day (SOD). It is incumbent upon the MOD to have current information prior to accepting patients for admission. No patients should be accepted without first checking with the Nursing Supervisor who also tracks admissions from other surgeries and the OR schedule.

Policy Concerning Transfers To or From Medical ICU

It is the responsibility of the transferring team to provide a transfer summary note prior to the physical transfer of a patient to or from the ICU. An interim OP10 placed in the chart can serve as a suitable transfer note, especially with complicated patients. In emergent situations when patients must be transferred to the ICU immediately, the transfer note should be written as soon as possible. Do not let paperwork delay emergent transfers to the ICU or from the ICU to the Wards when ICU bed availability is limited. Optimum patient care and effective use of resources is key.

Meaningful communication is expected between housestaff and housestaff regarding unit transfers. The ICU resident will inform the MOD. The MOD will inform the charge nurse. The charge nurse accepts report, and then the patient is sent to the Ward. The ICU intern should also communicate directly with the Ward intern and vice versa. Staff have the final authority when questions arise.

Transfers from the ICU to the Ward should occur as early in the duty day as possible to facilitate OR cases and optimize bed utilization. ICU and Cardiology residents should meet with their staff even before AM rounds if there are patients that are stable for discharge. Discharge of patients should be prioritized unless there are unstable patients requiring care. In some circumstances, the intern, may need to break away from rounds to prioritize transfers.

CONSULTS

In-patient consults on non-medicine, non ICU patients will be performed by the on call GM team resident if an Inpatient Consultative Service resident is not available. These consult patients will be managed by the GM team for their medical problems including recommending tests, writing notes, and signing out to the on-call intern. If there is a designated inpatient consultative service resident, the resident will staff with the designated consult service staff. The consult resident may make arrangements for cross-coverage of consult patients on weekends and holidays. The admitting non-medicine service retains responsibility for discharge orders and discharge summaries for the patient.

Cardiology consults will be handled by the in-patient cardiology resident and staffed with the Inpatient Cardiology staff. The ICU team through the guidance of the ICU Attending will handle ICU consults. Point of

contact for other services will be the MOD, who will notify the PAMC resident or assign the appropriate GM team and ask that the consult be left on the front of the patient's chart.

The resident's supervising attending physician or the Internal Medicine Consultative Service attending must review all consults within 24 hours of completion. The attending's name must be clearly indicated on all consultations. This requirement pertains to all consults completed by Dept. of Medicine housestaff, including those done on patients in the Emergency Room who are subsequently sent home without admission.

Resident Responsibilities

A. Duties of Inpatient Intern (PGY-1)

1. The intern will complete his/her own thorough history and physical. He/she will review laboratory data on each admission, present this information to the resident, and work together to construct diagnostic and therapeutic plans. As needed, he/she will also present the patient to the attending, at morning report, to their consultants, at conferences, etc. These presentations, particularly the more formal ones, should be reviewed with the resident whenever possible so as to perfect the skills of medical communication. The history and physical must be on the chart (and remain on the chart) within 24 hours of admission. Do not take the H&P out of the chart for presentation. Do not carry a completed H&P in your coat pocket. The H&P must be co-signed by your attending staff.

2. The intern will coordinate the appropriate tests according to their priority and notify the resident if there are problems in obtaining these tests. He/she will gather the results of these tests, as well as the findings and recommendations of the consultants, and present these to the resident. After reassessment of the plans with the resident, the interns implement the appropriate orders. The intern is responsible for updating the resident on the progress of the evaluation, potential problems, etc.

3. The intern is the primary physician for all the patients under his/her care. He/she is responsible for the day-to-day evaluation and management of these patients, to include orders, notes, and procedures. The intern should interface (**communicate**) with the patient and family, provide updates, and be identified by the patient as his primary physician. The intern must also work diligently to keep ancillary staff members updated as to the assessment, plan, and goals of patient care. In other words the intern must assume "**ownership**" of the patient. The intern's resident and attending staff should guide evaluations and management decisions. The intern might not lead all family conferences, but is expected (unless excused because of duty hours or days off) to attend and actively participate in all such conferences.

4. Before the inpatient intern leaves the hospital for the day:

a. The patients under his/her care will be stable and properly checked out to the on-call intern or hospitalist.

Please see the "sign-out" section in this handbook for minimal standards.

b. The orders and procedure notes will be completed and placed in CHCS.

c. The history and physical forms for all admitted patients will be completed and placed in the chart. The admission H&P should include an assessment, differential diagnosis, and plan for each problem noted.

d. The daily progress note will be written on all patients. Pace yourself throughout the day. An efficient intern should have all progress notes on current patients done early in the duty day. Duty hour restrictions will be strictly adhered to, but often there is a pattern of recurrent offenders that is a reflection of efficiency.

5. All patients in the intensive care unit will have at least one daily progress note. More notes may be necessary based on changes in condition or management.

6. All interns should prepare short presentations on topics related to patients under their care. Interns are required to be present at all teaching rounds, especially daily morning report and conference.

7. Computerized discharge order, discharge notes, and dictated summaries are the responsibility of the discharging intern. Dictations should be done within 48 hours of discharge. Interns/Residents rotating off a team are responsible for dictations for an additional 48 hours after they leave the team if the patient is discharged during that time. The OP10 can substitute for the discharge dictation.

8. Ward discharges should be done as early in the duty day as possible. This improves cost effectiveness by improving bed utilization, improves the flow of patients from the ICU, and does not place excessive burden on the afternoon nursing staff. In most cases, the meat of the OP10 can be completed prior to discharge (e.g. day before) and not at the time of discharge. In cases where it was impossible to have the OP10 done the day prior, a "shell" of the OP10 with admission, discharge diagnosis, major procedures, and discharge instructions, medications can be placed and updated later in the day. Efficient discharge practices reflect on the competency of Systems Based Practice.

9. The intern will be responsible to present cases at morning report and teaching rounds as directed by the Chief Medical Resident, attending staff or supervising resident.

10. Interns (first-year residents) are responsible for no more than five new admissions per admitting day or

more than 8 patients within a 48 hour time period. The intern should not be responsible for the ongoing care of more than 12 patients. If the admitting team receives more admissions than this, then the resident will write the History and Physical documents (instead of writing a Resident Admission Note) and enter admission orders.

Program Directors Note: Duty hour restrictions have resulted in an improved quality of life for residents with the primary goal of both resident safety and patient safety. I realize that the acuity and turnover of patients has also increased so that despite these recent restrictions, interns and residents during Ward and ICU rotations are still working as hard as ever. As the year progresses, you will improve on your efficiency and ability to multi-task. As you progress throughout the intern year, move from data gatherer, to interpreter to manager. In order to progress to the PGY2 year you must demonstrate the ability to function as a team leader. As a physician, you are also expected to teach and mentor the medical students on your team.

At the April 2004 retreat of teaching staff and residents, professionalism and leadership were emphasized. Concerns voiced by staff and residents were that many interns (and residents) have developed a “shift-work” mentality. Playing doctor is over – you are the primary physician for the patients under your care. Strive to be the best advocate for your patient. I cannot stress the word “ownership” enough, but ownership is just a word. You have to believe that you can make a difference in the care of your patient. Data collection and administrative work may seem mundane, but as an intern you provide a vital role in ensuring that “your” patient receives optimum care. Patients will still have bad outcomes, patients will still die, but make sure that you have fulfilled your duties as a physician. To cure seldom, to comfort often, to care always.

A typical intern day:

0600-0700: Preround on patients (sign-out from on-call intern, interview/examine patients, gather data)

0700-0745: Preround with resident; identify patients for discharge; formulate plans for day

0745-0830: AM report

0900-1100: Teaching rounds with staff attending

1200-1300: Teaching conference

1300-1800: Admit, discharge, patient care

1800-1900: Sign-out to on call intern. Interns may leave earlier in the duty day if approved by supervising resident.

B. Duties of the Inpatient Resident (PGY-2 or 3)

1. The resident will carefully evaluate the assessment and management plan created by the intern.

2. The resident will complete a legible and concise Resident Admission Note (RAN) on all patients admitted.

This RAN should include a succinct history and physical exam, an assessment, including the relevant differential diagnoses, and an initial plan for evaluation and therapy. This note must be in the patient's chart prior to the resident leaving at the end of the day.

Program Director Note: A good RAN should be no longer than front and back of a progress note or a one paged typed CHCS note. There is no need to rewrite the H&P. Include pertinent positives and negatives (or new information not available in H&P). The main emphasis of the RAN should be the differential diagnosis, assessment, and management plans. Focus on a thorough but concise relay of information. Writing a succinct but thorough Pan is important in time management.

3. The resident is responsible for conducting daily work rounds with the interns and any medical students, with special emphasis on bedside teaching and discussion. The residents are the highest level of housestaff organization and should set the rounding and educational schedule for the team for that day, ensuring that everyone attends the mandatory conferences. The resident will coordinate the team effort and update the attending, as necessary.

4. The resident will not leave the hospital until all the patients under his care are stable and an appropriate sign-out has been given to the on-call physician.

5. The resident will prepare the intern or medical student for morning report. This preparation will include rehearsal of the presentation when possible, and the discussion of pertinent current medical literature covering selected aspects of the case. The resident will provide educational guidance for the intern/ medical student.

6. The ward resident should provide short academic presentations during the month on topics relevant to patients under their care.

7. The resident will attend morning report as well as other teaching conferences and is responsible for the intern's attendance. He/she will be responsible for participating in the discussions at these various teaching conferences.

8. The quality of care should not deteriorate due to excessive workload. The resident is responsible for seeking back-up help from the AMOD, the attending, or the Chief Medical Resident, as he/she deems necessary. He/she may also elect to assume direct patient responsibility, depending on his/her judgment of the intern's workload and with approval of the staff attending physician. He/she will then be responsible for any dictations or orders required for the patient's under his/her direct care.
9. The resident will promote communication with the nursing staff. He/she will continually update the nursing staff about management changes, required specimen collections, and target discharge dates, etc. The resident will ensure attendance at discharge planning meetings
10. The resident will be prepared for check-out rounds with the On Call Ward resident, Night Float Resident, or hospitalist at 19:00 daily. Earlier signouts by Ward residents may occur if their inpatients are stable or if it involves residents on the same team. Ward residents are expected to be available by beeper at all times after check-out rounds (overnight) to answer any questions the covering resident might have. Designated days off are exceptions.
11. The resident must ensure maximal attendance at all assigned hospital committees. Committee assignment and active resident participation is mandated by both the RRC-IM and JCAHO. More importantly, it allows the residents to be involved in making decisions that affect the hospital (and ultimately patient care) and help meet the Systems Based Practice Competency.
12. The resident will assist his/her attending staff in generating a schedule on the first day of each rotation that enables each member of the team to have an average of one day in every seven free of patient care responsibilities. The resident will turn this schedule into Ms. Palomarez, within the first 5 days of the rotation. She should not have to continually prompt residents for this to occur.
13. The resident will monitor admissions to his/her interns to insure that no intern is assigned responsibility for more than five new patients per admitting day. If more admissions are received, then instead of writing a RAN, the resident will write the History and Physical Exam documents and take responsibility for the admission until the next normal duty day for the intern.
14. The PGY-3 resident has all the above duties but is expected to take an even greater role in informal teaching, formal teaching, hospital committees, QI, consultative medicine services and participate in faculty development seminars. The PGY3 resident should demonstrate increased autonomy and ability to both generate a broader but more specific differential diagnosis than the PGY2 resident with the goal of demonstrating the ability to function as an independent clinician. For further delineation of PGY-1, PGY-2, and PGY-3 responsibilities, refer to the Resident Supervision Policy in the appendix.

C. Duties of the ICU Night Float Resident, On Call Ward Resident and On-Call Intern

1. All PGY-2 and PGY-3 residents will rotate throughout each year as the ICU Night Float Relief Resident, participate in a modified night float system for ICU night call, or if schedule changes dictate serve as a Ward night float resident. Night float responsibilities will not exceed greater than 6 weeks per academic year or a total of 12 weeks for the three-year residency. The night call resident will be responsible for night call from 19:00 - 07:00. Check-out with the ward and ICU residents / interns will take place every day when night coverage starts and ends. The ICU Night Float and On Call Ward Resident must discuss all admissions and all consults on other wards or in the Emergency Room with the Staff Attendings. The Night Float resident must attend AM report.

2. Specific Duties of the ICU Night Float Resident and On Call Ward Resident:

The Ward 9E Night Resident will carry the MOD/code beeper and be responsible for all MOD duties, evaluating potential ward admissions, performing all the stated duties of the daytime ward resident, and assisting the on-call intern during the overnight period. The Ward 9E Night resident need not do thorough work-ups of patients that meet intensive care unit admission criteria, although it is hopeful that the Ward resident and ICU resident will work together to provide optimum patient care and timely triage.

The ICU Night Float Resident will carry a cardiac arrest "code" beeper and will manage the ICU patients to include new admissions. This ICU Night Float Resident will assume management of critically ill patients when the Ward 9E Night Resident has determined that a patient requires ICU admission. Night unit residents also should perform the same duties as their daytime counterparts with regard to teaching and supervision of the interns. When workload is excessive or other conditions require it, the two night residents are expected to work together to assure optimal patient care and avoid undue stress for each other or the interns. It is appropriate to notify the ICU attending staff, the Ward attending staff, and if necessary, the Chief Medical Resident if workload and/or patient care responsibilities become so complex that good patient care may be compromised. Transfer of pagers (MOD/code, code) should occur when Night Float Resident duty begins and ends. The unit and ward

call teams will be responsible for all medicine patient care during their hours of service. Disagreements about patient disposition should be referred to the ICU Staff and Ward Staff attendings.

3. The On Call Ward Resident will present a copy of all written consults to the call team's staff attending physician and discuss these patients every day. This includes consults done on ER patients who are sent home without admission. Consults done on ICU or Cardiology patients that were later transferred to other facilities because of lack of beds, must likewise be staffed.

4. The On Call Ward Resident will contact the attending staff and the Chief Medical Resident if it appears necessary to call in the back-up resident physician, the Assistant Medical Officer of the Day (AMOD). Necessity for this may be indicated by excessive numbers of patients requiring evaluation and/or admission. At no time should the MOD permit an excessive workload to impair the delivery of excellent medical care. The MOD should not call the AMOD directly, but should call the Chief Medical Resident if the assistance appears needed.

Sign Outs:

Program Director Note: I cannot emphasize the importance of sign-outs enough. Continuity of care must be maintained. There have been several Risk Management cases where the resident or intern did not have the necessary information readily available to make timely critical decisions. It is not merely enough to get the patient through until morning. Patient care should be ongoing 24/7. Sign-outs are a 2 way street – it is as much your duty as the night call resident or intern to request the information that you need to best manage patients, as it is for the daytime resident to provide that information. Residents should sign out to residents and interns should sign out to interns. Below is a sample sign out sheet. However, sign outs imply a relay of more than just data. The most important part of sign-outs are:

- **Face to face exchange of information, ideas, plans.**
- **What events can (should) be anticipated?**
- **What has happened to the patient in the past?**
- **Where is the patient on a trajectory, not just at this one point in time?**
- **What has worked, what has not worked (contingency plans)?**
- **Treatment goals**
- **Exchange is bi-directional. The covering resident must understand the big picture.**
- **Sign-outs are as important as any invasive procedure on your patient.**

1. Effective sign-outs are evaluated under the competencies of patient care, professionalism and interpersonal communication skills. The effectiveness of resident sign-outs will be measured with the following methods:

- a. Staff attendings and program director will ask to see resident sign-out sheets
- b. Staff attendings will watch residents perform sign-outs
- c. Peers will anonymously evaluate peers as part of the 360 degree evaluations with a specific question geared to effectiveness of sign-outs. This latter method will elucidate the most valid information regarding the resident's commitment to quality patient care.

2. At the monthly Graduate Medical Education Meeting (GMEC), residency program directors are required to report on the effectiveness of their program's sign outs and report on measurement tools and resident compliance.

3. Risk management cases involving residents will be reviewed to elucidate whether ineffective sign-outs (patient hand-overs) contributed to any deviation from standard of care.

4. A sample sign-out can be found in the appendix.

Medical Officer of the Day (MOD)

The resident assigned to the on-call team or the Inpatient Consultative Service resident is the MOD. He/she functions as the point of contact for evaluations by, or admissions to, the general medicine wards or units. The MOD will accept referrals from in-house clinics, other services within the hospital, the VA clinic, and the Soldiers and Family Clinic, and after duty hours (with staff approval) outlying military and/or civilian installations. During duty hours, transfers from other facilities should be referred to the Chief Resident (beeper #3002). Service-to-service transfers will be assigned by the MOD in conjunction with approval by staff providers.

Disagreements arising over the disposition of patients to the ward or ICU should be handled at the resident level in an attitude of co-operation among peers and in the best interest of the patient. Attending staff is the final authority for disposition of patients.

Telephone consult forms should be completed on all out-of-hospital calls, especially those received on nights or weekends. Taking this step allows for good documentation and makes certain that all appropriate information is passed along from an off-going Night MOD Resident to the on-call daytime MOD. Night MOD Resident's should present the carbon copy of all consults to the appropriate staff each morning.

Assistant Medical Officer of the Day (AMOD)

One resident on an elective rotation will be assigned each week to serve as back-up for any resident unable to fulfill their duties (e.g. emergency leave, maternity/paternity leave, illness, fatigue, TDY, etc.). This includes wards, ICU, Inpatient Cardiology and night call duties. The resident must be available at all times through pager or phone from 07:00 of the first Friday to 06:59 of the next Friday of the assigned week. No leave or passes may be scheduled during this time. Residents unable to work due to illness must be evaluated at their primary care clinic and given appropriate disposition. The AMOD will also be the primary resident utilized for transports, air evacuations, or the first back-up for a particularly heavy admission period. VA residents are exempt from air evacuation assignments but are expected to fulfill all other AMOD duties. In the majority of cases the resident requiring AMOD back-up will "pay-back" the covering AMOD when reasonably feasible.

General Policies

Military Readiness and Military Licensure Requirements

All military interns are expected to attend the Combat Casualty Care Course (C4) during their intern year and are expected to pass the Advanced Trauma Life Support course that is taught at C4. Additionally, all military interns are expected to complete the on-line Military Unique Curriculum prior to graduation.

All military housestaff are expected to pass the semi-annual Army Physical Fitness Test. Failure to do so may result in loss of residency position and assignment into a utilization tour, as per directions of the Dept. of the Army. All military residents are expected to have an updated DA photo in the Class A uniform and should periodically review their Officer Record Brief (ORB) for accuracy.

During the first month of the academic year, military interns and residents will be provided with a copy of the Program Director's and Chief Residents Officer Evaluation Report (OER) support form. It is expected that the individual military intern and resident will meet with their rater (in most cases the Chief Resident) and present their own OER support form prior to 30 September 2004.

Military residents MUST obtain a current, valid, unrestricted medical license in the United States within 12 months after the end of their PGY-1 year. Failure to do so requires that the resident be placed on administrative remediation and be considered for separation from the residency, as per directions of the Dept. of the Army if reasonable efforts are not made to achieve a license. When the resident is placed on administrative remediation their name and a monthly update is provided through the WBAMC Graduate Medical Education Committee to the Office of The Surgeon General. On paper, the OTSG will not allow the military resident to start their PGY3 year without a medical license. This does not necessarily mean that the resident's training will be extended and in most cases the resident is returned to good standing upon obtaining a medical license.

During the PGY2 or PGY3 year, military residents may choose to attend the Army Nuclear, Biological, and Chemical Casualty Care Course. This course is conducted at Aberdeen Proving Ground and Ft. Detrick, Maryland. Residents will also be given the opportunity to participate in sick call, learn how to write profiles, perform Medical Evaluation Boards (MEBs), and participate in military training exercises that have medical training benefit.

USMLE 3 and COMLEX 3 Requirements

All health care providers in the Army must possess and maintain a current license to provide patient care. The licensing jurisdictions include the individual states, District of Columbia, the Commonwealth of Puerto Rico, Guam, and the Virgin Islands. All trainees must show evidence of passing Part 3 of their respective Certifying Boards by the end of their PGY-2 year. Failure to have passed USMLE or COMLEX 3 are grounds for probation and extension of training. Residents may be placed on a remediation program by the midpoint of their PGY2 years if they have not passed Part 3. Do not delay obtaining this important requirement. Most interns will have passed Part 2 (USMLE or COMLEX) prior to the start of their intern year, but under no circumstance can the intern progress to the PGY2 level without passing Part 2 of their respective examinations.

Civilian Resident Licensure Requirements

Due to the requirement that International Medical Graduates (IMGs) require 2 years of ACGME approved training prior to applying for licensure, the requirement to have a license by the start of the PGY3 year is waived. Nonetheless, because of the length of time required to obtain a medical license, it is prudent for the civilian resident to begin applying for licensure late in the PGY2 year or early in the PGY3 year.

Program Directors Note: Take your USLME 3 or COMLEX 3 examinations in your PGY1 year, ideally before April. Eliminate this hurdle so that you can focus on Internal Medicine, optimizing your IM In-Training Examination Score and IM board preparation. PGY1 osteopaths should aim for the December testing date. For both allopathic and osteopathic students – June of your PGY1 year will be incredibly busy. USMLE Part 3 can be taken locally (but the paperwork can delay your testing for 2-3 months). USMLE fees are not reimbursable. Both military and civilian osteopath COMLEX examination fees and travel are not re-imbursable. Licensure application and licensure fees are not reimbursable.

Dress

All military interns and residents are expected to maintain high standards of military dress and decorum befitting active duty Army Medical Corps officers. The duty uniform is Class B's or BDU's. All military residents are required to have Dress Blues and a complete Class A uniform. During duty on weekends and national holidays, professional civilian attire is acceptable. Clothing will always be neat, clean, and of a professional nature. T-shirts, shorts, baseball caps and other types of casual wear are NOT acceptable professional clothing.

Civilian residents are expected to dress in an appropriate and neat manner befitting a professional physician, avoiding extreme styles or selections that could be considered offensive to patients or staff. (Avoid too little, too tight, or too short.) Open toe shoes and or sandals without socks are not allowed and considered a potential infectious disease problem. Artificial nails or long fingernails, likewise are not acceptable, due to infection control issues.

Surgical scrubs should not be worn all day every day. Surgical scrubs should be covered by a white coat when off the wards and may NEVER be worn to and from the hospital. Wearing hospital scrubs outside the hospital is a direct violation of the commander's policy and can result in UCMJ legal action. T-shirts may be worn underneath the surgical scrub top but not in place of the surgical scrub top. Ensure that you have a name tag that identifies your name and position.

Program Directors Notes: Recent violations of the dress code have included open toed shoes, low cut blouses with exposure of cleavage, too heavy of perfume, artificial nails, wearing non-authorized t-shirts with scrub bottoms, wearing only the BDU t-shirt without the BDU top. Look professional, be professional!

Mailboxes/CHCS/Outlook

All housestaff of the Department of Medicine have assigned mailboxes on the 8th floor. Mailboxes should be checked daily as important memos, messages, schedules, and other items are frequently distributed there. All residents will be held responsible for information distributed in the mailboxes. Many announcements, clinical questions, and information are distributed electronically via CHCS and Outlook. All resident must have an Outlook account. Increasingly, journal articles, critical pathways, algorithms, and communication will be distributed electronically. Command policy dictates that medical officers check their Outlook account once daily. Efforts to ensure that every resident and intern have their own PC should facilitate meeting this requirement.

Call Rooms/Food Availability

All Medicine interns and residents have designated offices and designated call rooms. Housekeeping will maintain the general appearance of these rooms (empty trash, vacuum, mop, clean restrooms), but it ultimately up to the housestaff to keep their rooms tidy. Clean linen is readily available. These rooms are equipped with telephones and computer access (CHCS, Outlook, Internet, IPAQ).

A wide selection of hot and cold food is available at an affordable rate in the hospital cafeteria from 0600-1800 daily. A snack bar and shopette is available from 0800-1630 M-F. The VA Clinic also has a snack bar and shopette. In addition carryout food service is available on the 1st floor around breakfast and the the noon meal to provide additional food access. Nutritional vending machines with microwave availability are available 24-7 on the 4th and 8th floor. A wide variety of fast food establishments deliver food free of charge to the hospital. Menus can be obtained in the ICU break room. Refrigerators and microwaves are available in the ICU and 9E break rooms to also facilitate after hours food access.

LEAVE /PASS /TDY/ PTDY

1. All military members request leave via a DA Form 31. Ms. Palomarez is available to help facilitate processing of administrative paperwork. Approving official is the Chief, Military Personnel after the Chief, Department of Medicine (or designate) approves the request. All leaves should be requested at least six weeks prior to the anticipated leave date to ensure processing and to help manage the call schedule. Leave, Pass, TDY, and Permissive-TDY may be denied or canceled by the Chief, Dept. of Medicine or Chief, Military Personnel because of failure to comply with administrative obligations such as medical records completion, Army Physical Fitness Test, or other serious breaches of professional behavior. This includes Paternity Leave (see below).

2. Residents are allowed 21 days of leave per academic year. Interns are allowed 14 days of leave. Leave time should be taken in 7-day blocks, but shorter durations are acceptable if requested six weeks in advance and approved by the Chief Medical Resident. Longer durations of leave may also be approved on a case by case basis. Interns should plan to take a 7-day block of leave during the Christmas holiday period as cross-coverage will be provided to facilitate every intern receiving either the week of Christmas or New Years off.

3. Leave should not be scheduled during in-patient services, PAMC rotation, during an ER rotation, or during educational block #13. Exceptional situations when leave must be taken during an unauthorized period will be handled on a case-by-case basis. Interns and residents are eligible for passes and emergency leave. These will be handled on an individual basis. PGY 3 residents must realize that their training period ends on 30 June and not immediately after the graduation ceremony. PGY3 residents must be able to cover any early departure from training with leave or vacation days.

5. Residents with presentations accepted to the Army ACP should expect to attend as a funded TDY. As with leave, requests are due at least 6 weeks prior to planned dates. Other opportunities for educational TDY may become available. Housestaff are encouraged to participate in such opportunities, but approval to do so must be obtained from the Chief, Dept. of Medicine or the Program Director.

6. VA leave should also follow the above guidelines and can also be initiated through Ms. Palomarez or through

Ms. Sherry Bailey. Approval of both WBAMC and VA supervisors is required. Sick leave needs to be processed also through Ms. Sherry Bailey at the VA.

Program Director Notes: Remember that leave days, vacation days, passes involving weekdays, sick days, paternity and maternity leave count against the minimum number of weeks required to meet RRC-IM graduation requirements and eligibility to sit for the American Board of Internal Medicine certification examinations. In most cases, this has not been a problem since residents can be excused for up to 4 weeks per year (12 weeks total) if required by special circumstances. In cases of pregnancy or other illnesses, training may need to be extended if minimum training requirements can not be met.

Pregnancy in Housestaff

1. Pregnancy may impact on the ability of an individual to perform duty that is a necessary part of accredited training. We strive to individualize the management of pregnant housestaff officers with regard to the GME program. In no case will either the mother or fetus be placed at risk in order that the requirements of the curriculum are met. Suspected pregnancy should be confirmed at the first opportunity and the Program Director should be informed. The resident and her physician will independently decide management of the pregnancy. The fulfillment of the curricular requirements should be decided by the Program Director after consultation with the house officer and, if necessary, her physician.

2. Occupational Health Considerations: There are circumstances in which the normal exposures of housestaff duty may be possibly teratogenic or otherwise increase risks to the fetus. Examples include rubella exposure, radiation, or specific drugs/anesthetic agents. The physician managing the pregnancy should know precisely what exposures are to be expected and inform the housestaff and Program Director of any contraindications.

3. Time and Stress Considerations: The ability of the pregnant house officer to fulfill the responsibilities of her training should be decided jointly by her and the physician managing her care. The Program Director will not independently make this decision, nor will it be left entirely up to the pregnant house officer.

4. Academic Consideration: Where possible, the curriculum will be adjusted to allow the pregnant house officer to fulfill the requirements of the program within the normal time restrictions.

a. When the pregnant house officer is not capable of duty compatible with fulfilling the requirements of her program, she will be assigned duties, where possible, that enhance the previous and subsequent portions of her education.

b. At the completion of the pregnancy and a 6-week period of convalescent Maternity Leave (or longer if determined to be necessary by the individual's physician), the Program Director in conjunction with the faculty of

the department, will review the educational continuum of the pregnant house officer and decide on the temporal and curricular requirements necessary to fulfill the educational goals of the program. If an extension of training is required, approval of the hospital Graduate Medical Education Committee will be sought.

c. There is no Army policy for Paternity Leave, however our program will grant Paternity Leave to male housestaff upon the birth of their child(ren). This period will consist of 96 hours immediately following the birth of a child, which (for military members) must be charged as “regular leave” for administrative purposes. These four days are in addition to the number of Leave days normally granted to housestaff for the given academic year but count against the number of weeks required to meet graduation requirements. In most cases, there is enough leeway in required training days that this is not an issue. As a point of clarification, if some of the four days fall on a normal weekend, national holiday, or training holiday they will still count as part of the four days of Paternity Leave. Official Leave is only required for days of absence which are normal duty days. As it is usually impossible to predict exactly when this leave will begin, a DA Form 31 should be prepared in advance with open dates which can be completed to cover the duty days during the 96-hour period after the child is (or children are) born.

VA residents (male and female) must adhere to regulations established by the VA for Maternity and/or Paternity Leave. If possible, the Leave durations and practices should closely approximate those for military housestaff members.

It is the responsibility of the housestaff member going on Paternity Leave to secure appropriate care of the patients for which he is responsible and to obtain relief from other duties (such as AMOD responsibility) when going on Paternity Leave. Whenever possible, the schedule will be adjusted in advance to preclude the need for obtaining such relief from patient care or administrative duties, but at a minimum the “new father” should inform his service’s attending and the Chief Medical Resident when the mother of their child goes into labor, and ask for assistance in being properly relieved of duty.

5. Adoption Leave: There is no Army policy for Adoption Leave, however our program will grant Adoption Leave to male or female housestaff upon the adoption of their children. This period will consist of 96 hours immediately following the adoption of a child, which (for military members) must be charged as “regular leave” for administrative purposes. These four days are in addition to the number of Leave days normally granted to housestaff.

6. Child Care: It is the responsibility of every individual to make necessary arrangements for care of dependents. If, after appropriate counseling, a housestaff member fails to do so, he or she will be subject to academic probation and/or termination from training.

Illness or Emergency Leave

1. Coverage for a resident on an inpatient service will be provided by the assigned AMOD, if the former has an excused absence.

2. If an intern or resident assigned to a ward or unit team finds that he/she will be late or absent from normal duty, it is that person’s responsibility to personally notify the Chief Medical Resident and the PAMC (if necessary) as early in the day as possible, so that coverage can be arranged. If a team member is not present in the hospital by 09:00 on normal duty days, it is the other team members’ responsibility to notify the Chief Medical Resident of this fact.

3. If the absence is due to illness, an appropriate evaluation and sick slip will be required and must be submitted to the Chief Medical Resident.

4. Coverage by the AMOD for another resident will be paid back at a mutually agreeable time set by the AMOD, as approved by the Chief Medical Resident

Fatigue

The WBAMC Internal Medicine Residency Program is committed to Resident and Patient Safety. Increasing amounts of research from both medicine and other industries point to performance lapses and poor judgment associated with sleep deprivation. Fatigue can contribute not only to safety problems at work, but as importantly safety problems associated with sleep deprived residents and automobile accidents. Sleep Deprivation training will be provided to 100% of residents and teaching staff in each academic year. While this is an ACGME mandate and monitored by the GMEC, it is the duty of the Program Director, the Chief Resident, and the teaching staff to monitor for fatigue and make alternative arrangements when resident or patient safety is in question. It is also the duty of the residents to report excessive fatigue to their teaching staff, Chief Resident or Program Director without fear of adverse action.

Policy on “Moonlighting”

It is the policy of this hospital that house officers will not moonlight - even when off duty. Physician staff members must obtain formal approval from the Commander before entering into any off-duty work arrangement that is not covered by leave.

ACLS/BCLS:

It is the responsibility of all housestaff to insure that their certification in Basic Cardiac Life Support (BCLS) and Advanced Cardiac Life Support (ACLS) NEVER lapses. If the BCLS expires, the resident must attend the full day course (no exceptions), which is usually held on a Saturday or offered in an all night session. Residents with expired BCLS cards cannot participate in patient care and therefore are mandated to take leave. Military residents may also be tasked with Administrative Officer of the Day duty. The AMOD may need to be activated to cover these unexcused absences with full payback by the perpetrator. Ample warnings are given to the resident throughout the academic year.

Medical Records

1. Standard Forms 504, 505, 506 ("Long Form" Admissions)

- a. The ward resident will determine on admission whether the admission represents a long or short stay, and will ensure that the appropriate long or short forms are completed in an organized and legible fashion.
- b. The admission H&P should be completed as soon as possible and must be complete and **in the chart** within 24 hours.
- c. A resident admission note (RAN) will be completed and in the chart prior to termination of the duty day. This may be a brief note particularly for patients admitted on a short form. The RAN must be completed by an PGY2 or PGY3 (even in period 13).
- d. Intern (and resident) H&Ps must be cosigned by the attending physician (a licensed independent practitioner).
- e. Interim notes are acceptable as admission paperwork if the patient is admitted within 30 days of a previous hospitalization, and if the reason for admission is similar. Interim notes should contain a capsule of the patient's past history, active problems, and interim history since the previous admission. For an Interim note to be acceptable, the patient must be cared for by the same physician who cared for him/her on the previous admission. A patient admitted at night or on the weekend by a call team, who will be cared for on the following day by the same GM team involved in the previous admission, may be placed on an interim note. Interim notes should be accompanied by at least a brief resident note documenting the resident's evaluation of the patient and circumstances of admission.
- f. Use of the problem-oriented format is strongly recommended.
- g. The intern's, resident's, and Attending's names should be printed or stamped under the appropriate signature as it first appears on the medical record.
- h. All patients admitted to an intensive care unit (ICU) will have a long form history and physical and a resident admit note regardless of the patient's status. Interim notes and short forms are not permissible.
- i. The formatting and content of the H+P long form has requirements that have been directed by the Chief of Medicine (Dr. LeMar). Below are the minimum requirements:

1) Chief Complaint: Brief reason why the patient presented.

2) HPI: This should be an expansion of the Chief Complaint, and should have clinically relevant Information to include pertinent positives and negatives for a particular complaint, that helps the internist develop a likely differential diagnosis.

3) History: A complete and rigorously obtained database of the patient. A complete listing of all Past Medical and Surgical history, Medications, Allergies (outline type of reaction), Social History (To include current and past Tobacco, EtOH, and illicit drug use, occupation and potential exposures; travel, current residence), and Family History of Medical Disease.

4) Review of Systems: This should be an organized approach using a complaint directed focus to help eliminate or include possible etiologies for the patient's current complaint, or by the patient's clinical presentation. See HPI is not acceptable.

5) Physical Exam: Vital signs must always be present, to include the patient's current weight. At a minimum a general exam is performed with special attention to the areas of concern.

Remember pain is the 6th vital sign and should be included in your physical exam and thoroughly delineated in your H&P or ROS.

6) Lab/Rad Database: This is to document initial laboratory data and impressions of radiographic studies that have been obtained at the time of admission.

7) Assessment: You will use a problem-based approach to the patient with an appropriate differential diagnosis that is patient specific.

8) Plan: A logical and well thought out diagnostic and treatment plan based on the problem list generated.

9) Finally, ensure that H&P is dated and signed. Use pre-printed name stamp. Ensure legibility of the entire medical record. All H&Ps must be co-signed by a licensed independent clinician (e.g. your attending staff). All medical student H&P in addition to being closely scrutinized by supervising interns and residents, also needs the cosignature of the attending staff along with a note demonstrating that key aspects of the H&P were reviewed and repeated.

Please see examples of H&Ps and other medical records documents in the "Sample Book".

2. Abbreviated Medical Record SF 539 ("Short Form")

- a. An abbreviated medical record, or "short form," may be used in lieu of the formal long form if the patient is expected to be hospitalized less than 48 hours.
- b. Patients admitted on a short form whose hospital stay lasts greater than 48 hours must have additional documentation that clearly explains why the patient has remained hospitalized longer than initially intended.

3. Transfer Notes

- a. Transfer acceptance notes may serve as initial paperwork upon transfer of the patient from other services in the hospital.
- b. Transfers from the medical service to other services must have a written transfer note accompanying the patient.
- c. Transfer to the medical service from other WBAMC inpatient services should also be accompanied by a written transfer note.
- d. The transfer note is the primary responsibility of the intern.
- e. Telephonic notification between transferring resident and accepting resident is mandatory to ensure continuity of care and that the present management plan is understood.
- f. Transfer accept notes should have pertinent history and physical findings outlined and should be treated like H&Ps by the attending with an appropriate co-signature and note acknowledging acceptance (change in attending staff) and an appropriate new staff acceptance.

4. Attending Staff Notes

- a. The attending staff will write a brief note on all patients after evaluating the patients and their care plan. Staff notes should be written on all new admissions, all transfers to or from the unit, any time there is a change in attendings (except for brief periods of coverage), and with any significant change in patient status.
- b. The attending staff should review the quality of housestaff medical record keeping, and make recommendations to the resident or intern to improve charting procedures as necessary.
- c. Attending notes should comment on Advanced Directives. All patients in a DNR status should have a staff note that addresses this issue.

5. Progress Notes

- a. All patients (Wards, Units) must have daily progress notes. All notes must be: 1) clearly legible, 2) have date and time, and 3) must bear the stamp and signature of the author. Printing of the author's name is a less ideal option.
- b. All blood product administrations and procedures must be documented in the progress notes. Consent is required for these procedures and an appropriate counseling note should be documented.
- c. Progress notes should be written in a SOAP (subjective, objective, assessment, plan) format.
- d. The daily progress note must contain specific and clear comments regarding the problem list and:

- 1) response to therapy
- 2) results of tests and consultations
- 3) plan changes with regards to 1 and 2.
- 4) pain assessment
- 5) restraint documentation if restraints required

e. Anticipated problems or complications should be noted in the progress notes, and should be verbally checked out to the on-call housestaff to ensure optimum follow-up and management during on-call hour.

6. Discharge

The discharge note is generated on the mandatory paper or computerized forms at the time of discharge with particular care in regard to discharge diagnoses, discharge medications, and follow-up appointments. Write this note with concise detail regarding in-hospital treatment and findings. Put in all the things that you would like to see regarding the patients you follow-up after they have been hospitalized. The discharge note is the primary responsibility of the intern. As noted previously, to facilitate timely discharges, a brief OP10 can be given to the patient with a more detailed OP10 to follow.

7. Narrative Summary

a. Unless a complete computerized discharge note is completed immediately prior to discharge, the team intern should dictate a narrative discharge summary within 72 hours of a patient's discharge for all hospitalizations lasting more than 72 hours.

b. Narrative discharge summary format is proscribed by the Medical Records section.

c. On transition to a new rotation, the previous ward or unit intern is responsible for completing narrative summaries on any patient discharged up to 48 hours after he/she leaves the team. This rule is suspended if the patient was in the care of the previous intern for less than 72 hours. Any patient discharged greater than 48 hours after the change in care is the responsibility of the current intern.

Performance Evaluation

The Department of Medicine uses several different methodologies for evaluation of the house officer's performance:

a. An In-Training examination is given each academic year, usually in October. The exam is prepared by the American College of Physicians and uses multiple-choice questions to simulate the American Board of Internal Medicine certification exam. The In-Training exam is not used to determine whether the resident will advance to the next academic year. It is, however, anticipated that the exam will give the residents feedback as to their academic standing within their class and nationally. In-Training exams will also be used by the Department of Medicine as a tool to assess the strength of its curriculum overall and in each specialty area. In general a score during the R2 year of < 35% has a 90% predictive value that the resident will subsequently fail his Certification exam. Any resident or intern that scores below the 35th percentile will be placed on a remedial plan or program remediation.

b. Each resident or intern will be evaluated monthly by his or her attending physician via MyEvaluation.com. The attending will review the evaluation with the intern or resident at the completion of the rotation. Residents will review their evaluation via MyEvaluations.co and indicate whether face-to-face feedback occur. The system allows the residents to immediately respond to their evaluation. Problems or questions should be directed up the academic chain of command if not resolved at the resident / Attending level. The forms are given final review by the Program Director/Chief of Medicine and placed into the permanent files within the Department of Medicine.

c. Each resident and intern fills out and submits an evaluation of the teaching faculty semiannually. Interns and residents will also complete peer review. In addition residents are evaluated by nursing staff and other ancillary personnel. Feedback from these sources (360 degree review) are utilized in the resident's annual summative evaluation. Residents meet every 6 months with the Program Director or designee.

d. An academic file is maintained on each housestaff in the Department of Medicine which contains all evaluations, procedures, licensure information, as well as favorable and unfavorable actions. This file is important even after graduation, since every application for licensure or staff privileges requires a review and summary of the academic file. Files may be reviewed but may not leave the office of the Education Technician.

e. The Program Director, Education Committee and inpatient ward staff meet after each rotation to discuss the progress of all housestaff within the department. Each trainee is discussed individually in this meeting. Interns and residents felt to have problems while on an individual service are counseled at the time of their problem.

Significant problems are referred to the Program Director for counseling. Records are made concerning this counseling. The Program Director or designate will formally meet with each housestaff at least twice a year to review their progress and obtain their input.

f. The Education Committee for the Internal Medicine Residency consisting of the Chief of the Dept of Medicine, the Chief Medical Resident, Program Director and four senior staff members will review the performance of residents quarterly. The form used to track progression during the individual PGY years is included in the appendix. In cases of marginal performance by a house officer, the group will vote regarding appropriate disposition of the resident. A two-thirds majority will be required for placement of the resident on probation, delay in his/her progression of training, termination of his/her training, or any disposition besides continuation of training.

g. Every medicine resident and categorical medicine intern is evaluated each rotation with a Mini-Clinical Examination (Mini-CEX). The Mini-CEX is an efficient, effective evaluation tool that is designed to assess your clinical skills. As part of our evaluation system, all residents are expected to participate in Mini-CEXs. The Mini-CEX is a short, focused activity that provides the opportunity for you to be observed interacting with a patient in any clinical setting (inpatient ward, ambulatory clinic, emergency department, etc.). During this 15-20 observation, you may be evaluated in the following areas: medical interviewing skills, professionalism, clinical judgment, counseling skills, organization/efficiency, and overall clinical competency. The Mini-CEX is one of a number of strategies we use in evaluating your performance throughout residency. The Mini-CEX will replace the once yearly comprehensive CEX evaluation.

. Instructions:

- Complete one Mini-CEX on each and every medicine rotation – this includes MICU, CCU, Ward, subspecialty Medicine rotations (to include dermatology). Minimum for interns is 10 for the year. Minimum for residents is 4 per year.
- Request attending or teaching faculty to observe you evaluate a patient.
- Provide faculty with Mini-CEX forms to document the exercise. Faculty also have received the Mini CEX forms and have been given instructions regarding this requirement. Ultimately, though, the responsibility for completion depends upon you. Contact Dr. Carmichael, Ms. Palomarez, or myself if you lose your book and a replacement will be provided.
- Conduct an “observed” patient interview and evaluation that is focused and appropriate to the patient’s complaint. Please be concise and organized.
- Ask the attending to complete the evaluation form and provide you with direct feedback. Once the evaluation is complete, both you and the faculty member are required to sign the form. I have attached a “parking ticket” type book. You should retain the “yellow” copy. The “white” copy should be forwarded directly to the Program Director or Department of Medicine Education Office. The original needs to be forwarded to Program Director or Department of Medicine Education Office.

h. The ACGME has outlined 6 core competencies that will be assessed during a resident’s training. These competencies and evaluation tools are further outlined in the ACGME Web Page. Particular evaluation tools that will be utilized this academic year are: Chart-Audit Recall, Mini-CEX, and 360 degree evaluations. In the appendix is an abbreviated description of the core competencies and a description of these measurement tools from the ACGME “toolbox” along with a recent review from Annals of Internal Medicine.

Scholarly Activities

Housestaff may select either a "Research" or an "Academic" track for their scholarly activities, as described below. Housestaff will be "mentored" through their scholarly activities by a staff member from the Dept of Medicine or an approved mentor from outside of the Dept of Medicine. This will insure quality efforts and quality results. Each housestaff member has 3 months to select a staff member as his or her mentor. After 1 November a staff mentor will be assigned. The mentor and housestaff together will determine the precise nature of the scholarly activity to be pursued.

The Research and Academic track projects must be approved by the Dept of Medicine Research Committee as fulfilling the scholarly intent of this residency requirement.

Research Track: This is the preferred and strongly encouraged track for fulfilling the scholarly activity requirement. Residents who are interested in fellowship training following residency should strongly consider choosing this track over the Academic Track. Consists of development, initiation, conduct, and presentation of results from a research endeavor. The research endeavor may be either basic science/animal model research, a clinical protocol involving human subjects, or a chart review of practice and/or outcome evaluations, etc.

For the research track, the resident must develop an idea and present it to the Dept of Medicine research committee for approval prior to submission to the Institutional Review Board for approval. This approval by the Dept of Medicine Research Committee should be done at an early stage of development of the project and should occur no later than 30 Nov of the 2nd year of residency. The formal IRB approval should occur by no later than 31 Jan of the 2nd year of residency in order to provide time for the completion of the protocol prior to graduation including a manuscript. A resident may also participate in an ongoing research effort to fulfill this requirement but must make a significant contribution to this effort and should be involved to the extent that they could submit a manuscript as the first author in order to fulfill the requirement. Augmentation of a smaller role in a research project with another scholarly effort may also fulfill the requirement if approved by the Research Committee.

A single Research Track effort may fulfill the scholarly activities for all three years of the residency if approved by the Dept of Medicine Research committee. This committee will determine if a Research Track endeavor fulfills partially or completely the scholarly activities requirement. Projects, which only partially fulfill the requirement, will be augmented by additional Academic or Research efforts.

Academic Track: Consists of literature reviews, papers, and oral presentations as described below for residents and interns.

Resident Paper and Lecture

The resident project entails a paper of publication quality with at least 5 references. This paper is then converted to a slide-type format for a 50-minute oral presentation to the Dept. of Medicine. Each resident is to write a paper and present a lecture pertaining to it in each year after internship. (The paper and lecture must be about a different topic each year.) This lecture will be presented at a morning conference attended by both staff and housestaff. Copies of the paper will be provided as a handout. Handouts, lecture materials, and slides should be the original material of the resident, or otherwise footnoted.

If the lecture is of sufficient quality, the staff will help the resident prepare it for presentation at a national or local meeting or for publication. Residents are encouraged to submit their work for publication or formal presentation, as this will significantly augment future aspirations towards fellowship and career paths.

The lecture will be evaluated by at least two pre-selected staff members and possibly other housestaff. The results of the evaluation and constructive feedback will be given to the resident by the staff members and/or the Chief Medical Resident.

Intern "Flea Circus" Presentations

One "flea circus" presentation is required of each medicine intern during his/her internship year. This consists of a 15-minute slide presentation structured around an interesting case that has been seen by the intern, followed by a concise review of the literature. At least five references should be included on the handout, which accompanies the presentation. The handout, lecture materials, and slides should be the original material of the housestaff. If they are not, notations should be included.

Interns may expand their flea circus case into a resident lecture during their residency years. Staff members are encouraged to help interns expand their presentations into abstracts and/or case presentations suitable for submission to medical journals and meetings such as the local, national, and U.S. Army American College of Physicians (ACP) meetings.

Resident Procedure Tracking

- a. All residents are required to keep a record of the invasive procedures, which they perform or assist with. Housestaff record the procedures in the CHCS computer system to track their procedures. Housestaff are responsible for having certified staff or housestaff evaluate each procedure performed. House officers are responsible for submitting the data at regular intervals for invasive procedure certification.
- b. Prior to being certified for a given invasive procedure, housestaff should not perform that procedure without direct supervision by a credentialed staff member or by another certified house officer. Housestaff are certified on a case-by-case basis by the Dept. of Medicine for proficiency with a given procedure when they have completed and properly documented the minimum number of successful attempts for that procedure.
- c. Procedure records are essential to the final evaluation of procedures at the completion of residency training.

Procedure credentials cannot be granted without proper documentation. Lack of credentials will negatively influence the future assignments and employment opportunities of graduating housestaff.

- d. Residents are not credentialed to do procedures. Credentials are only granted to staff physicians via the Credentials Committee under the guidance of the hospital commander. Residents are certified to perform a procedure after successfully performing a certain number. Certified residents perform the procedure under their attending staff's credentials.
- e. Minimum number of invasive procedures required by the WBAMC Department of Medicine before a resident can be certified:
- Radial arterial line: 5
 - Femoral arterial line: 5
 - Pulmonary artery catheter: 5
 - Internal Jugular vein cannulation: 6
 - Subclavian vein cannulation: 10
 - Femoral venous cannulation: 6
 - Electrocardioversions: 5
 - Temporary cardiac pacemaker insertions: 5
 - Thoracentesis: 5
 - Lumbar punctures: 5
 - Paracentesis: 5
 - Flexible sigmoidoscopy: 25
 - Endotracheal intubations: 5
 - Bone marrow biopsy: 5
 - Cardiac stress test: 50
 - Skin biopsy: 3
 - Knee arthrocentesis: 3
 - Nasogastric tube insertion: 3
 - Rectal examination: 5
 - Breast examination: 5
 - Pelvic examination and Pap smear: 5

The American Board of Internal Medicine (ABIM) recommends the following minimum number of directly supervised, successfully performed procedures to confirm proficiency: 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 and pap smear, including wet mount (5).

f. Resident procedure logs are updated monthly by a review of CHCS by Ms. Palomarez with a report given to the Program Director. Procedure certification is likewise updated monthly on the hospital Intranet to ensure that other key personnel have immediate access to procedures that residents are permitted to perform with indirect supervision.

Please see Resident Supervision Policy in appendix for more details regarding resident procedure supervision.

Resident Grievance Procedures and DUE PROCESS

Both DUE Process and the Resident Grievance Procedure can be found in the Graduate Medical Education Handbook. If there are any questions or concerns, residents have several points of contact to include the Chief Resident, the Program Director, the DME, the GME administrator, Ms. Palomarez, the DCCS, the Commander, and the ombudsman. The Grievance Procedure is part of the resident contract and the most current DUE Process is given to each resident for review and signature of acknowledgement.

Department of Medicine Resident Performance Standards

A. Ward and

1. Standard: satisfactory completion of all ward and clinic rotations (i.e an overall grade of 4 or higher for residents and interns)
2. Grounds for recommending program-level remediation or probation:

- A grade of one or two (fail) on any one evaluation (for interns “unsatisfactory” or “marginal”) or
- A grade of two or three on two evaluations during the three-year training program (for interns “below average”).

B. Continuity Care Clinic

1. Standard: satisfactory semi-annual evaluations.
2. Grounds for recommending program-level remediation or probation
 - Same as above.

C. Procedural Skills

1. Standard: satisfactory progress, as outlined below, toward acquiring the procedural skills required of a general internist.
 - First year: achieve 1/3 of the required skills.
 - Second year: achieve 2/3 of required skills.
2. Grounds for recommending program-level remediation or probation
 - Completion of < 50% of the required procedures by the end of the second year of training.
 - Residents will not graduate from the program if, in the judgment of the program director, significant deficiencies remain in their procedural skills at the conclusion of their final year of training.

D. Clinical Evaluation Exercise (Mini-CEX)

1. Standard: First year: Mini-CEX evaluation on 80% of rotations (10/13) and an overall grade of satisfactory or above on 60% (8/13 rotations).
2. Grounds for recommending program-level remediation or probation:
 - Failure, at the end of an academic year, to have achieved at least a satisfactory grade on 60% (8/13).

E. In-Service Examination

1. Standard: Take the examination every year and score above the national average.
2. Grounds for recommending program-level remediation or probations:
 - unexcused failure to take the examination
 - score < 35th percentile will result in program remediation.

F. Research Project

1. Standard: Interns will present a clinical vignette at the end of their PGY-1 year (target April, May). Each PGY-2 and PGY-3 resident will give a lecture annually on a selected core or subspecialty topic in Internal Medicine. These lectures will start in October and be spaced throughout the rest of the academic year in place of an AM lecture. Housestaff are required to provide a handout at the time of their lecture. This handout is not to be a simple reproduction of slides used in the presentation. It should be written similar to a textbook chapter and should contain five or more references. This is part of the scholarly activity required by the ACGME and it is described in more detail later in this handbook.
2. Grounds for recommending program-remediation or probation: Failure for interns to adequately prepare and present clinical vignette or residents to present academic lecture. Residents will not graduate from the program if, in the judgment of the program director, no satisfactory scholarly activity has been completed during the period of training.

G. Additional Performance Indicators:

Performance Checklist for PGY1 Residents (Interns)

- 10 mini-CEXs
- 4 Stressful Events (1 per quarter)
- 4 History and Physicals (due before 31 Dec 2004 or midpoint of academic year)
- Attend 5 Tumor Boards (Wed at 1300 – 2nd floor Surgical Conference Room)
- Research Requirement: Clinical Vignette
- 36 weeks of continuity clinics
- 210 inpatient evaluations (based on teaching team admission data not individual logs)
- Maintain ACLS and BCLS certification
- Military: Complete C4 (ATLS) and MUC; pass APFT
- Score > 35th percentile on ITE
- Performance of on average 1/3 of required procedures
- Process Improvement Project (group project)
- > 70 percent attendance at all teaching conferences

Additional recommendations:

- Pass COMLEX (Dec or June) or USMLE Part 3 (strongly recommend you get it out of the way now!)
- Presentation at Army ACP or Far Northwest Texas ACP Associates Forum
- Publication in *El Paso Physician*
- Prepare to submit research protocol to work on in PGY2 year

Performance Checklist for PGY2 Residents

- 4 MiniCEXs
- 4 Continuity of Care Cases
- 4 Evidence Based Medicine Case Reviews
- 2 Stressful Events
- Attend 5 Tumor Boards
- Research Requirement: Academic paper and presentation
- 36 weeks of continuity clinics
- Maintain ACLS and BCLS certification
- Obtain medical license (exception for IMGs if they require 2 yrs of training)
- Score > 35th percentile on ITE
- Performance on average of 2/3rds of required procedures
- Performance Improvement Project (group project)
- > 70 percent attendance at all teaching conferences

Additional recommendations

- Presentation at Army ACP, Texas ACP, Far Northwest Texas ACP Associates Forum or Southern Medical Journal Conference.
- Publication in *El Paso Physician*, *Military Medicine*, *Southern Medical Journal* or other peer-reviewed journal.
- Write and submit research protocol, conduct research.
- ACLS Instructors Course

Performance Checklist for PGY3 Residents

- 4 MiniCEX's
- 2 Continuity of Care Cases
- 2 Evidence Based Medicine Case Reviews
- 2 Stressful Events
- Attend 5 Tumor Boards
- Research Requirement: Academic paper and presentation
- 36 weeks of continuity clinics or total of 108 weeks for residency
- Maintain ACLS and BCLS certification
- Maintain medical licensure
- Geriatric rotation
- Score > 40th percentile on ITE
- Completion of required procedures (ideally) or minimum ABIM procedural requirements
- Do not forget to register for ABIM examination (usually end of November)
- Competency in EKG interpretation
- Process Improvement Project (group project)
- > 70 percent attendance at all teaching conferences

Additional recommendations:

- Presentation at Army ACP, Texas ACP, Far Northwest Texas ACP Associates Forum or Southern Medical Journal Conference.
- Publication in *El Paso Physician*, *Military Medicine*, *Southern Medical Journal* or other peer-reviewed journal.
- Write and submit research protocol, conduct research, analyze data, present research (WBAMC Research Day, Army ACP)
- Medical Management of Biological and Chemical Warfare Casualties Course

- Tropical Medicine Course
- Board Review Course
- ACLS Instructors Course

Incentives: > 75th percentile on ITE – Free CME trip within continental US
 > 90th percentile on ITE - Free CME trip Europe or Hawaii

Major Program RRC requirements:

1. 80 hour work week; 1 day off on average per 7 days
2. 24/6 Rule: After 24 hours of continuous duty cannot start new patient workups (does not apply to continuity clinics)
3. ½ day of continuity clinic per week for 36/52 wks of the year (total 108 for residency). Intern year 3-5 patients per clinic.
4. Cap: Interns – 5 new admissions 2 “bouncebacks or transfers” per 24 hours or 10 new admissions or 4 “bouncebacks or transfers” per 48 hours. Resident is 10 + 4 in 24 hours. Backup is resident, AMOD, or attending staff. Please see the acgme website or discuss with program director for further delineation of requirements.
5. Everything you do is directly or indirectly supervised. See Resident Supervision policy in appendix.
6. Interns: 210 H&Ps (calculated off teaching team admissions divided by number of medicine interns plus transitional intern equivalents).

DOM Requirement for inpatient charts:

1. All intern and unlicensed resident H&Ps must be cosigned by licensed independent physician (attending staff).
2. All medical student notes must be cosigned by licensed independent physician – pertinent portions of the history and exam must be repeated.
3. Restraint policy: Orders updated with re-evaluation q 24 hrs.
4. All signatures should be stamped
5. All entries must be TIMED and dated
6. Fill out Multi-disciplinary sheets at front of chart
7. Fill out physician portion of Educational evaluation
8. Visit chart room once weekly (sign-in roster)
9. Update Allergies on CHCS
10. Perform inpatient chart reviews (2 per month on the Wards)

CALENDAR OF EVENTS 2004-2005

July:	Meet with Chief Medical Resident Turn in Goals and Objectives of OER (military) Join the ACP as an Associate Start planning Army ACP abstracts Diablo Baseball Medicine night VA Resident Orientation 13 July 2004
August:	Counseling Session with Program Director for interns Pick a mentor Super Senior Rotations Deadline for Army ACP submissions Welcome Potluck Dept of Medicine Senior Resident Board Review Chief Resident Interviews
September	Military Fellowships Application completed Registration period for ABIM (1 Sep 04 – 1 Dec 04 for exam on Aug 2005) Select Chief Resident
October	In Training Examination

	Deadline for National ACP abstracts Doctor's Dilemma (Jeopardy) tune-up with Texas Tech
November	Texas ACP (San Antonio) – Nov 7-9 Army ACP (Crystal City, Virginia) – Nov 11-13 Seniors: Deadline registration for Aug 2005 ABIM examination is 1 Dec 2004. ABIM Board Results from Aug 2003 exam
December	Joint Selection Board 30 Nov – 4 Dec 2004 Holiday Time – Interns 1 week mandatory X-mas or post-Xmas Department of Medicine Christmas Party COMLEX 3 exam (for DOs)
January	ITE results come back Mid Year Counseling Awarding of Incentive trips for high ITE scores Interns plan to take USMLE 3 examination Rodeo
February	Retreat – chaplain service (interns) DOM Chili Cook-Off
March	Deadline for Southern Medical Journal Abstract/Posters
April	Resident and Teaching Staff Retreat Transition to Practice Seminar National ACP/Association of Program Directors IM/Chief Resident Meeting
May	Far Northwest Texas Associate's ACP competition WBAMC Research Day Schedule for Academic Year 2004 released Complete Military Unique Curriculum
June	Intern/Resident Graduation – Dress blues DOM End of Year Party COMLEX 3 exam (for DOs) New intern orientation All research requirements and MiniCEXs completed

Please Note: The date of the graduation ceremony is not the date your training obligations end. If you plan to sign-out of WBAMC before 30 June 2005, you must cover those days out of your leave (vacation) time. Plan ahead.

Websites

www.abim.org (American Board of Internal Medicine)
www.acgme.org (American College of Graduate Medical Education)
www.ecfmg.org (Education Committee for Foreign Medical Graduates)
www.mods.army.mil/medicaleducation

www.apdim.org
www.army.mil
www.navy.com
www.armymedicine.army.mil
www.va.gov
www.wbamc.amedd.org.med
www.mdconsult.com
www.acponline.org
www.ama-assn.org
<http://143.83.32.120/ami/html> (RadWorks)

APPENDIX

Updated 11 November 2003

WILLIAM BEAUMONT ARMY MEDICAL CENTER

INTERNAL MEDICINE RESIDENCY PROGRAM

SUBJECT: Policy on Resident Supervision

1. Purpose. This policy outlines requirements for supervision of internal medicine residents in training at William Beaumont Army Medical Center (WBAMC). WBAMC adheres to the requirements of the Accreditation Council for Graduate Medical Education (ACGME). The ACGME requires that “residents must be supervised by teaching staff in such a way that the residents assume progressively increasing responsibility according to their level of education, ability and experience.” This process is an underlying principle for the Internal Medicine Residency training program.
2. References.
 - a. 40-68, Quality Assurance Administration.
 - b. Accreditation Council for Graduate Medical Education (ACGME) Graduate Medical Education Directory.
 - c. Joint Commission on the Accreditation of Healthcare Organizations (JCAHO), Standard MS.2.5.
 - d. William Beaumont Policy on Supervision of Residents (WB Reg 351-3).
 - e. William Beaumont Army Medical Center Internal Medicine Resident Handbook
 - f. William Beaumont Army Medical Center Restraint Policy (WB Reg 40-3-9)
3. Special terms used in this regulation are listed in the Glossary.
4. Overview of Responsibilities.
 - a. Commander. Addresses graduate medical education program needs and makes necessary resources available to respective programs to ensure appropriate resident supervision is provided at WBAMC.
 - b. Deputy Commander for Clinical Services (DCCS). Oversees the quality of care provided by attendings and residents at WBAMC.
 - c. Director of Medical Education (DME). Oversees and administers the Graduate Medical Education (GME) programs.
 - d. The Institutional Administrator. Assist the DME in overseeing and administering the GME programs.
 - e. Internal Medicine Program Director.
 - (1) Ensures the quality of overall internal medicine resident education and training.
 - (2) Ensures the program is in substantial compliance with the policies of the respective accrediting or certifying body.
 - (3) Defines the levels of responsibility for each year of training by preparing a description of the types of clinical activities that residents may perform and those for which residents may act in a teaching capacity.
 - (4) Selects, in consultation with the Chief of Medicine, the attendings from available Licensed Independent Practitioners (LIPs) internal and external to WBAMC. All attendings will be board-certified or board-eligible internal medicine physicians.
 - (5) Ensures appropriate resident supervision.
 - f. Associate Program Director. Assists the program directors in their responsibilities.
 - g. Attending.

(1) Ensures, and is personally involved in, the care provided to individual patients in inpatient and outpatient settings.

(2) When a resident is involved in the care of a patient, continues to maintain a personal involvement in the care of that patient.

h. Residents.

(1) Must not attempt to provide clinical services or do procedures for which they are not fully competent. They must be informed by their program director of the graduated level of responsibility described for their level of training and instructed not to practice outside of their scope of capabilities.

(2) Must make all efforts to communicate to the attending significant issues as they relate to patient care and document such communication in the medical record.

(3) Must be aware that failure to function within graduated levels of responsibility may result in adverse action towards them as outlined in the due process section of the WBAMC Resident Guidelines.

5. Policies and Procedures.

a. General.

(1) WBAMC patient care and health profession training occurs together and there is a delineation of responsibilities to ensure that patients are cared for by qualified practitioners, whether they are trainees or staff. It is also required that as residents acquire higher levels of knowledge and skill they will assume increasing responsibility for patient care.

(2) Clinicians must be qualified to deliver patient care and this care will be documented in the patient's record. With medical care increasingly delivered in outpatient settings, these principles are as relevant to outpatient as they are for inpatient settings.

(3) Documentation of patient care, for the purposes of third-party billing, is governed by guidelines defined by payers and is not covered in this document.

b. Graduated Levels of Responsibility.

(1) As part of medical training, residents must be given progressive responsibility for the care of patients. The determination of an individual resident's ability to provide care to patients without a supervisor present or act in a teaching capacity will be based on documented evaluation of the resident's clinical experience, judgment, knowledge, technical skills and year of training. Ultimately, it is the decision of the attending as to which activities an individual resident will be allowed to perform within the constraints of the program directors assigned levels of responsibility. The overriding consideration must be the safe and effective care of the patient.

(2) The Residency Program Director will define the levels of responsibility for each year of training by preparing a document describing the types of clinical activities residents may perform and those for which residents may act in a teaching capacity for more junior trainees. The assignment of graduated levels of responsibility will be made available to other staff as appropriate and maintained on file at the department level and updated at monthly GMEC meetings. In addition, procedural certification status will be maintained on the WBAMC Intranet and made available to physicians, RNs and other professionals with granted Intranet access. Graduated levels of responsibility for procedures are noted below and an example of documentation of numbers and certification status of residents is included (Attachment 1).

(3) The Internal Medicine Program Director will meet, as a minimum, quarterly with the Education Committee to access progression of the trainee based on the attached summary statement which will be included in the individual resident education file and reviewed with the residents on a semi-annual basis. (Attachment 2).

(4) The level of supervision will be determined by the level of resident training, complexity of procedure, and ultimately by the attending staff's judgment. The guidelines below will categorize the expected level of supervision.

Minimum procedure requirements to become eligible for board certification by the American Board of Internal Medicine are:

arterial puncture – 5, arthrocentesis of knee – 3, central venous line placement – 5, lumbar puncture – 5, nasogastric intubation – 3, paracentesis – 3, pelvic exam and pap smear – 5, rectal exam – 5, and thoracentesis – 5. In all cases, the WBAMC Internal Medicine requirements meet and more often exceed these minimum numbers for certification.

(a) All residents may perform History and Physicals, rectal examinations, nasogastric tube insertion, Foley catheter insertion, anoscopy, IV lines, venous blood draws, arterial blood gases and restraint evaluations/orders at a Level 3. After achieving the requisite number of procedures all residents may perform pelvic examinations/pap smears and breast examinations and at a Level 3. Prior to attaining certification for these latter skills they will be performed at a minimum of Level 2.

(b) Invasive procedures to include radial arterial line, femoral artery lines, pulmonary artery catheterization, central venous catheterization, temporary cardiac pacer insertion, electrocardioversion, thoracentesis, lumbar puncture, paracentesis, bone marrow biopsies, cardiac stress tests, skin punch biopsies and knee arthrocentesis will be done at a minimum of Level 1 supervision. Once certified, with the exception of flexible sigmoidoscopies, PGY2 and PGY3 residents may perform these procedures at a Level 3; PGY1 residents will function at a Level 2.

(c) Residents performing specialized invasive procedures to include chest tube insertion, pigtail catheter placement, and pleural biopsies will only occur at a Level 1.

c. Scope.

(1) The Internal Medicine residency program permits residents to assume increasing levels of responsibility commensurate with their individual progress, level of training, and experience, skills, knowledge, and judgment.

(2) WBAMC adheres to current accreditation requirements of the ACGME, and the American Osteopathic Association (AOA) for matters pertaining to resident training programs, including the level of supervision provided. In addition, the requirements of the various certifying bodies, such as the member boards of the American Board of Medical Specialties (ABMS) and the Bureau of Osteopathic Specialists (BOS) are incorporated into WBAMC training programs and fulfilled through program level policy that ensures each graduate will be eligible to sit for the American Board of Internal Medicine certifying examination.

(3) The provisions of this regulation are applicable to all patient care services, including inpatient and outpatient services, and the performance and interpretation of diagnostic and therapeutic procedures.

d. Attending's Assignment. The credentials committee, the program director, and the Chief of the Department of Medicine must approve a practitioner to qualify them to supervise residents. Attendings may provide care and supervision only for those clinical activities for which they are privileged.

e. Attendings Involvement in Patient Care.

(1) Attendings are responsible for the care provided to their patients. This responsibility requires personal involvement with each patient and residents participating in the care of the patient. Each patient must have an attending whose name is recorded in the patient's record. Other attendings may, at times, assume responsibility for the care of the patient and supervision of the residents. It is the responsibility of the attending to ensure that the residents involved in the care of the patient are informed of such delegation and can readily access an attending at all times.

(2) Residents must function under the supervision of attendings. An attending must be available to the resident in person, by telephone or other telecommunication device and be able to be present within a reasonable period of time as defined by the department chief. The Department of Medicine publishes call schedules that identify the responsible attending and provide reliable methods of contacting the attending. If on-site supervision is not necessary, the attending physician must be able to be present, within a reasonable period of time, as determined by the department/service chief. Subspecialty staff is also readily identifiable and available via an updated call roster.

(3) When a resident is involved in the care of a patient, the attending continues to maintain a personal involvement in the care of that patient. The attending is expected to fulfill this responsibility, at a minimum, in the following manner:

(a) The attending must be available to direct the care of every patient and provide resident supervision based on the nature of the patient's condition, the likelihood of significant changes in the treatment plan, the complexity of care, and the experience and judgment of the residents being supervised. Medical care by residents must be rendered with attending supervision readily available or be personally furnished by the attending. The attending must document confirmation of resident supervision in the progress notes or be reflected within resident notes. Each outpatient record must reflect an attending and indicate if the case was discussed with the attending or another attending or more senior resident. All History and Physical Examinations performed by non-licensed independent practitioners (LIPs) will be co-signed with appropriate documentation that they concur with the assessment (or with exceptions) of the non-LIP.

(b) For patients admitted to an inpatient service, the attending must examine the patient early in the course of care (within 24 hours of admission) and document in a progress note, their concurrence or nonconcurrence with the resident's initial diagnosis and treatment plan and any modifications or additions to this plan. Attendings must be personally involved in the care of patients assigned to them in a manner consistent with the clinical needs of the patient and the graduated level of responsibility of the involved resident. The attending must document this by a note or be reflected in the residents' notes. At a minimum, documentation of attending involvement must be present every third day for ward patients, when there is a significant change in the treatment plan, or daily in intensive care settings.

(c) Attendings requested for consultation will either render the consultation or personally supervise the consultation. The consulting attending will meet the patient as soon as possible and will remain involved in the consultation process as long as their services are requested by the attending responsible for the care of the patient.

(4) In order to ensure quality patient care and provide opportunity for maximizing the educational experience of residents in the ambulatory setting, it is required that an attending be available for supervision during clinic visits. Patients followed in more than one clinic will have identified attendings for each clinic. Attendings are ultimately responsible for the quality of care provided to their patients.

f. Supervision Documentation of Residents.

(1) The medical record must demonstrate the active involvement of the attending. Documentation requirements for evaluation and management and ongoing care for inpatients and outpatients are outlined in paragraph 5.e. of this regulation.

(2) Some diagnostic or therapeutic procedures require a high-level of expertise in their performance and interpretation. Although gaining experience in performing such procedures is an integral part of the education of residents, such procedures may be performed only by those residents who possess the required knowledge, skill, and judgment, and under an appropriate level of supervision by attendings. Examples include procedures performed in the emergency room, intensive care units, medical wards, or outpatient clinics where there is the need for informed consent. Attendings must authorize the performance of such procedures. Excluded from the requirements of this section are procedures that are considered elements of routine and standard patient care. Examples are intravenous lines, blood draws, NG placement, Foley catheter insertion, arterial lines, routine radiologic studies, wound debridement, and drainage of superficial abscesses. Supervision for these are addressed through the requirements identified in paragraph 5.b. of this regulation.

(3) Attendings will provide appropriate supervision for the resident's evaluation and management decisions and for procedures.

(4) During the performance of such procedures, an attending, or more senior resident, will provide an appropriate level of supervision. Determination of this level of supervision is left to the discretion of the attending, within the context of the described levels of responsibility assigned to the individual resident by the program director. This determination is based on the experience and competence of the resident, the complexity of the specific case, and the assigned level of training.

(5) The "level" of attending or senior resident involvement will be consistent with the following scale:

(a) Level 1. Attending or more senior resident is physically present and directly involved in the procedure.

(b) Level 2. Attending or more senior resident is present and immediately available for consultation or intervention.

(c) Level 3. Attending is available to the resident for consultation and support via telephone or other communication device, and is available in person in a reasonable period of time as defined by the service/department chief. The program director will periodically review cases done under Level 3 supervision to ensure that such supervision is appropriate.

g. Emergency Situations.

(1) An emergency is defined as a situation where immediate care is necessary to preserve the life of, or to prevent serious impairment of the health of a patient. In such situations, any resident, assisted by medical center personnel shall, consistent with the informed consent provisions of WBAMC, be permitted to do everything possible to save the life of a patient or to save a patient from serious harm. The appropriate attending will be contacted and appraised of the situation as soon as possible. The resident will document this contact in the patient's record.

(2) In situations involving diagnostic or therapeutic procedures with significant risk to the patient, the resident must consult with, and obtain approval from an attending, who will be available to assist or to advise as appropriate. In such cases, the attending will determine whether to be present or to be available by telephone or other communication device. If circumstances do not permit the attending to write a pre-procedural note, the resident's note will include the name of the responsible attending. The note will indicate that the details of the case, including the proposed procedure, were discussed with and approved by the attending. In such cases, the attending must see the patient within 24 hours.

h. Evaluation of Residents and Attendings.

(1) Each resident will be evaluated according to accrediting and institutional requirements on the basis of clinical judgment, knowledge, technical skills, humanistic qualities, professional attitudes/behaviors, and overall ability to manage the care of a patient. Written evaluations will occur as required at a minimum of monthly for residents. Written evaluations will be available to and discussed with the resident and maintained by the program director.

(2) If a resident's performance or conduct is judged by the program director to be detrimental to the care of a patient(s), immediate action will be taken to ensure the safety of patient(s). Additional actions will be in accordance with the WBAMC Due Process Policy for Residents.

(3) Annually, each resident will be given the opportunity to complete a confidential written evaluation of attendings and the quality of their training program. Such evaluations will include the adequacy of clinical supervision by the attendings. The Program Director and Chief of Medicine will review these evaluations. The Program Director will provide feedback to the attendings to identify areas where improvements can be made.

(4) All written evaluations of residents and attendings will be kept on file by the Residency Program Director, in an appropriate location and for the required timeframe according to the guidelines established by the ACGME Internal Medicine Residency Review Committee or other accrediting or certifying agencies.

i. Monitoring Procedures. The Commander WBAMC will ensure WBAMC fulfills all responsibilities within this section. Monitoring of appropriate attending supervision will be accomplished in a number of fashions to include:

(1) The GMEC will document and discuss any citations regarding resident supervision on all Internal Residency Reviews, Residency Review Committee reports, and resident complaints of lapses of supervision related in annual evaluations of the training program and faculty. The GMEC will suggest correction and follow-up for such citations and forward these to the DCCS and Commander for review and approval.

(2) The chair of the GMEC will report any internal or external review issues or resident complaints regarding staff supervision to the Executive Board of Directors (EBOD) annually. This report allows a direct linkage of the GMEC and credentials chairpersons (DME and DCCS respectively).

(3) The DCCS and DME, along with all other members of the Risk Management Committee, will participate in discussion of all tort claims involving residents to determine if there are issues of the availability of appropriate levels of supervision or violations of the graduated levels of responsibilities.

(4) Individual program directors, Chief of Medicine, and the DME will review residents' annual anonymous evaluations of the program and faculty, including trainee assessment of the adequacy of attending supervision.

(5) The Internal Medicine Program Director will periodically monitor supervision of diagnostic and therapeutic procedures involving residents to ensure consistency with the graduated levels of supervision as established by the individual programs.

LISA L. ZACHER
LTC, MC
Program Director, Internal Medicine

Glossary

Attending

Licensed independent practitioners (LIPs) who have been privileged at William Beaumont Army Medical Center in accordance with applicable standards.

Board Certified

A diplomat of a specialty board approved by the American Board of Medical Specialties (ABMS) or Bureau of Osteopathic Specialists (BOS)

Board Eligible

Having completed an approved residency program in which the training, education, and experience would be expected to result in formal acceptance by the appropriate ABMS or BOS specialty board.

Graduate Medical Education

The process by which clinical and didactic experiences are provided to residents that will enable them to acquire the skills, knowledge, and attitudes/behaviors important in the care of patients. The purpose of graduate medical education is to provide an organized and integrated educational program providing guidance and supervision of the resident, facilitating the residents' professional and personal development, and ensuring safe and appropriate care for patients.

Program Director

The official, who is appropriately credentialed with accrediting and certifying body requirements and appointed by the Commander through a search committee, responsible for maintaining the quality of a GME program so that it meets the ACGME accreditation standards and for assuring appropriate evaluation and resident supervision.

Resident

An individual engaged in graduate medical education, including all specialties (e.g., internal medicine, surgery, psychiatry, radiology, nuclear medicine, dentistry, podiatry) and participates in patient care under the direction of attendings. The term resident includes individuals in approved subspecialty graduate medical education programs who historically have been referred to as “fellows.”

Supervision

The responsibility of an attending to enhance the knowledge of residents while ensuring that quality care is delivered to all patients. Such responsibility is exercised by observation, consultation, and direction, and includes the imparting of knowledge, skills, and attitudes/behaviors to the residents and the assurance that care is delivered in an appropriate, timely, and effective manner. Supervision may be exercised in many ways including person-to-person contact with residents in the presence of the patient, person-to-person contact in the absence of the patient, and through consultation via the telephone or other communication devices.

General Competencies

Minimum Program Requirements Language

Approved by the ACGME, September 28, 1999

Educational Program

The residency program must require its residents to obtain competencies in the 6 areas below to the level expected of a new practitioner. Toward this end, programs must define the specific knowledge, skills, and attitudes required and provide educational experiences as needed in order for their residents to demonstrate:

- a. **Patient Care** that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health
- b. **Medical Knowledge** about established and evolving biomedical, clinical, and cognate (e.g. epidemiological and social-behavioral) sciences and the application of this knowledge to patient care
- c. **Practice-Based Learning and Improvement** that involves investigation and evaluation of their own patient care, appraisal and assimilation of scientific evidence, and improvements in patient care
- d. **Interpersonal and Communication Skills** that result in effective information exchange and teaming with patients, their families, and other health professionals
- e. **Professionalism**, as manifested through a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population
- f. **Systems-Based Practice**, as manifested by actions that demonstrate an awareness of and responsiveness to the larger context and system of health care and the ability to effectively call on system resources to provide care that is of optimal value

Evaluation

Evaluation of Residents

The residency program must demonstrate that it has an effective plan for assessing resident performance throughout the program and for utilizing assessment results to improve resident performance. This plan should include:

- a. use of dependable measures to assess residents' competence in patient care, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice
- b. mechanisms for providing regular and timely performance feedback to residents
- c. a process involving use of assessment results to achieve progressive improvements in residents' competence and performance

Programs that do not have a set of measures in place must develop a plan for improving their evaluations and must demonstrate progress in implementing the plan.

Program Evaluation

- a. The residency program should use resident performance and outcome assessment results in their evaluation of the educational effectiveness of the residency program.
- b. The residency program should have in place a process for using resident and performance assessment results together with other program evaluation results to improve the residency program.

