baptisthealth system

Answering the call.

Graduate Medical Education

Resident Handbook

2013-2014 Academic Year

HOSPITAL EMERGENCIES AND IMPORTANT PHONE NUMBERS

CARDIAC OR RESPIRATORY ARREST: "CODE BLUE" is paged with location. All residents assigned to the Code Blue Team should respond. The senior medical resident is in charge until relieved by the patient's attending or a cardiologist. If adequate medical help is present at the code, residents should return to their duties and relieve congestion. **"CODE PINK" -** IM and TY residents immediately report to Emergency Room so ER physicians can respond to the "Code Pink" situation.

BEEPER DISPLAY: The **Code Blue** pager will display **"Code Blue"** plus the location.

TRINITY

Unit	Extension
CCU 2-West	5200
CPCU 4-West	5450
SICU 2-West	5250
CVICU 3-West	5350
CVSU 5-West	5449
MICU 3-West	5300

PRINCETON

Unit	Extension
CICU 3-East	3300
SICU 2-East	3200
MICU 1-East	3100

TO REPORT A "CODE BLUE" CALL: 1234 at Trinity
3456 at Princeton

FIRE: **"CODE RED"** is paged at Trinity
"CODE RED" is paged at Princeton

TO REPORT A "CODE RED" CALL: 1999 at Trinity
3199 at Princeton

If a fire occurs, residents should continue their duties. If the fire is in your area, then provide appropriate assistance.

"ALL CLEAR" CODES FOR FIRE ARE: **"CODE AMBER"** is paged at Trinity
"CODE AMBER" is paged at Princeton

DISASTER (train wreck, etc.) **"EXTERNAL DISASTER PLAN"** is paged at Trinity
"DISASTER PLAN" is paged at Princeton

If a disaster occurs, then all residents except those immediately involved with critically ill patients should report to the Medical Education Office at Trinity or to the Emergency Room Lobby at Princeton for assignment by the physician in charge.

TORNADO

Trinity:
"CODE GREEN" (Warning)
"CODE GREEN STAT" (Tornado spotted)

Princeton:
"Tornado warning/watch" is paged for Jefferson County only.

If a tornado occurs, then if possible, you should evacuate patients, personnel and visitors from areas with windows to area without windows.

TRAUMA CODE: ER (Major multi-system trauma patient)

Trinity:
Surgical Residents (will be paged) report to ER.

Princeton:
"Code T "
Surgical Residents (will be paged) report to ER.

SECURITY 1331 at Trinity
3090 at Princeton

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BAPTIST HEALTH SYSTEM, INC.
BIRMINGHAM, ALABAMA
RESIDENT HANDBOOK

July 2013

Introduction

Welcome to the Baptist Health System, Inc. (BHS) and the teaching hospitals Princeton Baptist Medical Center and Trinity Medical Center! We have sponsored graduate and continuing medical education programs since our inception in 1922, believing that the best patient care is provided in a scholarly environment where inquiring students and residents work side by side with experienced physicians, nurses and other healthcare professionals. The Administration, the Department of Medical Education, and the Faculty will help ensure that your training experience here will be personally and professionally rewarding. We look forward to working with you during your residency and in the years to come.

This handbook contains important information, including a summary of the goals, policies and procedures which govern the house staff; a description of your responsibilities and benefits; other useful information; and details about each of the residency programs.

This material is subject to change periodically. The official policies and procedures of the Baptist Health System and of the Department of Medical Education are maintained in the office of the Designated Institutional Official. This handbook does not constitute a contract and may be amended or modified by BHS at anytime with or without notice.

Note: Effective with the 2013-2014 Academic Year, this *Resident Handbook* will only be published electronically and made available on the BHS Residency Program website www.baptistresidency.com and shared drives.

The Baptist Health System, Inc. and Princeton Baptist Medical Center and Trinity Medical Center do not discriminate on the basis of race, sex, color, religion, national origin, age, disability, or any other criterion prohibited by applicable law.

baptisthealth system

Our Mission

As a witness to the love of God, revealed through Jesus Christ, the Baptist Health System is committed to ministries that enhance the health, dignity and wholeness of those we serve through Integrity, Compassion, Advocacy, Resourcefulness, and Excellence.

Our Values

- ***Integrity* --** To honor God in all we do.
- ***Compassion* --** To minister to the body, mind and spirit of those entrusted to our care. To treat each other as we would want to be treated.
- ***Advocacy* --** To improve the well-being of people in our communities.
- ***Resourcefulness* --** To advance the benefits of faith-based, not-for-profit health care in our communities. To make the best use of our God-given resources.
- ***Excellence* --** To support education and research to enhance performance. To continuously improve ourselves and our services.

Our Vision

To reach superior levels of performance throughout the organization and to expand our faith-based approach to healing and caring to more people in need by engaging those who share in our vision.

Our Mission Window

The Baptist Health System Mission Window is a unique symbol that reflects the commitment to service inherent in our Mission. The symbols found in the window represent the five values from our Mission Statement:

- ***Integrity* --**The Cruciform, the largest and most vivid element of the Mission window, represents Integrity. This timeless symbol of the Christian faith portrays our core mission as an organization...to honor God in everything we do.
- ***Compassion* --** The Dove represents our compassionate commitment to be a positive, transforming influence on the body, mind and spirit of every life we touch, whether it be patient, family, community or each other. The Dove is a symbol of Gods greatest gift of compassion to mankind.
- ***Advocacy* --** The Clouds symbolize our continuous quest to improve the well being of the communities God has given us the privilege of serving...always striving to do more and better.
- ***Resourcefulness* --** The Tree Branch in the dove's beak represents our commitment to being prudent stewards of the God-given resources that have been entrusted to us so that our Mission of Ministry thrives today and is perpetuated into the future. It is the smallest element of the window symbolizing that our focus is not on money but on ministry.
- ***Excellence* --** The Rays of Light that intersect and overlap represent the bringing together and blending of the God-given talents of all the individuals in our organization to create a health care ministry that transcends the abilities of any individual. Inherent in this is our commitment to continuously improve our services and ourselves.

GOALS OF THE DEPARTMENT OF MEDICAL EDUCATION

The following goals are set forth in keeping with the mission and values of Baptist Health System (BHS) and are applicable to all medical education programs and residents. The Program Directors and faculty of each program are responsible for further defining and implementing objectives specific to each program.

A. To develop and maintain a core faculty of highly qualified, academically grounded, and clinically oriented physicians to teach and to serve as role models for medical students, residents in training, physicians and surgeons in practice, and other health professionals within BHS;
B. To develop and maintain programs of graduate medical education to train young physicians to provide thoughtful, compassionate, and high-quality medical care;
C. To develop and support a program of relevant continuing medical education activities that foster excellence in medical practice and that encourage a professional lifestyle of learning and cost-conscious practice by the medical staffs within the Baptist Health System and Trinity Medical Center;
D. To develop and maintain a program of clinical instruction for medical students in the areas of expertise exhibited by our full-time and volunteer faculty members;
E. To assist BHS in adapting successfully to the changing health care environment; and
F. To provide ready access for residents, faculty and other BHS practitioners to the basic resources required to conduct scientifically sound and clinically relevant research.

1. THE GOVERNING BODY:

The governing body for graduate medical education (i.e., the residency programs) is the Graduate Medical Education Council (GMEC), which is charged with:

- establishing and monitoring policies for the Department of Medical Education,
- overseeing the quality of education provided,
- overseeing the work environment for residents in current residency programs,
- approving the establishment of new residency programs or the reduction in size or elimination of any programs,
- periodically reviewing each residency program's progress as measured against the Program Requirements,
- maintaining oversight and liaison with the Program Directors and with the participating institutions,
- monitoring the residency programs' quality assurance programs and the residents' participation in these programs,
- monitoring duty hours and on-call status of each program to ensure compliance with ACGME/RRC guidelines,
- reviewing resident salaries and benefits,
- monitoring funding issues that impact Medical Education (budgets, etc.),
- overseeing the selection, evaluation, promotion and disciplinary actions of residents proposed by the programs,
- serving as the final arbiter in the appeal process,
- ensuring that each residency program has a dedicated curriculum and evaluation system that is based around the six general competency areas,
- ensuring residents are appropriately supervised and are assuming responsibility commensurate with their training level,
- and approving all actions involving the residency programs with the ACGME.

The Council is chaired by the Designated Institutional Official (DIO), who oversees and directs the affairs of the Department of Medical Education. Voting membership of the GMEC includes:

- Designated Institutional Official (DIO)
- President/CEO of Princeton Baptist Medical Center or his designee
- President/ CEO of Trinity Medical Center or his designee
- Chief Medical Officer of Princeton Baptist Medical Center
- Executive Director, Medical Education
- All Program Directors and Associate Program Directors – Note: At least one of these representatives from each program should be in attendance at each meeting.
- Faculty representatives selected by the Designated Institutional Official with the advice of Program Directors
- A Chief Resident representative from each program
- Peer-selected resident representatives or his/her designee if unavailable from each of the residency programs

The Graduate Medical Education Council meets quarterly.

2. RESIDENCY INFORMATION:

A. Employment Source:

Residents are employees of the Baptist Health System, which is the Sponsoring Institution for the residency training programs which are accredited by the Accreditation Council for Graduate Medical Education (ACGME).

B. Responsibilities:

While appointed to the residency training program, the responsibilities of residents shall be to provide care, under the supervision of an attending medical staff member, to the patients admitted to the medical staff member by providing components of care, including writing of orders. Other patient care responsibilities will be specifically assumed by the resident with the collaboration of and under the supervision of the medical staff member. Delegation of responsibility by physician faculty members to residents is based upon the proven ability, competence, and level of training of the resident.

The resident is expected to demonstrate competence with documented evidence of the various procedures and/or operative cases required by the specific training program's requirements. The required level of procedural skills increases as the resident advances in the level of training, and demonstrated competence in specific skills contributes to the advancement of the resident from one level to the next.

Under the direct supervision of medical staff faculty, residents are expected to assume increasing responsibility in the care of patients as well as in the supervision of more junior residents and medical students commensurate with the responsibilities of the specific program as specified by the RRC for the particular training program.

C. Six General Competencies:

The curriculum of each BHS residency training program is based around the six general competency areas specified by the ACGME and the RRC for each training program. Each program's curriculum is designed to develop the resident's skill and understanding of these competencies which have been determined to be the foundation of a sound, quality and professional practitioner. The six general competencies are:

1. **Patient care** that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health.

2. **Medical knowledge** about established and evolving biomedical, clinical, epidemiological and social-behavioral sciences, as well as the application of this knowledge to patient care.

3. **Practice-based learning and improvement** wherein residents demonstrate the ability to investigate and evaluate their care of patients, to appraise and assimilate scientific evidence, and to continuously improve patient care based on constant self-evaluation and life-long learning.

4. **Interpersonal and communication skills** that result in the effective exchange of information and collaboration with patients, their families, and health professionals.

5. **Professionalism**, as manifested through a commitment to carrying out professional responsibilities and an adherence to ethical principles and sensitivity to a diverse patient population.

6. **Systems-based practice,** as manifested by actions that demonstrate an awareness of and responsiveness to the larger context and system of health care, as well as the ability to call effectively on other resources in the system to provide optimal health care.

As a resident, you should not only be thoroughly conversant with the six general competencies, but should also be aware of, and be able to recognize these components in the educational and patient care experiences.

D. **Evaluation of Residents' Performance:**

Members of the full-time and volunteer faculty and senior residents evaluate the performance of residents, both on inpatient services and in the outpatient setting upon completion of each rotation. These evaluations are routinely reviewed by the respective Program Directors. Appropriate suggestions for improvements are made to the individual resident. The resident may review his/her performance by appointment with his/her respective Program Director or designee.

Assessment of resident performance in his/her training program is the ultimate responsibility of the Program Director. The assessment is based on the quality of the resident's performance over time and on the successful attainment of, and performance related to the six general ACGME competency areas of:

- Medical Knowledge
- Patient Care
- Practice-Based Learning and Improvement
- Interpersonal and Communication Skills
- Professionalism, and
- Systems-Based Practice.

The Program Director will use information from faculty evaluations and from his/her personal observation of residents to make final judgments regarding the adequacy of resident performance for purposes of retention or advancement in the program. Written evaluations from the faculty are only "part of the equation" used in the determination of overall performance.

E. **Evaluation of Rotation, Attending Physician(s), and Program by the Resident:**

At the end of each rotation, each resident is asked to complete an evaluation form on the rotation and attending physician(s). This is a useful tool in improving the rotations and for counseling faculty members. These evaluations should be completed in a timely manner and returned to the applicable Program Director's office.

Each month, every resident will also have the opportunity to comment on any potential issues with the rotation via the monthly duty hours survey which is run by the office of the DIO. These individual survey responses will be kept strictly confidential from Program staff unless the resident asks for the response to be shared.

Additionally, in the spring of each year, every resident will have an opportunity to evaluate the overall residency program via the ACGME's annual resident survey.

F. **Appointment to the Proper Year**:

The resident must be appointed to the postgraduate year for which he/she has qualified through previous training as specified by the Accreditation Council for Graduate Medical Education. Therefore, a resident who changes from one specialty program to another, or who enters a postgraduate training program after having completed one in another discipline, must be appointed to the first postgraduate year of such specialty unless otherwise authorized by the American Board in that specialty. Residents seeking to change from one BHS residency program to another must consult with both their current Program Director and the Program Director of the Program to which they want to transfer. They will be required to interview with program faculty and may or may not be allowed to transfer.

G. **Residency Year**:

The official residency-training year for certificates and reporting credentialing data will begin on the day after the last day of New Resident Orientation and end at 8:00 a.m. on the day after the last day of New Resident Orientation the following year. Residents may start training off the normal residency year cycle, but only with the recommendation and approval of the Program Director.

H. **Resident Advancement:**

Residents will receive a "Letter of Renewal" in January of each calendar year advising they have been advanced to the next post-graduate training level. This letter serves as the renewal agreement for the contract signed when the resident initially begins training. Unless events occur that would revoke and void this letter, it will serve as the

renewal agreement/contract for the next post-graduate year of training. In the event a resident is not going to be advanced to the next level of training, the resident will be issued a letter stating the intent to not renew/advance four (4) months prior to the conclusion of the academic year. Should an event occur that would result in non-renewal after the four (4) month window has passed, the resident will be provided with as much notice as is reasonable.

I. **USMLE**:

As to USMLE Step II and the Clinical Skills Examination:

Residents entering a BHS residency program immediately following medical school graduation should have successfully completed USMLE Step II and the Clinical Skills Examination as evidenced by verification of passing scores documented in the resident's personnel file. These two examinations should be completed successfully before the student is allowed to graduate from medical school. However, it is recognized that all medical schools do not include passage of the Clinical Skills Examination as a requirement for graduation at this time.

BHS shall require successful completion of USMLE Step II before a candidate is considered and accepted into a residency training program. As to the Clinical Skills Examination, a grace period shall be extended to the candidate in the event he/she graduated from a medical school that did not make successful completion of this examination a requirement for graduation. All graduated medical students, both graduates from an LCME accredited medical school and International Medical Graduates (IMGs) are required to complete the Clinical Skills Examination as part of the USMLE examination package. International Medical Graduates should have completed the Clinical Skills Examination before their application is accepted for consideration as per the ECFMG protocols for IMGs. BHS shall require that all residents graduating from LCME accredited medical schools, who did not complete the Clinical Skills Examination prior to graduation, must make arrangements for, be accepted to sit for, and successfully complete the examination, before completion of the first six (6) months of residency training and provide to the program written proof of successful completion from the USMLE. Failure to complete this requirement by the end of the six (6) months grace period will result in immediate termination of the residency agreement and the resident will be terminated from the program.

Cost of the Clinical Skills Examination shall be the responsibility of the resident.

As to USMLE Step III:

Residents should register to take USMLE Step III prior to completion of the first year of residency training. USMLE Step III must be successfully completed before January of the resident's second year of residency training or he/she will not be extended a renewal contract to continue training beyond the second year. In the event a resident should successfully complete USMLE Step III between January and June of their second year of residency training, renewal of their contract will be based upon Program Director recommendation and Designated Institutional Official approval. In the case of special situations, the Program Director may allow an exception and an extension of the time prescribed for passage of USMLE Step III up to a maximum of three (3) additional months. Any exception granted must be upon recommendation of key faculty members of the program made to the Program Director and approved by the Designated Institutional Official. In the event a resident enters a program "off cycle", the dates for contract renewal will be "off cycle" as well. The general time frame for completion of USMLE Step III will be adjusted accordingly. No resident will proceed beyond the end of the second year of training without successfully completing USMLE Step III unless approved for the three (3) month extension described herein. It is understood the International Medical Graduates are not eligible for licensure in Alabama until they complete three years of residency training. However, USMLE Step III must be completed prior to the end of the second year of residency training.

Should the Resident start residency training at a date that is "off cycle" from July 1, the dates will be adjusted accordingly.

An individual residency program may enact more stringent USMLE Step III passage requirements. More stringent requirements would be outlined in the individual program's specific program information section of the Resident Handbook.

J. **New Resident Orientation and Advanced Cardiac Life Support**:

The residency-training year will begin on the day after the last day of New Resident Orientation and will end at 8:00 a.m. on the day after the last day of New Resident Orientation the following year. Orientation for all incoming residents usually begins mid-June each year. Incoming residents will be notified in advance of the time and place. Newly appointed residents are required to be certified in both Advanced Cardiac Life Support (ACLS) and Basic Cardiac Life Support/CPR (BLS) before training begins. If the resident has not certified in ACLS and BLS within 6 months prior to the beginning of New Resident Orientation, both courses will be offered immediately before the start of New Resident Orientation. Residents are required to re-certify at the appropriate time to keep their certifications active (certifications are usually for two year periods). Residents will be paid beginning with the first day of New Resident Orientation if they attend all required segments of orientation. **Payment will not be made if only segments of the orientation are attended.**

K. **Resident Pre-Employment Physicals:**

All residents are required to have a physical assessment and drug screen pursuant to the Residency Agreement prior to New Resident Orientation. Residents should be aware that violation of BHS's Substance Abuse Policy may be grounds for voiding their appointments. Residents continuing at BHS are responsible for undergoing a TB skin test each year. The House Staff Coordinators at Princeton and Trinity will coordinate the completion of this requirement.

L. **Residency Reduction or Closure:**

In the event that BHS reduces the size of or indicates an intention to close any of the residency programs, the affected residents will be notified and counseled as soon as possible, and every effort will be made to ensure the residents are able to complete their training program at BHS. If this becomes impossible, every effort will be made to place the residents in other programs where they will be able to complete their training. Provisions will be made to maintain resident files in perpetuity for purposes of future credentialing verification.

M. **Security**:

Excellent security offices at both hospitals are staffed and available to assist residents 24 hours per day. Security assistance is available for escort at night or in the event of any threatening or potentially dangerous situation. Security assistance and protection apply to the hospitals and related property, including call rooms, parking lots, Professional Office Buildings or treatment centers located on each hospital's campus. See phone numbers inside front cover to contact appropriate security offices.

N. **Duty Hours:**

BHS supports the Accreditation Council for Graduate Medical Education (ACGME) and the individual Residency Review Council (RRC) duty hours and on-call requirements. The overall BHS Medical Education policy is presented herein. In the event an individual RRC's requirements are more stringent than the overall policy, the program's RRC requirements take precedent. Each program's RRC requirements are stated in the program's information section at the back of the Handbook. The general duty hour and on-call requirements, as well as the individual program's duty hour and on-call requirements, are also available for reference in the Department of Medical Education Policy and Procedure Manual available in the Designated Institutional Official's Office. The institutional (general) duty hours and on-call requirements that a resident must adhere to are:

Duty Hours – Common Program Requirements	
Maximum Hours of Work per Week	• 80 hours per week, averaged over a 4-week period. • Includes in-house call and all moonlighting. • **Note:** This means a resident **can** work more than 80 hours in a given week as long as those hours are made up by reducing the hours worked in subsequent weeks so that the "averaged over a 4-week period" requirement is met.
Mandatory Time Free of Duty	• 1 in 7 days minimum (averaged over a 4-week period). • Note: Technically, this means a resident can work 24 days straight as long as he or she gets the last 4 days off. (Note: even though this is technically allowed, it is not advised.)

Duty Hours – Common Program Requirements	
	• At-home call cannot be assigned on free days.
Maximum Duty Period Length	• PGY-1 = 16 hours • PGY-2 and up = 24 hours • Should use alertness management strategies. • Consider strategic napping after 16 hours of continuous duty and between 10pm and 8am.
Additional 4-Hour Period allowed?	• PGY-1 = No • PGY-2 and up = Yes, but 1. No additional clinical responsibilities can be assigned after 24 hours. 2. Can continue to provide care to a single patient who is critically ill, unstable, in need of humanistic attention or if the case is academically important. 3. Must hand over care of all other patients.
Minimum Time Off Between Scheduled Duty Periods	• PGY-1 = Should have 10 but must have 8. • Intermediate Level (see definitions in next table) = Should have 10 but must have 8. • Residents in Final Years (see definitions in next table) = Desired to be at least 8 hours, but if return to hospital with fewer than 8 hours off, must document reason and submit to Program Director and GMEC office.
Minimum Time Off After 24 Hours of In-House duty	• Must be 14 hours
Maximum Frequency of In-House Night Float	• No more than 6 consecutive nights of night float
Maximum In-House On-Call Frequency	• PGY-1 may not take In-House Call, but they may be scheduled for night float • PGY-2 and above = 1 in 3 nights (averaged over a 4-week period), which means no more than 9 nights in a 4-week (28 day) period.
At-Home Call	• Not permitted for PGY-1 residents. • Time spent in hospital on “at-home call” counts toward the 80-hour limit. • At-Home Call is not subject to the 1 in 3 nights limitation. • At-Home Call cannot violate the 1 in 7 days free rule (when averaged over a 4-week period). In other words, At-home call cannot be assigned on free days. • At-Home Call cannot be so frequent or taxing as to preclude rest or reasonable personal time. • Residents can return to the hospital while on “at-home call” to care for new or established patients. These hours in the hospital must be counted toward the 80-hour limit but do not initiate a new “off-duty period.”

Duty Hour Issues for Particular Levels			
	PGY-1 Residents	**Intermediate-Level Residents**	**Residents in the Final Years of Education**
Moonlighting	None	Permitted with Program Director’s approval	Permitted with Program Director’s approval
Duty Periods	Must not exceed 16 hours	Up to 24 hours	Up to 24 hours
Additional 4-hour period allowed?	No	Yes. 1. No additional clinical responsibilities can be assigned after 24 hours. 2. Can continue to provide	Yes. 1. No additional clinical responsibilities can be assigned after 24 hours. 2. Can continue to provide

Duty Hour Issues for Particular Levels			
	PGY-1 Residents	**Intermediate-Level Residents**	**Residents in the Final Years of Education**
		care to a single patient who is critically ill, unstable, in need of humanistic attention or if the case is academically important. 3. Must hand over care of all other patients.	care to a single patient who is critically ill, unstable, in need of humanistic attention or if the case is academically important. 3. Must hand over care of all other patients.
Minimum Time Off Between Duty periods	Should: 10 hours Must: 8 hours	Should: 10 hours Must: 8 hours Must have 14 hours free after 24 hours of in-house duty.	Desired: 8 hours If return to hospital with fewer than 8 hours off, must document reason and submit to Program Director and GMEC office.
At-Home Call	None	Permitted	Permitted
In-Hospital On-Call Frequency	PGY-1 may not take In-House Call, but they may be scheduled for night float	No more often than every third night averaged over a 4-week period.	No more often than every third night averaged over a 4-week period.

O. <u>Outside Rotations:</u>

The Baptist Health System, Inc., as sponsor for the residency training programs, provides resources, facilities and faculty for the support and delivery of the curriculum including clinical rotations for the residency programs in Anatomic and Clinical Pathology, Diagnostic Radiology, General Surgery, Internal Medicine, and Transitional Year. The Program's first preference will always be to complete as much of the curriculum (rotations) as possible within the two major participating teaching hospitals (Princeton Baptist Medical Center and Trinity Medical Center).

It is understood that curriculum requirements necessitate the affiliation with and use of outside institutions for certain elements of the curriculum (i.e. outside rotations) not available within either teaching hospital. These rotations are arranged and governed by formal Program Letters of Agreement with outside teaching institutions for hospital-based rotations or with Educational Affiliation Agreements for the educational experiences within physician offices usually, but not in all cases, located on the campuses of and affiliated with one of the two teaching hospitals.

Should a hospital-based rotation/educational experience be mandated by a curriculum requirement at an outside institution not covered under the established outside rotation(s) in the Agreements specified in the preceding paragraph, these rotations will be arranged and approved by the Program Director after discussion with the DIO.

Should the resident select a hospital-based rotation at an outside institution for an experience that can be provided at one of the two major participating institutions (Princeton or Trinity) or as a rotation normally provided under the existing Program Letter of Agreement/Educational Agreements these will be limited to a maximum of one rotation per resident during the course of their training period (3 years for Internal Medicine, 5 years for General Surgery, etc). The rotation must be approved in advance by the Program Director. Arrangements should be made with the outside institution by the Program so they have full knowledge of the experience. Any expenses related to these specific outside rotations are the full responsibility of the resident and will not be paid/reimbursed by Medical Education or BHS. If a Program Letter of Agreement/Educational Agreement does not exist for the requested rotation, an Agreement must be formulated and approved by BHS and the outside institution before the rotation begins.

Outside hospital-based rotations should be limited to those that carry a curriculum requirement that cannot be met by one of the two major participating institutions. Therefore, outside hospital-based rotations are limited to one per resident per training period as specified in this policy. Rotations in private physician offices must be covered by an Educational Affiliation Agreement. If there are Agreements in place for these non-hospital based rotations, the resident may elect these rotations with the approval of the Program Director.

Any changes/deviations from this policy must be made with the full knowledge and approval of the DIO.

3. COMPLIANCE WITH HOSPITAL POLICIES:

All residents shall be subject to the personnel and administrative policies as may from time to time be adopted for residents, and shall be subject to all rules and regulations of the hospital at which they serve to the extent that such policies and procedures are applicable to residents. Special note should be taken of the following:

A. **Completion of Medical Records:** Policies and procedures for completion of medical records can be obtained from the Health Information Management Department at Princeton, ext. 3156 and the Health Information Management Department at Trinity, ext. 1280. Failure by the resident to complete medical records according to the policies and procedures of Princeton and Trinity Campuses for which he/she is responsible **may result in disciplinary action including suspension without pay.** Delegation of medical record responsibility by a faculty member to a resident carries the requirement on the part of the resident to complete the medical record under the guidelines prescribed for medical staff members.

B. **HIPAA:** Except as otherwise permitted or required by the Privacy Rule, BHS will not use or disclose protected health information without a valid authorization. All uses and disclosures pursuant to a valid authorization will be made only for the specific purpose(s) stated in the authorization and only by and to the persons or organizations described in the authorization. No authorization is required for the following uses and disclosures:

- For purposes of treatment, payment and health care operations (If BHS does not know the authority of the person requesting PHI for treatment, BHS will verify authority by obtaining an authorization. See Policy # 722.01);
- To the individual or his personal representative;
- Incident to a use or disclosure otherwise permitted or required by the Privacy Rule;
- For those requiring an opportunity for the individual to agree or object;
- Described in BHS Policy # 721.01 - Uses and Disclosures for Which No Authorization or Opportunity to Agree or Object is Required; and
- To the Secretary of Health and Human Services to determine BHS's compliance with the Privacy Rules.

C. **Substance Abuse:** The substance abuse policy of the Baptist Health System, Inc. (BHS) is binding upon residents of the BHS. Substance abuse is defined by BHS as the use of any illegal drug or the use of legally obtained drugs whose use adversely affects the resident's job performance. Residents will be subject to a mandatory drug screen at the pre-employment physical and may be subject to further drug screens at any time throughout their residency. Failure to submit to an alcohol or drug test or refusal to cooperate with any BHS initiated investigation will constitute grounds for discharge. A positive drug screen for an illegal drug upon the pre-employment screening will void appointment as a resident with BHS.

The Drug-Free Workplace Act of 1988 requires the company be notified of work-related substance abuse convictions within five days of that conviction. A resident who recognizes or suspects he or she may be using drugs or alcohol in a manner which might potentially cause damage to his or her personal life or career should seek counseling. The Employee Assistance Program of BHS will provide short-term counseling and referral to longer-term care if needed. All interactions with the Employee Assistance Program are confidential. The resident may also be referred to the Alabama Physician Health Program of the Medical Association for the State of Alabama for counseling and supervision.

Additionally, BHS buildings, including hospitals and Trinity Medical Center, are "smoke free". The use of tobacco products (i.e., cigarettes, chewing tobacco, and snuff) is not permitted in the buildings. Smoking is permitted in designated areas outside the hospital buildings.

D. **Physician Impairment:** Physicians, including residents, who are impaired or are suspected of being impaired as a result of mental or emotional illness or substance abuse or dependency may voluntarily seek assistance, or may be referred for assistance by the Program Director or the Designated institutional Official and/or Executive Director for Medical Education to the BHS-sponsored Employee Assistance Program, or to the Alabama Physician Health Program sponsored by the Medical Association of the State of Alabama for evaluation and counseling. Educational

programs presented by the Medical Director of the Alabama Physician Health Program related to physician impairment will be offered to residents during the course of their training.

E. **Harassment (including Sexual Harassment):** It is the policy of Baptist Health System (BHS) that a resident should be able to work in an environment free from all forms of harassment. BHS therefore prohibits any and all forms of harassment, including those based on sex, age, race, color, national origin, religion, disability or veteran status by supervisors, co-workers, faculty, physicians, vendors and volunteers.

All forms of harassment are serious offenses and any employee who harasses will be disciplined up to and including immediate termination of employment. Harassment of any form will not be tolerated at BHS. Every supervisor has a duty to monitor compliance and promptly respond to any complaint of or observation of any form of harassment, etc.

Harassment:
Harassment may consist of offensive comments, jokes, innuendoes or other statements, which are based on sex, age, race, color, national origin, religion or disability. BHS strongly disapproves of, and will not knowingly permit, sex discrimination in any form including sexual harassment, which includes any employment-related decision based upon an employee's submission or non-submission to sexual advances, or as deliberate or repeated unsolicited comments, gestures or physical conduct of a sexual nature which are unwelcome.

A supervisor or manager may not date, initiate or engage in a relationship of marriage (including common law marriage), with a subordinate (either direct report or through chain of responsibility).

Sexual Harassment:
Unwelcome sexual advances, requests for sexual favors, and other verbal or physical conduct of a sexual nature constitute sexual harassment when

- Submission to such conduct is made either explicitly or implicitly a term or condition of employment, or
- Submission to or rejection of such conduct by a resident is used as a basis for employment or advancement decisions affecting the resident, or
- Conduct that has the purpose or effect of substantially interfering with a resident's work performance or creating an intimidating, hostile, or offensive work environment.

BHS prohibits all acts of harassment of any employee by any other employee. If an employee feels he or she has been subjected to any form of harassment or discrimination, then he or she should immediately report to one of the following: Program Director, the DIO's office, Human Resources Director, VP/Chief Human Resources Officer, or Corporate Compliance. A prompt, impartial investigation will be made regarding the complaint, and the employee will be notified of the results of the investigation and the resolution. An employee who files a complaint of harassment will not suffer any adverse impact or retaliation for filing the complaint.

F. Vendor Relations: It is the responsibility of all BHS residents and trainees to adhere to and follow these policies to protect the privacy and safety of our patients and to ensure we provide the highest quality service.

Vendor representative activities will be confined to non-patient care areas at all times, with the exception of in-service lectures or other educational activities coordinated in conjunction with the Material Management/ Purchasing Department. Physicians requiring vendor presence during surgical cases and other procedures may have such presence after the vendor representative has completed all RepTrax requirements. The surgeon must notify the Director of Surgical Services or designee of the impending presence of the person. The surgeon will be responsible for informing the patient that the representative will be present and obtain the patient's permission. BHS reserves the right to limit the frequency, time and overall number of visits by any sales representative or vendor for any reason.

Sales activities for new, non-formulary or formulary medications must be confined to the facility Pharmacy Department. All sales activities including, but not limited to medications, approval of formularies, or the contacting of members of the Pharmacy and Therapeutics Committee to review the pending approval of

formularies must be coordinated through the Director of Pharmacy. Samples of medications or medication-related devices may only be dispensed through channels established by the facility Pharmacy Department.

Exhibits during educational sessions can only be provided on products approved by the facility Material Operations/ Purchasing Department.

Distribution of food items to physicians' lounges and classrooms are allowed only during educational in-services and should be coordinated with the departmental managers and the Material Management/ Purchasing Department.

Distribution of promotional items of minimal value are allowed if they relate to the recipients' work (i.e. pens, pencils, cups, note pads, etc.)

During evaluation and contract negotiation phases of product selection, no social contact, gifts, lunches, etc. will be allowed.

4. BENEFITS HANDLED BY THE HUMAN RESOURCES DEPARTMENT:

The main benefits are outlined below. A full menu of BHS benefits available for residents is detailed in the Baptist Health System "Benefits at a Glance" summary sheet especially for residents, which will be provided and discussed during orientation. BHS employee benefits may also be viewed in summary form or in detail on the Employee Portal section of the BHS website, www.bhsala.com. When viewing the website, please keep in mind there are some differences in benefits for employees (e.g. resident vacation time, sick time, etc. are different).

A. **Insurance:**

1. **BHS Health Plan (including Prescription Drug Coverage):** Residents are required to participate in the health plan sponsored by BHS, unless you indicate to BHS you are covered elsewhere for medical insurance. You must either enroll for or provide verification of other coverage within your first 30 days of employment -- you can do either of these online through BHS Employee Self-Service on the Employee Portal section of the BHS website, www.bhsala.com. Coverage also is available to immediate family members of residents who meet coverage eligibility requirements. At present, BHS pays a majority of each monthly premium (approximately 79%). The resident's share of the premium is deducted from the paycheck on a pre-tax basis. Each resident and his or her covered family members should carefully review the Enrollment Guide. Additional information is on BaptistNet.

2. **Life Insurance:** Residents are provided life insurance in the amount of one times the annual base salary with the option to buy additional insurance. Child and Spouse Life insurance is also available. Details on the portability of life insurance may be obtained through the BHS Corporate Benefits Office (715-5300) or on BaptistNet.

3. **Dental Plan:** Dental insurance coverage is available to residents and their immediate family members who meet coverage eligibility requirements. Most benefits are available immediately with no waiting period. Orthodontia benefits require a 12-month service obligation before eligible children are eligible to receive them. The resident shall be responsible for the per-member deductible amount and any amounts not paid under the plan.

4. **Vision Plan:** BHS offers a vision plan at the resident's personal expense. The plan provides additional coverage for eye exams, frames, lenses, contacts, and discounts on Lasik procedures to help defray the cost of vision related needs.

5. **Long-Term Disability Insurance*:*** Long-term disability insurance is provided to residents and provides disability benefits equal to 40% of monthly base salary. In addition, residents may purchase a long-term disability benefit that provides additional coverage equal to 20% of monthly base salary. The cost is age rated. If elected, this stacks on the BHS paid 40% coverage.

6. **Resident Professional Liability Coverage*:*** BHS's insurance program for medical liability is provided through the BHS Self Insurance Program and provides indemnity against claims for medical malpractice, $1,000,000 per

occurrence and a total aggregate sum not exceeding $3,000,000, for claims based upon acts allegedly committed while performing assigned educational duties. **Coverage applies to all claims arising while in residency training at BHS**, even those that may not arise until after training has been completed. There is no cost to the resident for professional liability coverage provided by BHS or for the legal defense that may arise as a result thereof.

In the event a claim or suit is filed, Baptist Health System will assign defense counsel, and the resident physician will be expected to fully cooperate with the assigned defense counsel.

In most instances, these educational duties will be performed on the premises of Princeton Baptist Medical Center and Trinity Medical Center with occasional rotations in other locations. Questions related to liability coverage should be directed to the Executive Director, Medical Education at 599-4823. **A separate policy for professional liability protection must be purchased by the resident if moonlighting is anticipated apart from the assigned educational program.**

B. **Dependent Care Spending Account:** BHS allows residents to set up an account to cover the costs of dependent care expenses. Residents estimate how much they expect to pay monthly for dependent care expense and elect to have this amount deducted from their pay before State, Federal and FICA taxes are assessed. If you enroll for the Fixed Reimbursement program, this deduction is then automatically reimbursed each pay period, and direct deposit is available.

C. **Medical Care Spending Account:** BHS allows residents to set up an account to cover anticipated medical, dental, and vision expenses that are not reimbursed by any insurance policy. This could include co-pays (physician office visits and pharmacy co-pays), the excess for dental care over and above the allowance provided for in the dental plan, etc. The amount for the resident and his/her family should be estimated from the effective date until December 31st of that year. The declared amount is divided by the number of pay periods in the insurance period to determine the amount that is deducted from the resident's paycheck each pay period. The deduction is made from the resident's pay before State, Federal and FICA taxes are assessed. Eligible expenditures can be made during the period and do not depend on having the funds available in the account. **You have until March 15th of the following year to spend your account balance. Funds not used by March 15th of the following year are lost to the resident if not used (per IRS regulations).**

D. **Tax Deferred Annuity Program:** 403(b) Retirement Plan**:** Residents may contribute, on a pre-tax basis, up to the maximum amount of their earnings as is allowed by law. This will "shelter" the contributions and earnings thereon from federal and state taxes until retirement. Resident and matching contributions are 100% vested immediately. After one year of employment, the first 6% contributed is matched at 50% by BHS. Information may be obtained by contacting the Benefits department.

E. **Funeral:** Residents will be granted time-off with pay in the event of a death of an immediate family member. Up to three consecutive days is afforded for the death of a parent, child, brother or sister, spouse, guardian, grandparent, grandchild, stepparent or mother/father-in-law. Bereavement time for other circumstances must be taken from vacation time.

F. **The Employee Assistance Program (EAP):** The Employee Assistance Program (EAP) is designed to assist residents and their families with problems, which may affect their work performance. The EAP program is administered by American Behavorial, a professional group outside BHS, and is a confidential service to residents and their dependents that refer themselves for counseling. The professional group includes basic counseling staff and a referral base of various professional personnel with expertise in the various areas.

The EAP provides free short-term counseling for residents and their dependents. Below are some examples of issues:

- Alcohol and Other Drug Dependency
- Family/Marital Issues
- Emotional Issues
- Financial/Legal Referrals
- Stress Related Issues

For more information, go to BaptistNet or to your Total Rewards Enrollment Guide. EAP may be contacted at (205) 879-7957 or 1-800-925-5327.

G. **Benevolent Fund:** Residents who wish to make charitable contributions to various organizations may do so through payroll deduction. Additionally, the Employee Benevolent Fund (EBF) fund provides emergency financial assistance for employees faced with unexpected crises. For more information about the benevolent fund, contact Human Resources.

H. **Credit Union:** Residents are eligible to join the Legacy Community Federal Credit Union and may use the credit union for personal checking, savings, and loans. Savings deposits and loan payments can be made through payroll deduction.

I. **Workers' Compensation:** Workers' Compensation is provided for BHS residents. It provides no fault benefits for occupational-related injury or illness. The program is totally funded by BHS.

5. BENEFITS HANDLED BY THE DEPARTMENT OF MEDICAL EDUCATION:

A. **Vacation:** Ten (10) days of vacation are provided during the first postgraduate year and fifteen (15) days per year thereafter. Residents must request vacation well in advance of the desired vacation dates; program-specific vacation policies will be defined by individual residency programs. All vacation requests must be approved in advance and in accordance with the program's policies. Vacation time does not accrue from one year of appointment to the next. Vacation unused at the time of termination is not reimbursable. Additional time off may be granted by the Program Director to allow residents to attend scientific or educational meetings. When vacation or other days off occur while the resident has primary responsibility for patients in the hospital, that primary responsibility **must** be transferred to another member of the house staff or to a specific member of the attending staff. This responsibility must be made clear to the person who is to be in charge of the patients during the absence of the house staff member. **Failure to make this arrangement will be considered a serious breach of responsibility and professionalism.**

- Vacations will not be approved for Internal Medicine and Surgery residents while assigned to the Staff Services.
- It is imperative that Internal Medicine and Surgery residents notify the Continuity Clinic manager, in person, of any planned absence from clinic sessions. Notification should be made in advance so scheduled clinic patients are adequately handled.
- Hospital operators must be notified of planned absences and of call coverage arrangements for the absent resident.
- Two residents assigned to the same service may not take vacation at the same time.
- No more than one week of vacation (5 weekdays) may be taken during any one clinical assignment.
- Residents are required to take at least one week of vacation during the first six months of the academic year and are encouraged to split their time off between assignments at the two hospitals.
- Vacation may generally not be taken in June without special consideration provided by the Program Director.
- Other program specific policies may exist. The resident should review his/her specific program section (IM, TY, Pathology, etc) for additional guidelines.

B. **Medical Leave:**

Sick days – Residents are expected to be at work unless they are seriously ill. Residents who are seriously ill may have up to 3 sick days per academic year. Any prolonged illness will require FMLA documentation.

Medical leave is provided to residents not to exceed thirty (30) calendar days due to illness, injury or delivery of a child. Normally, salary is continued for this leave time. If such time exceeds thirty (30) days, continuation of salary must be approved by the Designated Institutional Official (DIO). In order for the DIO to consider continuation of salary beyond the thirty (30) calendar days of medical leave, a written authorization from the resident's attending physician documenting the medical necessity must be submitted to the DIO via the Program Director. **Note: Generally, continuation of salary beyond the 30-day limit will not be approved.**

If the Program Director, in concert with the applicable specialty board or the RRC, determines that an excessive amount of time has been missed, it must be made up before BHS can issue a certificate of completion for training requirements.

Resident physicians are provided with options for long-term disability coverage and short-term disability coverage which may be used in cases of extended illness.

Medical Education's "Leave of Absence (and FMLA) policy EDU V.10" will also be used for guidance in resident leave situations.

Maternity Leave – A female resident who takes time off for the birth of her child will be allowed thirty calendar days of paid leave, which is inclusive of days taken off both during the pregnancy and following the birth of the child. The first week of maternity leave will be deducted from the resident's vacation time. Additional time off without pay may be granted at the discretion of the Program Director and in accordance with Medical Education's "Leave of Absence (and FMLA) policy EDU V.10". Note: Depending on the total time taken off and on the requirements of the program's Residency Review Committee, the resident may be required to extend the duration of her residency in order to fulfill all of the requirements for graduation.

Paternity Leave -- A male resident who takes time off for the birth of his child will typically be allowed 1 week of leave, which must be deducted from the resident's vacation time. Additional time off without pay may be granted at the discretion of the Program Director and in accordance with Medical Education's "Leave of Absence (and FMLA) policy EDU V.10".

Residents must meet with their Program Director before taking medical leave to be aware of the time required by the appropriate Residency Review Committee or specialty board (if applicable) that must be completed before credit can be given for a full year of training.

C. **Family Medical Leave Act (FMLA):** It is the policy of the BHS to comply with the requirements of the FMLA of 1993. Eligible residents will be granted up to 12 weeks of unpaid FMLA leave within a twelve month period for the following reasons:

- Because of the birth or placement for adoption or foster care of a child and to care for the child, if the leave is concluded within 12 months of the birth or placement of the child;
- To care for the resident's spouse, child or parent who has a serious health condition;
- Because of the resident's own serious health condition which renders the resident unable to perform the essential functions of his/her job.
- To address certain qualifying exigencies arising from a resident's spouse, son, daughter, or parent on active duty in the National Guard or Reserves in support of a contingency operation. Qualifying exigencies may include attending certain military events, arranging for alternative childcare, addressing certain financial and legal arrangements, attending certain counseling sessions, and attending post-deployment reintegration benefits.

FMLA also requires BHS to provide a special leave entitlement of up to 26 weeks of unpaid, job-protected leave to a resident who is the spouse, son, daughter, parent or next of kin of a covered service member to care for a covered service member during a single 12-month period. A covered service member is a current member of the Armed Forces (including Guard and Reserves) who has a serious injury or illness incurred in the line of active duty that may render the service member medically unfit to perform his/her duties for which the service member is undergoing medical treatment, recuperation, or therapy, or is in outpatient status, or is on the temporary disability retired list.

D. **Eligibility Requirements:** To be eligible for FMLA leave, a resident must have completed twelve months of service and must have worked a minimum of 1,250 hours during the twelve-month period immediately preceding the commencement of leave. (A resident who is in the initial year of training at BHS is NOT eligible for FMLA leave.)

E. **Definition of a Serious Health Condition:** A serious health condition is an illness, injury, impairment, or physical or mental condition that involves either an overnight stay in a medical care facility, or continuing treatment by a health care provider for a condition that either prevents the employee from performing the functions of the employee's job, or prevents the qualified family member from participating in daily activities.

Subject to certain conditions, the continuing treatment requirement may be met by a period of incapacity of more than 3 consecutive calendar days combined with at least two visits to a health care provider or one visit and a regimen of continuing treatment, or incapacity due to pregnancy, or incapacity due to a chronic condition. Other conditions may meet the definition of continuing treatment.

F. **Duration of Leave:** A resident is entitled to up to twelve weeks of FMLA (26 weeks to care for a covered service member) leave within a twelve-month period. For the purpose of determining how many weeks of FMLA leave a resident has taken within a twelve-month period, BHS uses a "rolling" twelve-month period counting backward from the date a resident uses any leave.

G. **Benefits During Leave:** BHS will maintain a resident's group health plan coverage and other benefits during FMLA leave under the same conditions as if the resident had not taken leave. A resident on FMLA must continue to pay any portion of insurance premiums normally paid by the resident when not on FMLA leave.

H. **Intermittent or Reduced Schedule Leave:** Where medically necessary due to the serious health condition of a resident's spouse, child or parent, due to the resident's own serious health condition, due to the injury of a covered service member or for qualifying exigencies, a resident may take intermittent leave or a reduced schedule leave. Residents must make reasonable efforts to schedule leave for planned medical treatment so as not to disrupt BHS or the residency program's operations.

I. **Leave Requests:** A resident who wishes to take FMLA leave must give written notice to the DIO and/or Executive Director for Medical Education of the need for leave, and must explain the reason for the leave to the extent necessary for the BHS FMLA administrators (FMLA Source) to determine whether or not the leave potentially qualifies as FMLA leave. The resident should also inform the DIO and/or Executive Director for Medical Education of the date leave is to commence and the expected duration of the leave. Where the need for leave is foreseeable, at least 30 days notice of the need for leave must be given. Failure to give at least 30 days notice of the need for a foreseeable leave may delay the commencement of leave. Where the need for leave is not foreseeable, notice of the need for leave must be given as soon as practicable, in most cases within two days of knowledge of the need for leave. Residents are expected to comply with BHS's normal call-in procedure.

If the need for leave is foreseeable based on planned medical treatment, the resident must make a reasonable effort to schedule the treatment so as not to unduly disrupt the operations of the residency program. A resident who needs intermittent leave or a reduced schedule leave must advise the DIO and/or Executive Director for Medical Education of the need for such leave and of the schedule for treatment, if applicable. Subject to the approval of the resident's health care provider, the resident and the DIO and/or Executive Director for Medical Education shall attempt to work out a schedule that meets the resident's needs without unduly disrupting BHS or the residency program's operations.

J. **Certification of Leave:**

Medical Certification. If FMLA leave is requested because of the resident's own serious health condition or because the resident is needed to care for a spouse, child or parent with a serious health condition, the resident must provide the DIO and/or Executive Director for Medical Education with medical certification of the need for leave. BHS reserves the right to require a resident to obtain a second opinion from a health care provider of its choice at its expense. If opinions of the resident's and BHS's health care providers differ, BHS and the resident will attempt to agree on a health care provider who will provide a third and binding opinion at BHS's expense.

Under certain circumstances, a resident on FMLA leave may be required to provide re-certification from a health care provider. Re-certification will generally be required if the leave exceeds the minimum duration specified on the certification of the health care provider or every 30 days, whichever is longer. Re-certification may be required at shorter intervals when an extension of leave is requested, when the circumstances described by the resident's previous certification have changed significantly, or when BHS receives information that casts doubt on the continuing validity of the previous certification.

Certification for Exigency Leave and Military Caregiver Leave. If FMLA leave is requested because of the resident's need to seek exigency leave or to care for a service member, the resident must provide certification and verification supporting the need for such leave.

K. **Eligibility and Designation:** BHS will inform residents requesting leave whether they are eligible for leave under FMLA. BHS will also inform residents if the leave will be designated as FMLA leave and the amount of leave counted against the resident's leave entitlement.

L. **Maintaining Contact During Leave:** A resident on FMLA leave must report to the DIO and/or Executive Director for Medical Education every two weeks as to his/her status and intent to return to work. Failure to maintain contact with BHS may result in termination of employment.

M. **Return to Work:** Upon completion of FMLA leave, the resident will be returned to the same or equivalent position in terms of pay, benefits and other terms and conditions of employment as the resident would have been in had he/she not taken leave.

Prior to returning to work following FMLA leave, a resident must submit a statement from his/her health care provider to the DIO and/or Executive Director for Medical Education certifying that he/she is able to return to work without restrictions. A resident who is unable to return to work following FMLA leave due to medical limitations or who is able to return to work subject to medical limitations should discuss those limitations with the DIO and/or Executive Director for Medical Education. A resident who is unable to return to work following FMLA leave may be eligible for a non-FMLA leave of absence.

N. **FMLA Compliance:** Pursuant to FMLA, BHS will not interfere with, restrain or deny the exercise of any right provided under FMLA, nor will it discriminate against or discharge any person for opposing any practice made unlawful by FMLA or for any involvement in any proceeding under or relating to FMLA.

O. **Military Leave of Absence:** It is the policy of BHS to comply with the requirements of the Uniformed Services Employment and Re-employment Rights Act ("USERRA"). BHS will grant a military leave of absence ("LOA") as required by law. Generally, residents reporting for active duty or training, whether on a voluntary or involuntary basis, in the Armed Forces, the Army National Guard, or the Air National Guard ("Uniformed Services") are eligible for military leave.

To receive a military leave of absence and be entitled to the provisions of this policy, a resident (or an appropriate officer of the uniformed service in which the resident is to serve) should give advance written notice of the need for leave to the DIO and/or Executive Director for Medical Education. BHS requests all residents seeking military leave to complete a leave request. The only exceptions to the written notice requirement arise when (1) such notice is precluded by military necessity, as defined by applicable law, or (2) giving such notice is impossible and unreasonable.

Military leave is unpaid. Upon request, residents may be allowed to use paid time-off (if any) for which they were eligible before the military leave of absence begins.

Service with BHS will continue to accumulate and past service will be protected during military leave. Upon reinstatement, residents are entitled to service-based seniority and other rights and benefits as required by law (to the extent applicable to the Residency Program requirements).

Except where BHS is not required by applicable law to provide coverage, residents may continue health coverage (including any dependent coverage) while serving in the uniformed services for the lesser of the following two time periods: (1) the 24-month period beginning on the date the person's leave of absence begins or (2) the period from the date the leave of absence begins until the day after the date the resident was eligible for re-employment but failed to apply for or return to a position of employment within the time frame set by federal law (and outlined below).

Residents who elect to continue health coverage under this section and who are on military leave for thirty-one (31) days or more may be required to pay up to 102 percent of the full premium under the plan. Residents electing to continue such coverage and who are on military leave for less than thirty-one (31) days may be required to pay their normal resident share of the premium.

Upon completion of a period of service in the uniformed services, residents will be reinstated in a position of employment in accordance with applicable law.

Residents returning to work after serving fewer than thirty-one (31) days in the uniformed services or residents who are absent for uniformed services fitness examinations should report to BHS no later than the beginning of the first full regularly scheduled workday following the completion of military service plus eight hours used for safe transportation back to the resident's residence. However, if reporting within this period is impossible or unreasonable, through no fault of the resident, the resident should report as soon as possible after the expiration of the specific period.

Residents returning to work who served more than thirty (30) days but fewer than 181 days should submit an application for re-employment no later than fourteen (14) days after completing the period of service, unless it is impossible or unreasonable to do so through no fault of the resident. If that is the case, the resident should submit an application for re-employment on the next full calendar day when submission of the application becomes possible.

Residents returning to work who served more than 180 days should submit an application for re-employment with BHS no later than ninety (90) days after completion of the service.

Residents who are hospitalized for or convalescing from an illness or injury incurred or aggravated during service in the uniformed service should report to BHS or apply for re-employment at the end of the period that is necessary for the person to recover from the illness or injury. This period of recovery may not exceed two (2) years, unless circumstances beyond the person's control make reporting within the applicable time period impossible or unreasonable, in which case the two (2) year period may be extended by the minimum time required to accommodate such circumstance. Upon the request of BHS, persons applying for re-employment should provide documentation in accordance with the provisions of applicable law, including documentation establishing the timeliness of the application and the length and character of service.

P. **Professional and Personal Leave:** Requests for professional or personal leave without pay will be considered by the DIO and/or Executive Director for Medical Education on a case-by-case basis based on extenuating circumstances and will be subject to any applicable BHS policies and procedures.

Q. **Uniforms, Meals and Laundry Service:** BHS provides $150.00 prior to the start of first service to be used for the purchase of three white physician laboratory coats and to cover the cost of monogramming. Physician laboratory coats will be replaced as required by contacting the Program Coordinator. Residents' dress shall reflect the professional image expected of a physician. This includes a clean white laboratory coat and shirt and tie for men. Female residents are also expected to dress professionally and to wear closed-toe shoes. Scrub suits may not be worn outside the operating room suite except in emergency situations; for temporary, one-stop activities; or while on call at night after 5:00 pm. **RESIDENTS MUST WEAR THE BHS AND THE TRINITY MEDICAL CENTER PICTURE IDENTIFICATION BADGES.**

Meals are provided at no charge in the physician's dining room when assigned to the Trinity Campus. When at Princeton, residents may eat in the physician's dining room. The charge to the resident is $2.50 per day. Laundry service is not provided. Residents are responsible for laundering/cleaning their white lab coats. Scrubs are provided by the hospital (including laundering of the scrubs).

R. **Book Allowance:** Each resident is provided with a $250 book allowance each year. The book allowance may be applied to the purchase of computers and/or PDA's and related software.

S. **Post-Graduate Courses and Scientific Meetings:** Program Directors may grant residents in the second and subsequent years of post-graduate training time off and partial reimbursement of expenses for attending scientific or educational meetings. Residents at the PGY-2 level and above shall receive an allowance of $1,000 per year to be used for these professional activities outside of the residency-training program. The unused allowance can be carried forward from year-to-year. In addition, Categorical residents receive an additional $1,000 in their final year of training that may be used for a board examination review course. The board review course **must** be taken, and reimbursement **must** be requested **before** the resident completes his/her training program. Residents must submit a request in writing to their respective Program Director at least six weeks in advance of the meeting date and include appropriate supportive material for review. Program Directors must approve meeting attendance in advance of registration.

T. **Travel Reimbursement:**

Although residents have money budgeted to attend educational conferences, these funds must be used in a fiscally responsible manner.

Program Directors may grant residents in the second post-graduate year or above, time off with compensation and partial reimbursement of expenses to expand knowledge through attendance in post -graduate courses and scientific meetings in accordance with the following guidelines:

1. Residents Qualified:
   a. Time off for attending post-graduate courses and scientific meetings will be at the discretion and approval of the Program Director.
   b. Residents selected to present professional papers at state, regional or national meetings may, upon approval from the Program Director, be granted compensated time off, and reimbursement of meeting-related expenses in addition to the courses and meetings listed above.

2. Acceptable Programs:
   a. Post-graduate courses and scientific meetings must be related to the residency-training program and must directly benefit the resident in the educational program.
   b. Courses and meetings must be approved in advance by the appropriate Program Director.
   c. Category AMA/PRA Credit must be approved for the course or meeting.
   d. Organized post-graduate courses are recommended rather than professional society meetings.

3. Travel with Spouse:
   In the event the resident is accompanied by a spouse, the resident will be required to pay for the spouse's meal, travel and other expenses.

4. Reimbursable Expenses:
   Expenses for approved post-graduate courses and scientific meetings will be reimbursed, provided funds are available, as determined by the Program Director of the residency program and the Designated Institutional Official.
   a. Travel:
      i. Travel expenses will be based on regular air coach fare. The airline ticket stub must be attached to the travel reimbursement form.
      ii. Personal auto travel will be reimbursed at the approved BHS per mile rate allowance up to the amount allowed for travel by plane to the meeting destination.
      iii. Taxi fare will be allowed for one trip to and from the airport in the city where the course is attended, and to and from the meeting site if lodging is separated from the meeting site by a significant distance (more than a few blocks).
      iv. Car rental will not be reimbursed unless authorized, in advance, by the Executive Director for Medical Education or Program Director.
   b. Registration Fee -- Registration fees will be reimbursed for the resident only in conjunction with the registration form in the course or meeting brochure.
   c. Lodging -- Lodging will be paid on the basis of the lowest cost, single room, provided by the hotel where the meeting is held. This will cover one day prior to the beginning of the course, each day of the course, and the night following termination of the course. If the event or meeting is not held in a hotel, the above shall apply to the nearest reputable hotel. The hotel bill must be submitted with the travel reimbursement form.
   d. Food Allowance -- Reasonable food expenses will be paid as entered on the travel reimbursement form. Receipts are required for all meals. Generally, total meal expenses should not exceed $50 per day. Bar bills will NOT be paid.
   e. Payment of Expenses:
      i. The Seminar/Out-of-Town Expense Report must be completed within one week of return. Airline ticket stubs, hotel bills, and receipts for taxi fares, meals, and receipts for other expenses (registration, etc.) must be attached.
      ii. Seminar/Out-of-Town Expense Report and required attachments must be submitted to the Program Coordinator.

5. Presentations at Scholarly Meetings -- Residents selected to present papers or research at state, regional or national meetings may, with the Program Director's approval, have expenses reimbursed, in addition to the meetings noted above. Funds for international travel must be approved in advance by the Program Director prior to the submission of an abstract. BHS will make no reimbursement for spouse travel or expenses.

6. Other Comments:
   a. Resident Physicians are expected to be fiscally responsible when making travel arrangements and when on an actual trip. For example, if you have $1,000.00 allotted for a conference and your airfare plus hotel costs $600.00, you do not have an automatic $400.00 left to use at your discretion. You have a daily allowance as described above to cover food and necessities, and you are expected to consider this only as a maximum, not an amount you should feel compelled to spend. Any overages of the daily per diem amount must be justified on the expense report and approved by the Program Director and DIO's office. Overages will be approved only in exceptional circumstances.
   b. It is expected that travelers will use appropriate judgment and not seek reimbursement for unreasonable or unnecessary expenses. Some examples of expenses that will not be reimbursed under any circumstances are: Alcohol, rental cars, limousines, golfing fees, beach umbrellas, tours, attractions, medications, personal items, clothing, in-room movies and out-of-room movies or expenses of any other person who may be accompanying the resident on the trip.
   c. Residents are free to choose the activities in which they wish to participate; however, the traveler is expected to bear the cost of any expenses over and above what is necessary to the trip.

U. **On-Call Sleeping Quarters:** Sleeping quarters are provided in each hospital for nights "on call" and for resident lounge/recreation areas. Residents are not to use these facilities at other times except in times of severe weather or snow/ice storms (then only if space is available after the rooms have been assigned to the "on-call" residents).

V. **Parking:** Residents at Princeton may park in the designated lot(s) behind the hospital. Residents at Trinity may park on the first level of the Visitor's Parking Deck (across from the hospital). Parking cards will be issued by the House Staff Coordinator at each hospital. There is no parking charge for residents.

6. WORK RELATED PROBLEMS AND COMPLAINTS:

Residents should initially present any grievance or other problems to the Program Director, who shall attempt to resolve the grievance or problem. If the problem or grievance involves the Program Director, or if the resident is in any way uncomfortable reporting the matter to the Program Director, or if the Program Director is unable to remedy the problem, the resident should take the matter up the chain of command in the following order: (1) the Executive Director for Medical Education, (2) the DIO, and (3) the physician members of the Graduate Medical Education Council, with any involved member(s) recused. If the Program Director and the DIO are one and the same person, the resident may skip step (2).

7. DISCIPLINARY ACTIONS:

During residency training, a problem involving an individual resident may be identified which will require remedial action. This policy outlines the plan to be followed should such a problem arise.

A. **Prevention:**

At orientation, incoming residents will be advised about the availability of assistance or counseling by: faculty, the pastoral counseling services, and the Employee Assistance Program. Participation in stress management seminars will also be encouraged when available and appropriate.

B. **Problem Remediation:**

1. **Identification** - any physician or member of the residency staff or nursing staff may identify a problem involving a resident. The nature of the problem - personal, interpersonal, emotional, or clinical - and its manifestations need to be described.

2. **Documentation** - the problem, as evidenced by specific objective situations, should be documented, with a copy to the Program Director.
3. **Discussion** - the Program Director should discuss the problem, its details and possible solutions, with the resident. If the resident denies the problem and resists working toward a resolution, the matter should be referred to the DIO and/or Executive Director for Medical Education for further action.

C. **Corrective Action:**

The DIO may impose such corrective action as (s)he deems appropriate, including but not limited to the following:

1. Dismissal of complaint.
2. Limitation of clinical privileges. Does not carry the right of appeal.
3. Counseling. Does not carry the right of appeal.
4. Remedial work, to include repeating portions of the curriculum or the entire year. Requires the approval of the DIO. Written notice of extension of residency beyond the scheduled date of completion, or of non-reappointment, does carry the right of appeal.
5. Leave of absence with or without pay. Requires approval of the DIO. Carries the right of appeal.
6. Probation -- defined as a period of intense observation to correct a specific problem(s). It represents formal notice of possible termination or refusal to promote or to qualify for Boards if the problem is not satisfactorily resolved within the time period specified. The time period should be at least two months but no longer than four months; it may be extended. Requires approval of the DIO and carries the right of appeal. Written notification must be used and signed by both the resident and the Program Director with copies provided to the resident and DIO for the resident's file.
7. Suspension (without pay). The Program Director is authorized to recommend to the DIO that a resident's privileges be suspended for disciplinary reasons that are less urgent than those warranting permanent recall of privileges. Grounds for temporary suspension of privileges include, but are not limited to, unprofessional conduct and violations of medical records requirements. In all such cases, the resident and the DIO shall be notified in writing by the Program Director. If the Program Director and the DIO are one and the same, the Program Director shall provide written notice to the resident and the Executive Director for Medical Education. The DIO shall notify the resident in writing of the opportunity for the resident concerned to have a hearing as provided in these policies. If the Program Director and DIO are one and the same, the Executive Director for Medical Education shall notify the resident in writing of the opportunity for the resident concerned to have a hearing as provided in these policies. If the resident does not request a hearing, the DIO will act upon the Program Director's recommendation.
8. Revocation of appointment (termination). In all cases in which revocation of a resident's appointment has been recommended by the Program Director, the resident and the DIO shall be notified in writing by the Program Director. If the Program Director and the DIO are one and the same, the Program Director shall provide written notice to the resident and the Executive Director for Medical Education. The DIO shall notify the resident in writing of the opportunity for the resident concerned to have a hearing as provided in these policies. If the Program Director and DIO are one and the same, the Executive Director for Medical Education shall notify the resident in writing of the opportunity for the resident concerned to have a hearing as provided in these policies. If the resident does not request a hearing, the DIO will act upon the Program Director’s recommendation.

D. **Outcome:** The person(s) responsible for assessing the outcome of the problem remediation process will document the outcome at the end of the time allotted, discuss with the resident, and both will sign and date the documentation. Copies will be provided to the resident and to the DIO.

E. **Failure to Comply:** Failure to comply with prescribed remediation could result in termination, either immediate or at the end of the current residency year. In the case of a resident in the final year of residency, options include immediate termination, a decision not to issue a completion certificate, or not to approve the resident to sit for the American Board examination. These actions carry the right of appeal.

8. HEARINGS AND APPEAL PROCEDURES:

A. **Request for Hearing:** If an individual wishes a hearing for an action that carries a right of appeal, he/she must submit a written request for an appeal to the DIO within ten (10) days of receiving the written notice of disciplinary action. The written request for an appeal should specify the reasons for the appeal and why he/she believes the action taken against him/her was not appropriate. Failure to request a hearing within the time specified shall constitute a waiver of the right to a hearing and to appellate review. The DIO shall appoint a Judicial Review Committee consisting of three members of the active medical staff and two members of the residency staff who have not taken an active part in the matter contested. The DIO shall name one of the Committee members as Chair. The DIO shall determine the time and place of the hearing and mail a notice of the same to the Judicial Review Committee and to the resident requesting the hearing. The resident is responsible for providing BHS with his/her current mailing address. The Program Director shall prepare a written statement of the reason for the disciplinary action and furnish a copy to the DIO who shall furnish it to the resident claiming to be aggrieved. In the event the Program Director and the DIO are one and the same, the Program Director shall recuse him or herself from his/her DIO role and the aforementioned responsibilities of the DIO in this Section and in Section B., below, will be delegated to and assumed by the Executive Director for Medical Education.

B. **Conduct of the Hearing:** The personal presence of the resident who requested the hearing shall be required. If a resident fails to appear and proceed at the hearing without good cause, the resident shall be considered to have waived all rights hereunder. The Chair shall be the Presiding Officer of the hearing. The Presiding Officer shall maintain the decorum and assure all participants in the hearing have a reasonable opportunity to present relevant oral and documentary evidence. The Presiding Officer shall determine the order of the proceedings and shall make rulings on procedure and evidence to be considered. The hearing need not be conducted according to technical rules relating to evidence and witnesses. Any party shall be given a reasonable opportunity to refute matters of record by evidence or by written or oral presentation. The resident and the Judicial Review Committee may have an advisor at the hearing; however, the role of any third party representative or advisor will be limited to serving as an observer and/or an advisor to the resident or to the Committee. The advisor will not be allowed to participate in the hearing. The name of the advisor must be provided to the DIO at least seven days prior to the hearing. Failure to timely provide the DIO with the name of the advisor shall constitute a waiver of the right to an advisor, and the advisor shall not be allowed to attend the hearing.

The full Judicial Review Committee must be present throughout the hearing and the deliberations. Upon conclusion of the presentation of oral and written evidence, the hearing shall be closed. Thereafter, the Judicial Review Committee will conduct its deliberations. The Judicial Review Committee may vote to uphold the discipline or to alter the discipline to make it more or less severe. The vote of the Judicial Review Committee must be by a majority vote of the Judicial Review Committee.

Upon the adjournment of the hearing, the Presiding Officer of the Judicial Review Committee shall make a written report of its findings and decisions. This report shall be sent to the resident at his/her last known address.

C. **Request for Appeal:** Within 10 days of receipt of a negative decision by the Judicial Review Committee, the resident must submit a written appeal to the Graduate Medical Education Council, addressed to the DIO by certified mail return, receipt requested. The written appeal shall set forth any findings or conclusions with which the resident disagrees. If the resident fails to request appellate review within the time frame and manner set forth herein, any right for review is waived, and the DIO will then act on the recommendations of the Judicial Review Committee. If the resident submits a written appeal, the Program Director may provide a written statement in reply.

The Graduate Medical Education Council shall convene and review the appeal, the resident's file, the proceedings below and any written evidence submitted at the hearing below.

If a majority of the Graduate Medical Education Council agrees with the decision of the Judicial Review Committee, a written decision by the Graduate Medical Education Council will be submitted within a 30-day period following the appeal. If the Graduate Medical Education Council disagrees with the decision of the Judicial Review Committee, the Graduate Medical Education Council will meet with the Judicial Review Committee within a 30-day period following the appeal. The final written decision by the Graduate Medical Education Council will be rendered ten days after the meeting.

An individual shall be deemed to have received notice of action: 1) four days after the same is deposited in the U.S. Mail, postage prepaid addressed to the individual at his/her address; or 2) upon the date of actual delivery if the same is personally delivered to the individual. It is the responsibility of the resident to provide the Program Director with his/her most current mailing address.

1. **BHS DISPUTE RESOLUTION PROGRAM:**

As consideration for the agreement by BHS and Baptist Princeton and Trinity Medical Center (the "Hospitals") to submit any claims they may have against the resident, now or in the future, to arbitration, the resident hereby agrees that any dispute that the resident may have with BHS or the Hospitals, or that BHS or the Hospitals may have with the resident, will be handled in accordance with the BHS Dispute Resolution Program under which binding arbitration is the exclusive method for deciding any legal claims the resident may have against BHS or the Hospitals (including any claims that the resident may have against BHS or the Hospitals for refusing to hire the resident), or that BHS or the Hospitals may have against the resident; neither BHS nor the Hospitals nor the resident will have any claims against the other heard and decided in court. The BHS Dispute Resolution Program includes all claims or controversies, whether or not arising out of employment or termination of employment, that would constitute a cause of action in a court, including but not limited to claims for wages or other compensation due; claims for breach of contract or promise (express or implied); tort claims; claims for discrimination or other employment-related claims; claims of retaliation for filing or prosecuting worker's compensation claims; claims for benefits (except where an employee benefit or pension plan specifies that its claims procedure shall result in an arbitration procedure different from this one); and claims for violation of any federal, state, local, or other governmental law, statute, regulation, or ordinance (including but not limited to claims based on the Civil Rights Act of 1991, Title VII of the Civil Rights Act of 1964, the Civil Rights Act of 1866, the Americans with Disabilities Act, the Rehabilitation Act of 1973, the Age Discrimination in Employment Act, the Older Workers Benefit Protection Act, the Family and Medical Leave Act, the Employee Retirement Income Security Act of 1974, the Equal Pay Act, the Fair Labor Standards Act, the Vietnam Era Veteran's Readjustment Assistance Act, the Uniformed Service Employment and Reemployment Rights Act of 1994, the Worker Adjustment and Retraining Notification Act, or the Fair Credit Reporting Act, the Alabama Constitution, the Alabama Age Discrimination in Employment Act, and any amendments to any of the foregoing), except claims for workers' compensation benefits and unemployment compensation benefits. Nothing in the Program shall be construed as prohibiting the resident from filing an administrative charge of discrimination, an unfair labor practice charge, or other alleged violations of the law with the Equal Employment Opportunity Commission, the National Labor Relations Board, or any other government agency acting pursuant to state or federal law. Also excluded are certain claims by BHS or the Hospitals for injunctive or equitable relief to protect trade secrets and other confidential matters.

The resident further understands that a copy of the BHS Dispute Resolution Program is available for the resident to review, and that the resident has either reviewed the Program and voluntarily agrees to be bound by it or has voluntarily decided to be bound by it without reading it.

10. **MISCELLANEOUS INFORMATION:**

A. **Medical Education Offices:** The Corporate Medical Education Office may be reached by calling (205) 599-4822. The Medical Education Office at Princeton is located in POB III 2nd Floor. Call 783-3190 to reach the house staff coordinator.

The Medical Education Office at Trinity is located on the first floor. Call 592-1591 to reach the house staff coordinator.

Administrative support staff are on duty at all facilities Monday through Friday. For any urgent problem when the office is closed, the appropriate Program Director should be contacted.

B. **Libraries:** The Medical Library at Princeton is located in POB III 2nd Floor, next to the Medical Education Offices and On-Call rooms. The Medical Library at Trinity is located on the first floor next to the Medical Education Office. Both libraries are open from 8:00 a.m. - 5:00 p.m., Monday through Friday. Either a Librarian or the Library Assistant will be present at each library to assist residents and faculty with library requests/needs. Both libraries can also be accessed at night and on weekends by using the resident's ID badge.

C. **Pagers:** Pagers will be assigned to all residents for use at both Princeton and Trinity. Residents are responsible for these devices; they should be handled properly. Extra batteries are available in the Medical Education Offices. For repairs, return them to the house staff coordinators.

D. **Call Schedule:** PGY-1 residents will not take call per ACGME requirements. Internal Medicine, Surgery, Radiology, and Transitional Year, residents may be expected to work in the hospital to admit patients and respond to emergencies that may arise during the night. This in-house service is "on average" every fourth night. Program-specific call policies exist and should be complied with. A call schedule will be posted on the bulletin board in each Office of Medical Education and will also be given to each resident by the 15th of the preceding month. Separate call schedules are provided for Pathology and Radiology residents. If a change in the schedule is made and approved by the appropriate program personnel after distribution, the hospital operator, chief residents, and Emergency Department should be notified by the residents involved.

E. **Licensure:** All resident physicians who are graduates of a college of medicine accredited by the Liaison Committee on Medical Education or are graduates of a college of osteopathy accredited by the American Osteopathic Association are eligible for full medical licensure in the State of Alabama after completing one full year of residency training. Resident physicians not graduating from an institution accredited by the Liaison Committee on Medical Education or the American Osteopathic Association are eligible for licensure after completing three (3) years of training. Residents who participate in moonlighting activities are required to hold a valid Alabama medical license. An application form may be secured **only** by contacting the State Board of Medical Examiners (1-800-392-5668), P.O. Box 946, Montgomery, Alabama 36102. Residents must comply with the licensure requirements as specified by their respective programs.

F. **Narcotic Numbers:** A narcotic registration number will be assigned by the Pharmacy Office at each hospital for first year residents. This number is good for only one year and must be renewed until the resident becomes fully licensed.

Residents at the second year or above obtaining full Alabama medical licensure must obtain a Drug Enforcement Administration number. Applications are available in the Medical Education Offices at Princeton and Trinity.

G. **Advanced Cardiac Life Support (ACLS) Certification:** Newly appointed residents are required to be certified in ACLS. ACLS courses are offered in June of each year. Newly appointed residents who have been ACLS- certified within 6 months prior to starting orientation at BHS may present such certification in lieu of taking the required course. All reappointed residents are expected to recertify as necessary to keep their certification active. Recertification courses are offered annually in June and at various other times during the year in conjunction with certification classes for all other hospital personnel.

H. **Long Distance Telephone Calls:** Long distance telephone calls can be made by the residents for purposes related to patient care or official BHS business. Under no circumstances are the residents to charge personal calls to either BHS, Princeton, or Trinity.

I. **Moonlighting:** PGY-1 residents are not permitted to moonlight. Moonlighting is not required by BHS and is not expected of the residents. Residents who moonlight (either in-house or externally) must count these hours toward the 80-hour duty limit. The Program Directors may define program-specific policies for moonlighting by residents, consistent with the educational and professional requirements of the individual residency programs. Residents must obtain the Program Director's written approval for moonlighting activities prior to engaging in the activity, and residents are not permitted to participate in any activity which distracts from performance of regularly assigned duties and achievement of expected educational goals during the training program. The attainment of the educational goals and objectives is monitored by the respective Program Director. The Program Director will determine whether or not participation in the activity in question interferes with the resident's ability to meet the educational goals and objectives. If outside employment is approved by the Program Director, a valid license for the independent practice of medicine in Alabama is required for such activities. **Additional medical liability (malpractice) insurance must be obtained at the resident's expense for professional activities other than the internal moonlighting educational opportunities that occur in the BHS residency programs.**

J. **Duty-Related Injury or Illness:** In the event a work-related injury or illness (e.g., needle sticks, falls, lifting injuries, etc.) occurs while on duty,

1. Immediately report the injury to the department manager where the injury occurred.

2. During weekday work hours, notify the Hospital Employee Health Nurse of the injury.
    - At Princeton: 783-7718 (Sabrina Powell, RN or Kesha Thomas, RN)
    - At Trinity: 592-5057 (Cathy Lloyd, RN)
3. The employee health nurse will either administer treatment for your injury or else direct you to another level of care.
4. After hours, and on weekends and holidays, you should report to the House Supervisor for medical attention and tell them you were injured on the job.
    - At Princeton: 783-3906
    - At Trinity: 592-2550
5. Within 24 hours of the injury, contact Debra Smith in the Medical Education office at 599-4822. Ms. Smith will complete the "First Report of Injury" form.
6. You will then be contacted by Brentwood Insurance Company for any additional information regarding the injury.

Note: The BHS Workers' Compensation plan **will not** provide payment coverage for: 1) Self-inflicted injuries/illnesses, 2) Injury while under the influence of drugs or alcohol, or 3) Failure to use prescribed safety equipment. Injuries that occur at Trinity should be reported as outlined, and you should identify yourself as a BHS employee/resident. This is to ensure the Workers' Compensation billings are sent to BHS for processing and payment. Trinity is a separate entity from BHS and is not responsible for Workers' Compensation claims that are applicable to BHS employees.

K. **Clinical Competency Committee**: In his or her discretion, a Program Director may establish a Clinical Competency Committee and appoint and remove its members, who must be faculty physicians and/or appropriate non-physician BHS employees. The Clinical Competency Committee will meet with the Program Director from time to time regarding general or specific program issues raised by the Program Director (including, but not limited to, matters regarding the progress, competence, performance, remediation and discipline of residents) and may make non-binding recommendations to the Program Director regarding program decisions to be made by the Program Director.

TRANSITIONAL YEAR RESIDENCY PROGRAM

OBJECTIVES

The Transitional Year Residency at BHS is designed to provide a broad-based clinical experience to medical graduates who:

- Have chosen a career specialty for which the categorical program in graduate medical education (e.g. anesthesiology, radiology, or ophthalmology) has, as a prerequisite, 1 year of fundamental clinical education, which may also contain certain specific experiences for development of desired skills.
- Have not yet made a career choice or specialty selection and desire a broad-based year to assist them in making that decision and preparing for future training.

The BHS Transitional Year Residency is not meant to be a complete preparatory program for the practice of medicine.

GENERAL GUIDELINES FOR THE TRANSITIONAL YEAR RESIDENT

Transitional Year residents are held to the same high standards as other BHS residents and are expected to conduct themselves in a professional and courteous manner in all relationships with patients, hospital staff, and other physicians. When assigned to Medical or Surgical Services, Transitional Year residents may be under the supervision of the senior/chief residents on those services, as well as the attending physician to whom they are assigned. Transitional Year residents are expected to participate in all educational activities of the department to which they are assigned (Medicine, Pathology, Radiology, or Surgery), as do other PGY-1 residents.

CURRICULUM

The BHS Transitional Year Residency Program is jointly sponsored by the Internal Medicine, Surgery, and Radiology residencies of BHS. Transitional Year residents will spend the majority of their year in training on clinical rotations learning fundamentals of patient care. Curriculum planning by TY residents should take into consideration their intended future specialty training and practice goals. For example, Transitional Year residents preparing for future careers in surgically-oriented fields can expect to spend a minimum of two months on Surgical Services, including the one-month general surgery block. Special educational needs and goals should be discussed with the Program Director. To meet ACGME requirements for Transitional Year residency training, a minimum of 24 weeks of each TY resident's curriculum will consist of rotations in disciplines providing instruction in fundamental clinical skills. Rotations that meet these ACGME requirements include Ambulatory Medicine, Inpatient General Internal Medicine (Staff Medicine and Hospital Medicine), General Surgery, and Critical Care Medicine.

Goals and objectives for each Transitional Year rotation and other rotation-specific information for which the Transitional Year resident is held responsible are outlined in the Transitional Year Curriculum distributed to each resident at orientation.

CLINICAL ROTATIONS

Transitional Year residents are assigned to the services of clinician educators who are members of the teaching faculty of BHS and will also do rotations on the Medicine and Surgery Inpatient Residency Staff Services ("Staff Services"). Requests for specific rotation assignments should be made by Transitional Year residents prior to the beginning of the academic year, and assignments to specific services will be made at that time. Once a master schedule for rotations is finalized and distributed, residents are expected to follow this schedule throughout the subsequent academic year. Changes will be made in these assignments only under exceptional circumstances with the approval of the Program Director.

1. Private Services

Much of the educational experience for residents at BHS is available through daily exposure to the patients of clinician educators who are BHS faculty. Residents are expected to participate in daily rounds with their attending physicians, to be prompt and readily available, and to assume an active role in patient care. Residents should know all clinical information about assigned patients. Residents are expected to assess patients and to present diagnostic and therapeutic plans to the attending physician on daily rounds.

The assumption of responsibility for patient care is an important aspect of residency training. Private attending physicians have professional responsibilities for the care of their patients which must be balanced with the educational needs of the resident. Residents are responsible for contacting private physicians at least 2 days prior to the beginning of each rotation to discuss the upcoming assignment, to inform the attending of any scheduled absences, and to clarify the following points:

- The objectives the resident hopes to achieve during the rotation and the expectations of the attending physician.
- The time, method, and procedure for making rounds.
- The weekly schedule including any days off and vacation planned by the attending. Residents are expected to make rounds and to follow patients even when their attending physician is off, and to work with the covering attending on call in performing this responsibility.
- The selection of patients for assignment to the resident if the patient load becomes unduly heavy. Note: BHS strictly adheres to the ACGME requirements for maximum patient care responsibilities/loads.
- The opportunity to see patients after discharge in the attending physician's office.

Defined goals and objectives for each rotation are delineated within the Curriculum provided to each Transitional Year resident upon their matriculation at BHS.

Staff Medicine Service

As part of the Transitional Year curriculum, TY residents will be assigned to the Staff Medicine Service at Princeton Baptist Medical Center or Trinity Medical Center. A major goal of the Staff Medicine Service is to provide residents with the experience of primary responsibility for the care of patients with a variety of medical problems. PGY-1 residents assigned to the Staff Medicine Service are supervised by an upper level resident in Internal Medicine and by attending physicians from the core faculty. Transitional Year residents assigned to the Staff Medicine Service should take full advantage of this educational experience by formulating clear diagnostic and therapeutic plans for each patient seen prior to discussion with the upper level resident and attending physician.

With oversight by the attending physician, the upper level resident has supervisory responsibility over the Transitional Year residents on the Staff Medicine Service. The upper level resident assigned to the Staff Medicine Service or his or her designee must be consulted regarding discharges or significant changes in the clinical status of Staff Medicine Service patients according to the following guidelines:

- All significant problems with Staff Medicine Service patients or major changes in their clinical condition must be discussed with the upper level resident overseeing the service. This particularly applies to those patients being moved to an ICU or to those patients who become critically ill or who expire. The attending physician should also be notified of such changes.
- The Staff Medicine Service intern admitting or assuming care for Continuity Clinic patients admitted overnight or on weekends is responsible for identifying and personally contacting the patient's regular clinic physician notifying him/her of the admission.

There are also situations in which the PGY-1 resident or the senior resident in charge should consult the attending physician. These situations include:

- Admission of new patients to the service, as directed by each individual attending.
- Death of any Staff Medicine Service patient.
- Any difficult patient management decision in regard to patient admission, discharge or treatment.
- Any conflict with another physician (especially over a question of patient admission or consultation).

Residents must communicate about patient problems in detail when signing out to each other at night or on weekends. Formal mechanisms for patient hand-off are in place and should be followed by Transitional Year residents who are assigned to the Staff Medicine team.

Transitional Year residents assigned to the Staff Medicine Service may be required to work extended duty hour periods, not to exceed the ACGME-required 16-hour limit, as assigned to him/her by the Chief Medical Resident. Duty hours will be in compliance with ACGME guidelines, and TY residents are required to log and report their work hours.

Vacation time is not allowed during assignment to the Staff Medicine Service.

2. Surgical Resident Staff Service

(See Surgery Section)

3. Consultations

Resident responsibilities on many inpatient rotations will include performing consultations on patients of other services. The attending physician should be notified directly of any such consultation requests, even if the resident feels certain the referring physician or nursing staff has already notified the attending physician.

When medical subspecialty consultations are required for Staff Medicine Service patients, the requesting resident physician should personally contact the sub-specialist and request consultation. Additionally, an order should be written in the order section of the patient's chart.

All surgery consultations for Staff Medicine Service patients should be obtained from the Staff Surgery Service. Surgical problems should be discussed with staff surgeons before consultation with surgical specialists/subspecialists is requested.

4. Ambulatory Rotations

Transitional Year residents are required to complete an ambulatory block month in order to further develop fundamental clinical skills. Residents are expected to perform in the same professional manner as they do on hospital-based services and to treat patients with courtesy and respect. Specific requirements for individual ambulatory care rotations will be defined by the attending physician at the beginning of each assignment. During a clinician educator's absence (due to off days or vacation) from an ambulatory rotation, the resident will be automatically reassigned to work with the covering attending. The resident should be available by pager for program-related issues during work hours and continue to attend required conferences.

PROCEDURAL SKILLS

Background

The BHS Transitional Year residency program provides residents with instruction in the indications, contraindications, complications, limitations, and interpretation of findings for a variety of invasive procedures. TY residents will have the opportunity to learn to perform such procedures under the supervision of faculty and/or qualified residents from the Medicine, Surgery, and Radiology programs, as appropriate for their individual educational needs and goals. Those residents who will perform invasive procedures as a part of future training and practice (e.g. anesthesiology) are expected to learn these procedural skills and to demonstrate basic competence by the time they complete their TY residency.

Policy:

1. All BHS PGY-1 Internal Medicine and Transitional Year residents will attend a series of didactic lectures regarding the indications, contraindications, complications, and technical performance of basic invasive procedures. Residents will also learn interpretive skills for each of the basic invasive procedures. Reference articles from the medical literature regarding each procedure will be provided for review.

2. Preliminary training in the performance of invasive procedures will be available to TY residents in the Simulation Lab at Princeton Baptist Medical Center.

3. All BHS residents will maintain current Advanced Cardiovascular Life Support certification as provided by the American Heart Association.

4. Residents will perform invasive procedures only under the supervision of qualified faculty or upper-level residents, until (a) at least the minimum numbers of these procedures as listed below have been successfully performed, **and** (b) the resident has been approved to perform these procedures independently. Once a resident has been approved to perform a procedure independently of direct supervision, he/she will be notified of the new clinical privilege in writing. A periodic report regarding residents' procedural competence will be made available to the hospital administration and nursing staff for review and verification.

5. All residents will be required to keep an ongoing online record of the procedures they have performed by logging those procedures into the appropriate website. The name of the supervising physician should be included on each record. Only those procedures completed successfully, in the judgment of the supervising physician, will be counted toward the demonstration of technical competence.

6. Residents will continue to maintain an ongoing record of their procedures even after achieving the minimum required numbers to demonstrate technical competence.

7. Transitional Year residents who plan to use invasive procedures in future practice settings will be expected to demonstrate proficiency by satisfactory performance of at least the minimum number (as required of Internal Medicine residents) of these procedures under the direct supervision of faculty or qualified supervising residents. The minimum number of successfully-performed procedures expected of BHS residents for demonstration of basic competence include:

    - Lumbar Puncture (5)
    - Central Venous Line insertion (5)
    - Arterial puncture for blood gas analysis – ABG – (5)
    - Nasogastric intubation (3)

8. Transitional Year residents are required to attend a series of lectures providing the knowledge and skills to recognize common normal, abnormal, and technical artifact patterns in electrocardiography. In addition, training will focus on the understanding of the pathophysiology of electrocardiographic abnormalities as well as the opportunity to apply this knowledge in bedside clinical decision-making.

EXTENDED DUTY HOUR PERIODS

Duty Hours

The duty hours at the BHS Transitional Year Residency Program are defined as all clinical and academic activities related to the residency program. Restrictions on duty hours for BHS TY residents are intended to comply with ACGME requirements for the residency programs which sponsor the Transitional Year residency. Duty hours do not include reading, study and preparation time spent away from the duty site.

- Duty hours are limited to 80 hours per week, averaged over a four-week period.
- Residents will be provided with 1 day (24 continuous hours) in 7 free from all educational and clinical responsibilities, averaged over a four-week period.
- Extended Duty Hour periods, defined as always being less than or equal to 16 hours, may be required of TY residents periodically. Direct supervision by a senior level resident and indirect supervision by an attending physician are always available.
- Adequate time for rest and personal activities will be provided by requiring at least an 8-hour time period between all daily duty periods and after in-house call.
- Continuous on-site duty will not exceed 16 consecutive hours.

Patient Load Limits

- A first-year resident must not be assigned more than 5 new patients per admitting day; an additional 2 patients may be assigned if they are in-house transfers from the medical services.
- A first-year resident must not be assigned more than 8 new patients in a 48-hour period.
- A first-year resident must not be responsible for the ongoing care of more than 10 patients.

Extended Duty Hour Period Schedule

Transitional Year residents will be required to take extended duty hour periods which will vary depending on service assignment and holiday/vacation scheduling. When averaged over any 4-week rotation or assignment, residents must have at least one day out of seven free of patient care duties.

Responsibilities During Extended Duty

Transitional Year residents assigned to take Medicine extended duty have the same responsibilities as PGY-1 residents in Internal Medicine. All residents assigned to Medicine extended duty are required to be physically present in the designated hospital for the entire duty period. The Chief Medical Resident must approve in writing any change in the extended duty schedule. The resident making the change after the change has been approved should notify the hospital operator, Program Coordinator, and the senior resident.

Specific Responsibilities for All PGY-l Residents on Medicine Extended Duty include:

- Respond to any Code Blue or other hospital emergency. If the resident must leave the hospital during the day (for ambulatory clinic), he or she MUST arrange coverage of Code Blue calls. Residents will respond to "code blue" calls on all hospital patients and assist in stabilizing such patients until the appropriate attending physician can be contacted and assume responsibility for the patient's care.
- Respond to non-Emergency Department Code Stroke calls occurring at the Princeton campus.
- Examine and complete an incident report on patients who sustain trauma or develop a medical emergency while in the hospital.
- Pronounce deaths if requested to do so, and assist in obtaining permission for autopsy and organ donation where appropriate.
- Cover the Medicine Staff Service under the supervision of the senior resident responsible for this Service, admitting patients to that service after hours or on weekends.
- Perform consultations for the Staff Medicine/Staff Surgery Services (depending upon the assignment) during extended duty hours with supervision by senior level resident.
- All PGY-1 physicians who are responsible for the primary care of patients will be asked to "check out" those patients with the upper level Resident on Night Call. This will provide the resident on night call with the names and major medical problems of the patients that he/she is expected to cover during the night hours.

Extended Duty - Surgery

When assigned to surgical services, Transitional Year residents will be required to take surgery extended duty under the supervision of the senior/chief surgery resident. Expectations and responsibilities of Transitional Year residents taking surgery extended duty are outlined in the surgical section of the Resident's Handbook and in the Transitional Year Goals and Objectives document.

CONFERENCES AND EDUCATIONAL ACTIVITIES

When assigned to Internal Medicine Services, Transitional Year Residents are required to attend Medicine conferences and Morning Report just as are all Internal Medicine residents. Attendance at all conferences is mandatory unless urgent patient care responsibilities preclude attendance. 80% attendance is required for satisfactory completion of the Transitional Year. TY residents must sign an attendance log indicating their attendance at conferences, which is then documented by the Program Coordinator.

The BHS Internal Medicine Program provides the following conferences:

- Journal Club (monthly)
- Morning Report (four days per week)
- Noon Conference (three days per week)
- Tumor Board (weekly)
- Board Review (weekly)
- Morbidity and Mortality Conference (monthly)
- Grand Rounds (three per month)

Transitional Year residents assigned to Pathology, Radiology or Surgery are required to attend the respective departmental conferences and to participate in all of the department-specific resident activities. Transitional Year residents are excused from all medicine conferences when on non-medicine rotations. Residents should consult the Curriculum or Program Coordinator for rotation-specific conference requirements prior to beginning each rotation.

EVALUATION OF PERFORMANCE

Faculty and senior residents are required to provide performance evaluations of the Transitional Year residents at the completion of each rotation. These evaluations include the following:

- Rotation evaluations
- Mini-Clinical Evaluation Exercises (Mini-CEX)
- 360 Degree evaluations

These evaluations are reviewed periodically by the Program Director. Appropriate suggestions for improvement may be made to individual residents. Residents may review their evaluations by appointment with the Program Director or designee. Formal reviews of Transitional Year residents' performance are conducted on a regular basis in conformance with ACGME requirements and with the expectations of terminating specialty training programs. An exit interview and final performance evaluation will be conducted with all TY residents.

Transitional Year residents are required to complete faculty and rotation evaluations at the completion of the service. These should be completed by accessing the on-line residency evaluation program.

MEDICAL RECORDS

Part of the professional responsibility of each Transitional Year resident is the timely completion of accurate, legible medical records at the hospital(s) to which he/she is assigned. Princeton has recently transitioned to a completely Electronic Medical Record (EMR) using the Epic system. Trinity Hospital is beginning its transition to an EMR system. BHS Transitional Year residents should dictate (or enter in the Electronic Medical Record) a complete history and physical at the time of admission for all patients admitted by them. In addition, discharge summaries should be completed (dictated) prior to or at the time of patient discharge. Detailed instructions regarding organization and content of admission evaluations (H&Ps), discharge summaries and consultation notes will be provided to all housestaff. Residents may complete most medical records delinquencies at Princeton and Trinity electronically. Repeated failure to complete assigned medical records is an indication of inadequate development of competency in the required realms of Professionalism, Patient Care, Interpersonal/Communication Skills, and Systems-Based Practice, and will be documented in the resident's performance evaluation file.

History and Physical Exam

Residents are expected to write an admission note on each patient indicating the primary problem, pertinent physical findings, the initial impression or problem list and a diagnostic and therapeutic plan. A **complete** history and physical examination shall be completed within 24 hours after admission by the resident admitting the patient. Attention to detail with both the history and the physical exam is essential.

Daily Progress Notes

Daily progress notes with all pertinent data, proper documentation of procedures, and with correct documentation of attending involvement are required. Correct documentation is essential for good patient care as well as for medico-legal considerations. Any significant change in a patient's condition should be recorded.

Physician Orders

All orders for treatment shall be in writing at Trinity, or entered directly into the Epic system at Princeton. All verbal orders given by telephone shall be signed/authenticated by the responsible practitioner within 24 hours.

Discharge Summaries

Discharge summaries are dictated on all patients assigned to a resident upon patient's discharge. Specific instructions regarding the format and content of discharge summaries will be made available to all TY residents at the beginning of the academic year.

Incomplete Charts

It is the responsibility of the resident to promptly complete all medical records. Residents will be notified of any delinquent charts by periodic postings in the Medical Education common areas and/or by the Program Coordinator. Residents are subject to disciplinary action for failure to complete medical records in a timely fashion

SCHOLARLY ACTIVITY

Research Paper Preparation -- Transitional Year residents are required to prepare a written case report, based on a patient encountered during training at BHS, with discussion and references to the medical literature. This paper will be written in a form appropriate for publication in peer-reviewed journals. Specific instructions and guidelines will be provided for the preparation of this manuscript. All manuscripts must be presented to the Program Coordinator on or before **March 1st** of the academic year. Case reports will be reviewed by faculty and are to be revised by residents in response to editorial feedback.

Poster Presentation -- TY residents are also required to participate in the BHS Medical Education Department's annual "Resident Research Week" event in the spring of the academic year. Each Transitional Year resident will prepare and present a poster based on his/her case report (or another appropriate case). These poster presentations will be judged by faculty.

MISCELLANEOUS

Vacation

Transitional Year resident vacation time must be coordinated with the vacation requests of residents in the Medicine and Surgery programs. TY residents must submit requests for vacation to the Program Coordinator at least one month in advance. Transitional Year residents should plan to take half of their allotted vacation during the first six months of the academic year, and the remainder during the second half of the year. No vacation will be granted during the last two weeks of June or the first two weeks of July. No vacation will be allowed in the weeks abutting the Christmas/New Year Holiday schedule. Vacation will not be allowed during assignment to a Staff Medicine rotation.

Illness

In the event a resident becomes unable to perform assigned daily clinical responsibilities or must leave the hospital due to illness, he or she MUST contact the attending physician on the service to which he or she is assigned, the CMR at the appropriate hospital, and the Program Coordinator as soon as possible.

Pagers

The resident's pager MUST be activated at all times while on hospital premises. If the resident's clinical responsibilities are completed and the resident leaves the campus, he or she should be available by pager until 5:00 p.m. for questions concerning his or her patients. Special service requirements may supersede this general rule and would require the resident to leave his or her pager activated continuously. Code pagers should never leave the hospital premises, nor should they be deactivated for any reason.

Moonlighting

Transitional Year residents are not permitted to moonlight.

RESIDENCY PROGRAM IN INTERNAL MEDICINE

OBJECTIVES

- To provide a learning environment that fosters the acquisition of knowledge and the diagnostic and therapeutic skills essential for the general internist.
- To provide a broad experience in the subspecialties of Internal Medicine, thereby strengthening the training of residents as generalists, and at the same time exposing residents to fields of possible interest for future subspecialty training.
- To nurture the learning of both the art and science of medicine, with particular emphasis on the humanistic qualities needed by the compassionate and caring physician.
- To prepare physicians in training for future practice in an ever-changing medical and social environment with an emphasis on cost-effectiveness, evidence-based medicine, a commitment to lifelong learning, preventive medicine, and ambulatory care.
- To assure that Internal Medicine residents at BHS obtain the necessary training and credentials for certification by the American Board of Internal Medicine (ABIM), and to assist those residents in preparation for the ABIM certifying exam.
- To provide educational activities and a curriculum that allows residents to have an opportunity to achieve excellence in the six general competencies as defined by the ACGME and required by the RRC-IM.

GUIDELINES FOR THE MEDICAL RESIDENTS

GENERAL

BHS Internal Medicine residents are expected to conduct themselves in a professional and courteous manner in their relationships with patients, hospital staff, and other physicians. PGY-1 residents in Internal Medicine work under the supervision of more senior medicine residents and attending physicians who are members of the Internal Medicine faculty. All residents are held to high standards of responsibility for patient care and are to participate actively in the educational opportunities offered them in the BHS Internal Medicine Residency Program. Preliminary Internal Medicine residents are considered in the same manner as first year Categorical Internal Medicine residents and, as such, have the same duties and responsibilities as those outlined below for PGY-1 Categorical Internal Medicine residents.

The official certificate year for the Internal Medicine program begins on the first business day following New Resident orientation at the beginning of the year and ends on the first business day following New Resident Orientation at the end of the year. The exact dates for the end of the academic year will be determined annually by the Designated Institutional Official.

CURRICULUM

The curriculum of the BHS Internal Medicine residency is designed to meet the educational objectives of the program as well as the requirements of the Internal Medicine Residency Review Committee of the ACGME and the American Board of Internal Medicine. Among these requirements is a minimum of 30 months of "meaningful patient care responsibility" during the 36 months of Internal Medicine training. Required hospital rotations including general Internal Medicine and medical subspecialty services are supplemented by ambulatory care rotations and a variety of electives to provide a solid educational framework for the future practice of Internal Medicine and of its subspecialties. The upper-level resident is expected to assume greater responsibility for patient care and for teaching PGY-l residents and medical students. The Internal Medicine Curriculum is updated annually and provided to each resident at the beginning of each academic year. Curriculum goals and objectives are provided to each resident upon matriculation at BHS and remain on file in the Program Coordinator's office. **The rotation-specific Goals and Objectives should be reviewed with the attending physician at the beginning of each educational assignment**.

CLINICAL ROTATIONS

Internal Medicine residents will be assigned to the services of physicians who are members of the teaching faculty of the BHS. This includes rotations on the Internal Medicine Resident Services ("Staff Services"). Once a master rotation schedule is finalized and distributed, residents are expected to follow this schedule throughout the subsequent academic year. Changes

in assignments will be made only under exceptional circumstances and with the prior approval of the Program Director. **Requests for changes in rotation assignments should be made directly to the program coordinator.**

Private Services

Much of the educational experience for residents at BHS is provided through daily exposure to the patients of clinician educators who are BHS Internal Medicine faculty. Residents are expected to round with their attending physicians, to be prompt and readily available, and to assume an active role in patient care. Residents are expected to know relevant clinical information about assigned patients. Residents are expected to assess patients and to present diagnostic and therapeutic plans to the attending physician on daily rounds.

Residents are required to contact their attending physicians at least 2 weekdays prior to the beginning of each rotation to discuss the upcoming assignment, to inform the attending of any previously approved vacation absences, and to clarify the following points:

- The rotation-specific Goals and Objectives and the individual expectations of the resident and attending physician.
- The diagnostic and therapeutic procedures which may be part of the rotation.
- The time, method, and procedure for making rounds.
- The weekly schedule including any days off and vacation planned by the attending. **Residents are expected to make rounds and follow patients even when their attending physician is off and to cooperate with the supervising attending in performing this responsibility.**
- Those situations occurring at night or on weekends for which the resident should notify the attending physician.
- The selection of patients for assignment to the resident if the patient load becomes unduly heavy. The BHS Internal Medicine Residency Program strictly adheres to the ACGME requirements for maximum patient care responsibilities/loads.
- The opportunity to see patients after discharge in the Attending Physician's office.

PGY-2 and PGY-3 residents will be assigned to some services on which they have supervisory responsibilities for PGY-1 Internal Medicine and Transitional Year residents as well as medical students. The senior residents are expected to review the work of first year residents and medical students, to provide direction and instruction, to stimulate reading and research, and to assist the attending physician in managing the clinical service. PGY-2 and PGY-3 residents are expected to supervise and actively teach medical students assigned to their services.

Medicine Staff Service

As part of the educational experience at BHS, Internal Medicine residents will be assigned to the Staff Medicine Service at Princeton and/or Trinity. A major goal of the Staff Medicine Service is to provide residents with the experience of primary responsibility for the care of patients with a variety of medical problems. PGY-l residents assigned to the Staff Service are supervised by an upper level resident in Internal Medicine and by attending physicians from the core faculty. Residents assigned to the Staff Medicine Service must formulate clear diagnostic and therapeutic plans for each patient seen, prior to consultation with the senior resident and attending physician. In addition to inpatient responsibilities, the Staff Medicine team may be responsible for the evaluation and treatment of outpatients from the Continuity Clinic requiring medical care at times they cannot be in a regularly scheduled clinic. With oversight by the attending physician, the upper level medicine resident has supervisory responsibility for the PGY-l Internal Medicine or Transitional Year residents on the Staff Medicine Service and for patients admitted to the service. The upper level medicine resident assigned to the Staff Medicine Service or his/her designee must be consulted regarding admissions, discharges, or significant changes in clinical status of Staff Service patients, according to the following guidelines:

- All significant problems with Staff Medicine Service patients or major changes in their clinical condition must be discussed with the upper level resident overseeing the Service. This particularly applies to those patients being moved to the ICUs or to those patients who become critically ill or expire. **The attending physician should be notified of such changes.**
- The Staff Medicine Service intern admitting or assuming care for a Continuity Clinic patient admitted overnight (or on weekends) is responsible for identifying and **personally contacting the patient's regular clinic physician, notifying him or her of the patient's admission.**
- **All transfer calls should be directed to the attending physician.**

There are also situations in which the PGY-1 resident or the upper level resident in charge should consult the attending physician. These situations include:

- **Admissions of all patients.**
- **Death of any Staff Service patient.**
- **Any difficult decision regarding patient admission.**
- **Any conflict with any other physician (especially over a question of patient admission or consultation).**
- **All transfer calls.**

PGY-1 residents assigned to the Staff Medicine Service will have the primary responsibility for management of all patients admitted to the Staff Medicine Service. The upper level resident will review notes written by PGY-1 residents and will provide teaching and direction. Daily work rounds, led by the upper level resident, must be conducted prior to attending/teaching rounds. PGY-1 residents assigned to the Staff Medicine Service will be afforded adequate time off with the approval of the attending physician and in accordance with ACGME regulations. If the patient load is excessive, the upper level resident and attending physician will assume primary responsibility for overflow patients. The BHS Internal Medicine Residency program strictly adheres to the ACGME requirements for maximum patient care responsibilities/loads.

The upper level resident is responsible for the service and is expected to be present to direct patient care, as such; he or she should make daily rounds, except on designated days off. It is mandatory that an upper level resident be available at all times to cover the Staff Medicine Service. Residents must communicate about patient problems in detail when signing out to each other at night or on weekends. **Vacations are not permitted during assignment to the Staff Service rotation.**

The Staff Medicine PGY-1 and PGY-2 residents are required to take call on nights assigned to him/her by the Chief Medical Resident using a pre-designed uniform template. Time off will be afforded to comply with ACGME requirements. PGY-1 residents will have extended duty hour periods which will also be scheduled according to the template, as will the night float schedule.

Discharge planning on Staff Service patients should be accomplished so the patient can be discharged by 9:00 am.

Consultations

Resident responsibilities will include consultations on patients of other services. **The attending physician should be notified directly of any such consultation requests, even if the resident feels certain that the referring physician or nursing staff has notified him/her. Failure to promptly notify the attending physician may result in the patient not being seen by the attending, which might give rise to medico-legal issues as well as inflict damage upon our collegial consultation environment.**

When medical subspecialty consultations are required for Staff Medicine Service patients, the requesting physician must personally contact the subspecialist, request consultation, and give the reason for the consultation. Additionally, an order should be written in the order section of the patient's chart.

All surgery consultations for Staff Medicine Service patients should be obtained from the Staff Surgery Service. Surgical problems should be discussed with staff surgeons before consultation with surgical specialists/subspecialists is requested so as to maximize learning opportunities for all residents.

Ambulatory Rotations

Internal Medicine residents are required to achieve ≥ 33% of their training in the ambulatory setting. As PGY-1 residents they complete an ambulatory rotation in General Internal Medicine in addition to their continuity clinic and other rotations with ambulatory components. On Ambulatory rotations, residents are expected to perform in the same professional manner as they do on hospital-based services and to treat patients with courtesy and respect. Specific requirements for individual ambulatory care rotations will be defined by the curriculum and the attending physician at the beginning of each assignment. When a clinician educator on an ambulatory rotation takes days off or is on vacation, the resident is expected to attend conferences and morning reports at the assigned BHS Hospital and to be available by pager for program-related issues during regular work hours. Emergency Department rotations do not satisfy ambulatory experience requirements and cannot exceed two months in 36 months of training. **During on-campus ambulatory rotations, residents are required to attend conferences.**

MEDICAL RESIDENT CONTINUITY CLINIC

The Continuity Clinic is the continuity care setting in which Internal Medicine residents gain much of the experience in ambulatory care required for future practice. Residents are responsible for evaluating and treating their patients' acute and chronic medical problems. They also provide appropriate routine and preventive health care. Patients are followed in an ongoing fashion for the duration of the resident's training at BHS.

A secondary purpose of the Continuity Clinic is the provision of medical care to patients who might otherwise have no access to health care because of inadequate financial resources or insurance. However, the Continuity Clinic should not be considered a "free clinic". Hospital charges for lab work and/or x-rays will be paid by the patient's insurance or by the patient when, in the judgment of the Business Office, such payments will not impose an unreasonable financial hardship. Residents will learn to appropriately determine evaluation and management service coding through didactic lectures and periodic chart reviews.

PGY-l residents will be assigned to the Continuity Clinic for one half-day session each week; upper level residents will be assigned for two half-day sessions each week. Residents will maintain their patient panels during all years of training at BHS.

Medical Residents will be supervised in the Continuity Clinic by a Chief Medical Resident and/or a faculty physician who is a member of the Internal Medicine faculty. After initial evaluation by the resident, each patient will be presented to and discussed with the attending physician. The attending physician will see the patient along with the resident and review the diagnostic and treatment plan. As the resident's experience and clinical skills increase, he/she will assume more independent responsibility for patient care. Every patient must be reviewed with an attending physician prior to that patient leaving the clinic.

Consideration for patients and professionalism are paramount. As in a private setting, the resident is primarily responsible for his or her patient's care. Hence, the resident must be available for calls on his or her clinic patients, regardless of whether he or she is "in-house" at the time. **Each medicine resident is responsible for notifying the clinic in advance of any planned absence (vacation or meeting) but only after the approval of the Director of Medical Clinics.**

No resident is allowed to cancel his or her clinic for any reason without advance approval by the Director of Medical Clinics, Dr. Erin Townsley (783-7663).

The patients seen by a resident in the Continuity Clinic may come from several sources, which include:

- Patients assigned to the resident from the established Clinic population
- Patients hospitalized on the in-patient Staff Medicine Service while the resident is on this rotation
- Patients newly referred to the Continuity Clinic by physicians in the community and from the Emergency Department and approved by the Director of Medical Clinics
- Patients evaluated by the resident on private in-patient services and referred (with approval of the Director of Medical Clinics) to the Continuity Clinic
- Patients referred from the Surgical Continuity Clinic for Medical consultations
- Patients assigned to the Continuity Clinic through the Medicaid Patients First program

All patients are selected for the Continuity Clinic on the basis that they will provide valuable educational experience in the training of Internal Medicine residents and must be approved for acceptance into the clinic system by the Director of Medical Clinics.

The Core Data Sheet is required on all patients in the Continuity Clinics. Appropriate forms are available and must be continuously updated and complete. The resident is expected to maintain a neat, orderly, and complete medical record which includes a list of current medications (with dosages), health-screening tests, with dates and results, as well as an updated problem list. This is particularly important professional habit for physicians in training to develop, as good records are necessary for effective continuity of care. Additionally, the resident is responsible for follow-up of all laboratory results and studies returned after the patient leaves the clinic. Critical laboratory values must be followed up closely either by the resident in clinic or the resident on call. **NO CHART CAN LEAVE THE OUTPATIENT CLINIC WITHOUT APPROVAL OF THE CLINIC PERSONNEL.** However, copies of pertinent data from the charts may be obtained on request from the Clinic staff.

PROCEDURAL SKILLS

Background

The Residency Review Committee of the Internal Medicine residency program and the American Board of Internal Medicine (ABIM) require that residents be instructed in the indications, contraindications, complications, limitations, and interpretation of findings for a variety of procedures. Additionally, physicians completing residency and applying for hospital privileges will be expected to verify their training and qualifications to perform such procedures as part of the credentialing process. In order to meet these educational goals, all BHS Internal Medicine residents are required to develop competency in the performance of the basic invasive procedures during their residency training, as detailed in the attached policy.

The ABIM sets minimum competency standards regarding the number of procedures that residents must perform successfully under direct supervision in order to confirm proficiency and to qualify for Board certification. The BHS Internal Medicine residency program has amended those minimum standards for selected invasive procedures, requiring BHS residents to satisfactorily perform a greater number of selected procedures prior to being certified to perform them independently in order to assure the resident's competence.

Policy

1. All BHS PGY-1 Internal Medicine (Categorical and Preliminary) residents will attend a series of didactic lectures regarding the indications, contraindications, complications, and technical performance of basic invasive procedures. The resident will also learn interpretive skills for each of the basic invasive procedures. Reference articles from the medical literature regarding each procedure will be provided for review.

2. **All BHS residents will maintain current Advanced Cardiovascular Life Support certification as provided by the American Heart Association.**

3. Residents will perform invasive procedures only under the supervision of qualified faculty or upper-level residents, until (a) at least the minimum numbers of these procedures as listed below have been successfully performed, and (b) the resident has been approved to perform these procedures independently. Once a resident has been approved to perform a procedure independently of direct supervision, he/she will be notified of the new clinical privilege in writing. A periodic report regarding residents' procedural competence will be made available to the hospital administration and nursing staff for review and verification.

4. After approval is granted by the Program Director's office to perform a certain procedure independently, upper-level residents will be considered qualified to supervise junior residents in the performance of that procedure.

5. All residents will be required to keep an ongoing record of the procedures they have performed with the web-based tracking system. All appropriate patient-identifying information must be completed as required to provide subsequent verification of completion of these procedures. Only those procedures completed successfully, in the judgment of the supervising physician, will be counted toward the demonstration of technical competence.

6. Residents will continue to maintain an ongoing record of their procedures, even after achieving the minimum required numbers to demonstrate technical competence.

7. All PGY-1 categorical residents are required to demonstrate proficiency in the following procedures in order to complete the PGY-1 year. Residents failing to make satisfactory progress toward developing appropriate procedural competence (as determined by the Program Director or his designee) may be assigned additional extended duty hour periods or given alternative educational assignments as necessary to complete these procedures.

   - Lumbar Puncture (5)
   - Arterial Puncture for ABGs (5)
   - Nasogastric Intubation (3)
   - Central Venous Line (Non-femoral) (10)

8. Categorical Internal Medicine residents must demonstrate their competence by successfully completing the required numbers of all the listed procedures by the end of their three-year residency in order to qualify for ABIM certification. Residents failing to make satisfactory progress toward developing appropriate procedural competence (as determined by the Program Director) may be assigned additional call or given alternative educational assignments as necessary to complete these procedures.

- Abdominal Paracentesis (3)
- Arthrocentesis of the Knee Joint (3)
- Lumbar Puncture (5*)
- Thoracentesis (5)
- Rectal Exam (5)
- Arterial Puncture for ABGs (5*)
- Central Venous Line (Non-femoral) (10*)**
- Nasogastric Intubation (3*)
- Breast Exam (5)
- Pelvic Exam with Pap Smear (5)

***Required** to complete PGY-1
**Insertion of Central Venous Line must be performed with ultrasound guidance.

7. BHS Internal Medicine residents are also encouraged to seek experience and to develop proficiency in performing and interpreting results of additional procedures, including those listed below. These and other procedures may be particularly useful for future clinical practice, but are not required by the BHS Internal Medicine program or the ABIM. When performed, records of these procedures should be entered in the ABIM Documentation Log Book and signed by the supervising physician. These procedures must also be entered into the E-Value system. Except as indicated, the BHS Internal Medicine Residency Program has not established a specific minimum number of these procedures necessary for the demonstration of clinical competence.

- Bone marrow aspiration and biopsy (3)
- Bladder Catheterization
- Elective Cardioversion
- Supervision and Interpretation of GXT
- Flexible Sigmoidoscopy
- Skin (punch) Biopsy
- Endotracheal Intubation

8. All residents will be required to attend a series of lectures providing the knowledge and skills to recognize common normal, abnormal, and technical artifact patterns in electrocardiography. In addition, training will focus on the understanding of the pathophysiology of electrocardiographic abnormalities as well as the opportunity to apply this knowledge in bedside clinical decision-making. **HOUSE CALL**

Duty Hours

The duty hours at the BHS Internal Medicine Residency Program are defined as all clinical and academic activities related to the residency program. Duty hours do not include reading and preparation time spent away from the duty site.

- Duty hours are limited to 80 hours per week, averaged over a four-week period, inclusive of all in-house call activities.
- Residents will be **provided w**ith 1 day (24 continuous hours) in 7 free from all educational and clinical responsibilities, averaged over a four-week period.
- Adequate time for rest and personal activities will be provided by requiring at least an 8-hour time period between all daily duty periods.
- In-house call for PGY-2 and PGY-3 residents will not occur more frequently than every third night.
- Continuous on-site duty, including call, will not exceed 24 consecutive hours for PGY-2 and PGY-3 residents. Duty for PGY-1 residents will not exceed 16 hours. Residents can remain on duty for up to 4 additional hours to participate in didactic activities, transfer care of patients, conduct outpatient clinics, and maintain continuity of patient care. **Residents must remain available by beeper for administrative issues that occur during business hours after they leave the hospital/clinic.**
- No new patients will be seen after 24 hours of continuous duty.

Patient Load Limits

- A first-year resident must not be assigned more than 5 new patients per admitting day; an additional 2 patients may be assigned if they are in-house transfers from the medical services.
- A first-year resident must not be assigned more than 8 new patients in a 48-hour period.
- A first-year resident must not be responsible for the ongoing care of more than 10 patients.
- When supervising more than one first-year resident, the supervising resident must not be responsible for the supervision or admission of more than 10 new patients and 4 transfer patients per admitting day or more than 16 new patients in a 48-hour period.
- When supervising one first-year resident, the supervising resident must not be responsible for the ongoing care of more than 14 patients.
- When supervising more than one first-year resident, the supervising resident must not be responsible for the ongoing care of more than 20 patients.

Call Schedule

Internal Medicine residents will be required to take call according to assignments made by the Chief Medical Residents.

Call hours are: 6:00 p.m. – 6:00 a.m. Monday – Friday
6:00 a.m. – 6:00 a.m. Weekends and Holidays
In-house call for PGY-2 and PGY-3 residents must occur no more frequently than every 3rd night.
PGY-1 residents will not work more than 16 hours of continuous duty.

Resident at Risk

When special events or unforeseen circumstances arise, such as resident illness or emergency, the Program Director may require certain residents to take call. This call will be assigned based on the "resident at risk" schedule, by the CMR. No additional compensation is provided for taking call under these circumstances. The Resident at Risk for the month may not leave town and must be available by pager at all times.

Responsibilities On Call

All residents assigned to Medicine call are required to be physically present in the designated hospital for the entire call period. **Any change in the call schedule must be approved in writing by the Chief Medical Resident at the assigned hospital as well as the program coordinator.** The hospital operator, program coordinator, and the senior resident should be notified by the resident making the call change after the change has been approved.

First Year Internal Medicine Residents:

- Respond to any Code Blue or other hospital emergency, beginning at 6:00 a.m. on the day of call. If the resident must leave the hospital during the day (for ambulatory clinic), he or she MUST arrange coverage of Code Blue calls.
- Examine patients who sustain trauma or develop a medical emergency while in the hospital and complete an incident report.
- Pronounce deaths if requested to do so, and assist in obtaining permission for autopsy and organ donation where appropriate.
- Cover the Medicine Staff Service under the supervision of the senior resident responsible for this Service, admitting patients to that service after hours or on weekends.
- Perform consultations for the Staff Medicine/Staff Surgery Services (depending upon the call assignment) during call hours with supervision by senior level resident.
- All PGY-1 physicians on subspecialty services who are responsible for the primary care of patients are required to "check out" those patients with the night float intern. This will provide the night float intern with the names and major medical problems of the patients that he/she is expected to cover during the night hours as per the departmental check-out/check-in policy. This is crucial for critically ill patients and for those patients who need close monitoring.
- Residents will respond to all "code blue" calls.

Second and Third Year Internal Medicine Residents:

- Supervise the activities of the PGY-1 residents, providing advice, guidance and teaching; including review of the PGY-1 residents' evaluation and treatment plans, writing a note in the chart indicating such supervision and making suggestions for changes in or additions to those plans if necessary. **The supervising resident must personally see and examine all patients admitted and write a complete history and physical on each patient.**
- Respond to all Code Blue beginning at 6:00 a.m. on the day of call, and be responsible for running the Code according to American Heart Association ACLS protocol. If the resident must be out of the hospital during the day, for any reason, he or she MUST arrange coverage of Code Blue calls.
- Supervise and assist the PGY-1 resident with invasive procedures as qualified.
- Serve as the Admitting Resident for Staff Medicine during call hours as outlined above, making decisions regarding evaluation and treatment of patients admitted from the ED to the Staff Medicine Service. **Notify the attending physician of all admissions, deaths, and serious changes in patients' condition.**
- Residents will respond to all "code blue" calls.

- The supervising resident is required to be on site from 6:00 a.m. – 5:00 p.m. Monday – Friday unless post call (24+4) and on all weekend days as designated by the Staff Medicine template. The template provides for strict adherence to ACGME work hour regulations.

Night Float

The night float rotation is designed to provide improved continuity and senior level resident supervision of the Staff Medicine interns and patients during the nighttime hours. The night float resident functions as an integral component of the Staff Medicine Service, and is responsible for teaching and evaluating the interns assigned to that service. Responsibilities and educational objectives are as listed above in the section "Responsibilities on Call: Second and Third Year Internal Medicine residents" and as outlined in the Internal Medicine Curriculum.

The night float resident is assigned shifts using a pre-designed uniform template. **Residents may not take vacation time during the night float rotation.** Adequate time for rest, personal activities, and days off will be provided in accordance with ACGME regulations.

All resident continuity clinics are cancelled during the night float rotation.

Coverage hours are:

Princeton:
Monday 12:00 p.m. to Tuesday 6:00 a.m.
Tuesday 5:00 p.m. to Wednesday 6:00 a.m.
Wednesday 5:00 p.m. to Thursday 6:00 a.m.
Thursday 5:00 p.m. to Friday– 6:00 a.m.
Friday to Saturday 12:00 p.m.

Trinity:
Monday 5:00 p.m. to Tuesday 6:00 a.m.
Tuesday 5:00 p.m. to Wednesday 6:00 a.m.
Wednesday 5:00 p.m. to Thursday 6:00 a.m.
Thursday 5:00 p.m. to Friday 6:00 a.m.
Friday 5:00 p.m. to Saturday 12:00 p.m.

Educational opportunities during night float will include:

- The Staff Medicine Attending will provide daily follow-up on the clinical decision making by the night float resident.
- The night float resident will make "check out" rounds with the Staff Medicine Team both at the start of and again at the completion of his/her shift so as to assure smooth transfer of care.
- The night float resident will have ongoing dialogue with the Staff Medicine Attending to discuss the pathophysiology, diagnosis, and treatment of cases the resident has admitted and to receive a critical assessment of their performance. Discussion of the relevant current medical literature along with applicable evidence-based medicine will be incorporated into this academic experience. The attending physician will have daily interaction with the float resident so as to provide direct supervision, teaching, and feedback to the float resident.
- **During the night float rotation, residents are excused from all scheduled conferences.**

CONFERENCES AND EDUCATIONAL ACTIVITIES

Throughout the academic year, a variety of medical conferences are presented at both Princeton and Trinity, with special emphasis on subjects of importance to physicians in training. Residents are required to present and discuss clinical cases during morning report, or to prepare material on an assigned subject from the medical literature for some conferences.

A schedule of educational activities is posted in the Medical Education areas at each hospital. Attendance at all conferences is strongly encouraged unless urgent patient care responsibilities preclude attendance. Satisfactory participation in these conference activities is a prerequisite to completion of the PGY-1 year and to continued advancement in the residency program. **80% conference attendance is required to meet minimal BHS Internal Medicine standards.** Residents must sign an attendance log indicating their attendance at conferences. Residents are excused from all noon conferences and

morning reports while assigned to the Emergency Department and off-campus rotations.

The BHS Internal Medicine Residency Program provides the following conferences:

- Journal Club/Evidence-Based Medicine
- Morning Report
- Noon Conference
- Board Review (weekly)
- Morbidity and Mortality Conference (monthly)
- Grand Rounds (weekly)
- Tumor Board if on Hematology/ Oncology Rotation

Other conferences (surgery, radiology, etc.) are conducted weekly, and attendance is encouraged when subjects of interest to Internal Medicine residents are presented.

The Chief Medical Residents will also conduct required educational activities. These academic opportunities include, but are not limited to:

- Medical Jeopardy
- Board Review Questions
- ABIM Review

SCHOLARLY ACTIVITY

Research Paper Preparation

Each year, the BHS Internal Medicine residents are required to prepare a case presentation or a clinical research project report, with discussion and references to the medical literature. This paper must be written in a form appropriate for publication in a peer reviewed internal medicine journal such as "The New England Journal of Medicine" or "The Annals of Internal Medicine". Specific instructions and guidelines will be provided for the preparation of this manuscript. All manuscripts must be submitted on or before **March 1st** of the academic year. The winner of the best paper will be afforded a trip to the annual regional meeting of the American College of Physicians to present his/her research or case.

In addition, participation in and attendance at the Annual Residents' Research Day is required. No vacation may be taken during Research Week.

All papers should be personally submitted to the Program Coordinator.

TEACHING

All residents are expected to teach their colleagues. It is expected that the ability to teach will increase with experience and seniority. Consequently, more will be expected of PGY-2 and PGY-3 residents.

EVALUATION OF PERFORMANCE

The faculty evaluates the performance of Internal Medicine residents in each of the core clinical competencies as outlined in the Internal Medicine Curriculum:

- Patient Care
- Interpersonal Skills and Communication
- Professionalism
- Practice-Based Learning and Improvement
- Systems-Based Practices
- Medical Knowledge

Additionally, the Internal Medicine Milestones indicating the resident's performance will be reviewed with the program director semi-annually.

These evaluations will occur in the following forms:

- Rotation Evaluations
- Mini-CEX
- Medical Knowledge Review Questions
- Procedural Competence
- In-Training Examination
- Prescriptions-For-Learning
- Journal Club/ Evidence-Based Medicine
- Medical Records Evaluation: Practice-Based Learning Initiative
- Continuity Clinic Evaluations
- 360-Degree Evaluations
- Morning Report – Case Presentation Skills
- Others as Developed

Each of these evaluations is reviewed by the Program Director. Appropriate suggestions for improvement are made to the individual resident. The resident may review his/her performance by appointment with the Program Director or designee. Formal reviews for Internal Medicine residents are conducted on a scheduled basis, twice yearly, in conformance with Residency Review Committee requirements.

Internal Medicine residents are required to complete faculty and rotation evaluations at the completion of the assignment. These should be completed in a professional and timely manner, by accessing the on-line residency evaluation program.

MEDICAL RECORDS

Part of the professional responsibility of each Internal Medicine resident is the timely completion of accurate, legible medical records at each participating hospital. **The Internal Medicine resident MUST dictate a complete history and physical within 24 hours on all admitted patients, unless otherwise directed by the Attending Physician. In addition, all discharge summaries should be completed prior to or at the time of patient discharge.** Failure by the resident to complete the medical records according to the policies and procedures of Princeton and Trinity Campuses for which he/she is responsible **may result in disciplinary action** including suspension without pay.

Problem Oriented Record (POR)

Residents are encouraged to use the Problem Oriented Record (POR). This system allows for identification of the patient's problems and encourages a rational diagnostic and therapeutic plan. There are 4 components of the POR:

(1) Data Base (History, Physical Examination, Laboratory Studies)
(2) Problem List - Numbered
(3) Initial Plan
(4) Progress Notes (Narrative Notes, Flow Sheets, Discharge Summary)

Progress notes are numbered in accordance with the problem being discussed, titled, and written in the S.O.A.P. (Subjective, Objective, Assessment, and Plan) format. The discharge summary should also be problem oriented, discussing problems, which require continuing intervention. Demonstration of satisfactory ability in record keeping is an essential part of Internal Medicine training and is required of all residents.

History and Physical Exam

Residents are expected to write a complete history and physical on each patient admitted. **A complete history and physical examination must be dictated within 24 hours after admission by the intern admitting the patient**. **If no intern is involved in the patient's admission, the resident must dictate the history and physical of record**. Attention to detail with both the history and the physical exam is compulsory. It is important to document in the dictated history from where and by what physician a patient is referred, as this information will be needed for follow-up communications with the referring physician. **ALL Histories and Physicals MUST have ≥ 10 Review of Systems Components.**

Daily Progress Notes

Residents are responsible for all chart work on patients assigned to them. The POR format is recommended. All chart entries must be dated and timed. Daily progress notes with all pertinent data, proper documentation of procedures, and with correct documentation of attending involvement are required. Correct documentation is essential for good patient care as well as for medico-legal considerations. Any significant change in a patient's condition should be recorded.

Physician Orders

All orders for treatment shall be in writing or entered via the Electronic Medical Record. A verbal order shall be considered to be in writing if dictated to a duly authorized person functioning within his/her sphere of authority and signed by the responsible practitioner (or appropriate resident). All orders dictated over the phone shall be signed by the appropriately authorized person to whom dictated with the name of the practitioner per his or her own name. The responsible practitioner shall countersign such orders within 24 hours. All orders written on patients under the care of resident physicians must be written by the resident physician or his/her designee save in an emergency situation where an attending physician may write orders as per departmental policy.

All orders written by medical students shall be signed by the student with the "M.S. III" or "M.S. IV" following their names to indicate Medical Student, third year or Medical Student, fourth year. All orders written by Medical Students MUST be countersigned by the attending physician or by the resident to whom the student is assigned. Orders for medications or for invasive procedures should be countersigned by a resident or by a member of the medical staff before being carried out.

Discharge Summaries

Discharge summaries should be dictated on all patients assigned to a resident upon patient's discharge. The POR is recommended. The discharge summary should include the initial problem(s), brief clinical course in the hospital, pertinent laboratory and x-ray findings, conclusions, final impression, treatment, condition on discharge, and follow-up plans for the patient including medications, diet, activities, and return visits. **All discharge summaries should be dictated prior to or upon patient discharge. Failure to complete medical records in a timely fashion will result in disciplinary action per program policy.**

IMPORTANT: Discharge planning on Staff Service patients should be accomplished in sufficient time to discharge the patient no later than 9:00 am.

MISCELLANEOUS

Vacation

Vacation time must be scheduled in advance by submitting the request to the Internal Medicine Program Coordinator, Ms. Susan Elders. Vacation requests will be evaluated and approved by the Chief Medical Residents according to the program guidelines. No vacation will be granted during the month of June or the first two weeks of July as the yearly transition from one academic year to another is taking place. Additionally, no vacation will be allowed in the weeks abutting the Christmas/New Year Holiday schedule or on the staff services or the float service or during Research Week.

Illness

In the event a resident is unable to perform his/her daily activities, or must leave the hospital early due to illness, he or she MUST contact the attending physician on the service to which he or she is assigned, the CMR at the appropriate hospital, and the Program Coordinators at both Princeton and Trinity. The resident at risk will be called in the event of illness of the staff resident or in the event that the admissions cap has been exceeded by the staff internal medicine service. All residents have 3 sick days per academic year. Any prolonged illness will require FMLA documentation.

Pagers

The resident's pager MUST be activated at all times while on hospital premises. If the resident's daily activity is completed and the resident leaves the campus, he or she should be available by pager until 5:00 p.m. for questions concerning his or her

patients or administrative issues. Special service requirements may supersede this general rule and would require the residents to leave his or her pager activated continuously. Code pagers should never leave the hospital premises, nor should they be deactivated for any reason. **Residents at risk should have their pagers activated at all times during their "at risk period."**

USMLE and Medical Licensure

All categorical internal medicine residents (graduates of a college of medicine accredited by the Liaison Committee for Medical Education, a college of osteopathy accredited by the American Osteopathic Association and international medical colleges) **must sit for USMLE Step III during the PGY-1 year**. Categorical internal medicine residents identified as above must obtain an Alabama Medical License after completion of the PGY-1 training year. Categorical internal medicine residents who did not graduate from an institution accredited by either the Liaison Committee for Medical Education or a college of osteopathy accredited by the American Osteopathic Association must sit for USMLE Step III during the PGY-3 year and are eligible to obtain Alabama Medical License after completion of the PGY-3 training year.

Moonlighting

PGY-1 residents are not permitted to moonlight.

Residents are not required to, but may be allowed to "moonlight" both within and outside the BHS provided this moonlighting does not interfere with the resident's performance on his/her service or interfere with his/her educational development. **All moonlighting hours must be counted toward the 80-hour limit on duty hours.**

THE PROGRAM DIRECTOR MUST APPROVE ALL MOONLIGHTING ACTIVITY, AND MUST HAVE ON FILE IN THE PROGRAM DIRECTOR'S OFFICE A COMPLETED, CURRENT RESIDENT MOONLIGHTING TRACKING SHEET. It is the resident's responsibility to keep this document current. Residents will be responsible for securing the additional endorsements to the base malpractice coverage for "extra-mural" moonlighting and must also pay for the additional premium. Residents are not permitted to moonlight on the staff internal medicine services or cardiology due to the time-intensive nature of these services and the institution's desire to avoid exceeding the 80-hour work limit for resident physicians.

PATIENT HANDOFFS

1. Scheduling will be completed in a manner which minimizes the number of patient handoffs on a daily, weekly, and monthly basis.
2. Attending physicians responsible for the care of the patients being discussed will periodically monitor patient handoffs by resident physicians.
3. Handoffs are recognized as a passage of information, patient care responsibility, and accountability by all housestaff.
4. Handoffs will occur in face-to-face fashion and contain both a verbal and written element at all times.
    - Night upper level resident will handoff care to day upper level (and vice versa)
    - Night intern will handoff to the individual interns caring for the patient during the day
    - Day interns will handoff to long-call intern
    - Long-call intern will handoff to night intern
5. Handoff information will be updated a minimum of twice daily and more often if need dictates; this responsibility is primarily that of the intern caring for the patient but belongs to all physicians on the healthcare team.
6. Handoff information will include at all times the following elements:
    - identifying information, inclusive of:
        - patient name
        - date of birth
        - medical record number
        - hospital room number
        - admission date
    - admitting diagnoses and relevant current diagnoses
    - intern following the patient
    - consulting physicians
    - allergies
    - medications

- events of prior shift
- items requiring follow-up and anticipatory guidance for possible upcoming events

7. Written handoff forms will be maintained on the secure resident SharePoint site at all times and treated as the confidential documents that they are.
   - https://portal.bhsala.com
   - Sign on using unique username and password
   - Choose icon "SharePoint – Signout"
   - Choose "Shared Documents" from column to left
   - Select handout list for the appropriate service and site (Princeton vs Trinity)
8. Handoff forms should be disposed of properly (shredded) at the conclusion of their use.

SUPERVISION OF RESIDENTS

The Internal Medicine Residency program will utilize standards and criteria for supervision of residents as established by the Accreditation Council for Graduate Medical Education. In particular,

a. All internal medicine PGY-1 resident activities at Princeton Baptist Medical Center and Trinity Medical Center are performed under the general supervision of attending physicians, who accept full responsibility for resident actions provided the residents are in compliance with the specific guidelines set forth in this document.

b. The requirement for internal medicine PGY-1 resident supervision is intended to provide for high quality patient care and safety and to allow residents to perform with increased responsibility as they advance toward the PGY-2 year. Direct supervision will be by more senior residents and attending/teaching staff physicians. Residents will be given responsibilities for patient care commensurate with their level of training and demonstrated competence. This involves review of written evaluations of resident performance and direct observations by supervising physicians.

Supervision Requirements

a. All activities of PGY-1 residents are closely supervised. PGY-1 residents should discuss all procedures with more senior residents or attending/teaching staff physicians prior to performance.
b. In emergency situations, immediate action should be initiated primarily by more senior residents. PGY-1 residents may initiate emergent action only if there is imminent danger of loss of life or limb and no senior resident is immediately available.
c. In general, PGY-1 residents will not act as supervisors for procedures. At the discretion of attending/teaching staff physicians, PGY-1 residents with demonstrated competence may provide supervision for students performing minor noninvasive procedures.

1. Documentation of Resident Supervision -- PGY-1 residents will record the supervision provided in progress notes and procedure logs. If mandated by service-specific requirements, PGY-1 residents will provide completed progress notes and procedure logs to attending/teaching staff physicians for co-signature.

2. Specific Supervision Policies

The table, below, lists common functions performed by PGY-1 residents.

PGY-1 Resident Procedures	Level
Admitting and Discharging Patients/ Order writing	B
History and Physical Examination	B
Arterial Puncture	A (advance with competence)
Lumbar Puncture	A
Nasogastric Tube placement	A (advance with competence)
Breast Exam/ Pelvic Exam	A
Central Line Placement	A
Thoracenteses/ paracentesis	A
Incise/drain abscess	A

Note the following:

a. Procedures designated level A require the presence and direct observation of supervising physicians.

b. General non-procedure physician functions such as obtaining a history and performing a physician examination, writing orders, and admitting or discharging a patient are tasks for which residents are trained in medical school. These activities will ordinarily not require direct observation by supervisors and will be designated as level B.

c. PGY-1 residents ordinarily will not be advanced to supervising procedures until the completion of the academic year. Attending/teaching staff physicians may advance residents to a higher level of competence based on assessment of individual performance and sound clinical judgment.

CIRCUMSTANCES REQUIRING FACULTY INVOLVEMENT

PGY-1 residents are under indirect supervision of attending physicians at all times. Additionally, direct supervision by an attending physician is available at all times. The following circumstances mandate prompt contact of the attending physician of record, or the attending acting in a supervisory role, by the PGY-1 resident:

a. Admission of a patient who requires ICU placement
b. Transfer of a patient to or from ICU care
c. Need for intubation or other ventilator support
d. DNR or other end of life decision
e. Cardiac arrest
f. Changes in hemodynamic status requiring intervention
g. Neurological changes
h. An urgent medical or surgical consult because of a deteriorating situation
i. Any instance where a patient's course deviates from the course outlined with the attending providing oversight during the previous 24 hours.
j. Medication errors requiring clinical intervention
k. Clinical problem requiring an invasive procedure
l. Care of medically complex patient
m. Any incident that compromises patient safety
n. Requests from an outside facility or physician for transfer of a patient to the care of the attending physician – these calls MUST be referred to the attending physician

RESIDENCY PROGRAM IN GENERAL SURGERY

OBJECTIVES

To provide training appropriate for surgeons entering private or academic practice, with a strong basic science and surgical foundation which expands into the treatment of a broad variety of surgical diseases. It is our philosophy that the majority of surgeons entering private practice will benefit from broad training in an atmosphere that realistically represents that in which they will practice. The program also prepares residents for application for further specialty training and provides the scholarly background for careers in the academic practice and teaching of surgery.

OVERVIEW

The surgery program is supervised by the Program Director for Surgical Education and Associate Directors at each hospital (Princeton Baptist Medical Center and Trinity Medical Center). We are currently approved for four categorical residents at each level of training in the five-year program. During the first three years of training, residents may be assigned to general surgery and rotations on plastic surgery, cardiovascular/thoracic surgery, pediatric surgery, vascular, anesthesiology, transplant surgery, trauma, and ENT. The fourth year includes vascular surgery, surgical endoscopy, trauma and general surgery. The Chief Resident (fifth year) has responsibility for the Surgical Staff Services, which includes both inpatients and outpatients and is under the supervision of the Surgical Residency Associate Program Directors and Program Director.

Residents from the Transitional Year Residency Program may rotate on surgical services depending on their needs and interests. There are also a number of Preliminary Surgery residents each year who are expected to further their training in surgical or other specialties at the end of their first year of BHS training.

GENERAL GUIDELINES FOR THE SURGICAL RESIDENTS

All surgical residents are expected to conduct themselves in a professional and courteous manner in their relationships with patients, hospital staff and other physicians. Resident dress shall reflect the professional image expected of physicians. A clean white coat should be worn at all times.

PRIVATE SERVICES

Residents and medical students will be expected to participate in daily work rounds with their attending physician and to be prompt at the beginning of rounds and surgical procedures. The assumption of clinical responsibility is an important aspect of surgical training. Accordingly, as ability is demonstrated by residents, an increasing amount of reliance will be placed on their judgment and treatment skills. Residents should be mindful that although they exercise almost complete responsibility for patient care, the attending physician still has certain legal and ethical responsibilities to his/her patients, which transcend the educational process. It is, therefore, imperative that the resident and the attending come to a clear understanding at the beginning of each rotation with regard to the following points:

1. Resident performance of operative procedures.
2. The extent to which the resident is expected to write orders for diagnostic procedures.
3. The extent to which the resident is expected to write orders for treatment.
4. The diagnostic and therapeutic procedures which may be carried out without prior approval of the attending, those which may be carried out after approval and without supervision, and those which should be carried out only with supervision and the level of supervision required.
5. The time, method and procedure of making rounds.
6. Those situations occurring at night or on weekends for which the resident should notify the attending physician.
7. The selection of patients for assignment to the resident if the patient load becomes unduly heavy.

Residents are capable of varying degrees of patient care responsibility depending on their level of training and competence. Attending physicians also vary in their willingness to delegate responsibility for patient care to residents. By reaching a clear understanding on the matters listed above, at the start of a rotation, there will be less chance for confusion of responsibilities or unrealized expectations. Reliability is an important matter in transferring responsibility for procedures the resident can

perform. A list of Goals and Objectives for each rotation will be provided and also available on-line. These should be read and discussed at the beginning of each rotation.

SURGICAL RESIDENT STAFF SERVICE

The Surgical Staff Service provides experience in primary responsibility for patient care. The Chief Resident in Surgery is responsible for the conduct of this service under the direction of designated supervising faculty. Junior surgical residents are, at times, assigned to this service and will share in the responsibilities of patient management. It is important that surgical residents learn to function independently within their limitations. Help is always available. Residents are expected, however, to analyze their respective situations thoroughly and to be prepared to recommend appropriate diagnostic or therapeutic maneuvers when help is sought. Residents discuss all cases admitted or taken to the operating room with assigned staff surgeons.

Patients with limited financial resources and/or without insurance may be referred to the service by their physician. Admission is contingent upon approval of the Chief Surgical Resident and the designated supervising faculty

Discharge planning should be accomplished in sufficient time to allow for a 9:00 a.m. discharge time of the patient. The 9:00 a.m. discharge time will be observed in all cases.

CONSULTATIONS

The surgical residents will assist their attending physicians in providing consultations to hospital patients.

SURGICAL CONTINUITY CLINIC

Criteria for admission and procedures for admission to this clinic are the same as for admission to the Staff Services (see above). Many patients are admitted to the Surgical Continuity Clinic who have limited financial means. Patients with third party insurance are also accepted in the clinic. The clinic provides an educational opportunity for surgical residents in the provision of cost-effective, high quality patient care and for the follow-up of patients seen in the hospital. The clinic also provides an opportunity for residents to learn office procedures and management. The clinic is managed by the Chief Resident in Surgery under the attending physician. All patients are treated with respect and consideration for them and their families irrespective of their financial, social or other personal considerations. Each patient will have a designated attending faculty member assigned to them regardless of inpatient or outpatient status.

PATIENT ACCEPTANCE POLICIES

Questions often arise on how patients are accepted on the surgical teaching service. Cases accepted fall within the scope of general surgical practice for educational purposes. They may come from unattached ER patients, BHS staff physicians, and outside referring physicians. Some cases accepted require the participation of sub-specialists.

Patients accepted through the Continuity Clinics must be cleared by the hospital's financial counselor according to established policies. Acceptance on the teaching service does not mean we assume responsibility for all future conditions and hospitalizations. An example would be a teenage appendectomy patient who later becomes pregnant. The surgical teaching services want to be of assistance to BHS staff and referring physicians but that assistance cannot extend to **all** categories of patients and circumstances.

To discuss referring a patient you may call the Chief Resident through the hospital operator at Princeton 783-3000 or at Trinity 592-1000. Speak with the surgery resident on call, then he or she can route your request to the Chief Resident, Program Director, or a designated attending surgeon in his absence. Speak with the clinic nurse, who can assist with calls during the day, at 783-3505 or 592-1406.

EMERGENCY DEPARTMENT

Surgical residents shall participate in the activities of the ED under the supervision of the Program Director and/or Associate Director of Surgical Education and/or members of the surgical faculty. Surgical residents on call will cover the emergency

room for referral and surgical treatment. The junior residents always have more senior back-up available and are encouraged to call them whenever more help or experience is needed.

MEDICAL STUDENTS

Surgical residents are expected to participate in the proper supervision and teaching of medical students assigned to rotations in the hospital.

CONFERENCES AND EDUCATIONAL ACTIVITIES

Numerous conferences and educational activities are scheduled throughout the year for the surgical residents. An average of 3-4 conferences are held weekly at each hospital, including resident teaching sessions, Tumor Board, and Morbidity and Mortality conferences. Various subspecialty conferences are scheduled on a monthly basis and are open to the Medical Staff and Resident Staff. Attendance for the resident teaching sessions and Morbidity/Mortality conferences are mandatory with the exception of residents assigned to rotations in other hospitals or involved at the bedside of critically ill patients. Attendance for subspecialty conferences is encouraged. Residents take the American Board of Surgery In-Training Exam each January. (ABSITE)

Research Projects: Residents are expected to participate in a clinical or basic research project each year during their residency. Residents are encouraged to present their findings at appropriate state, regional and national programs. All residents are required to produce one manuscript each year during the residency.

DUTY HOURS, ON-CALL AND MOONLIGHTING

Duty Hours

The ACGME program requirements for General Surgery state: Duty hours are defined as all clinical and academic activities related to the program; i.e., patient care (both inpatient and outpatient), administrative duties relative to patient care, the provision for transfer of patient care, time spent in-house during call activities, and scheduled activities, such as conferences. Duty hours also include all moonlighting time. Duty hours do not include reading and preparation time spent away from the duty site.

1. Duty hours must be limited to 80 hours per week, averaged over a four-week period, inclusive of all in-house call activities.

2. Residents must be provided with one day in seven free from all educational and clinical responsibilities, averaged over a four-week period, inclusive of call.

3. Adequate time for rest and personal activities must be provided. This should consist of a 10-hour time period provided between all daily duty periods and after in-house call.

On-Call Activities

1. In-house call, for PGY-2 and above residents, must occur no more frequently than every third night, averaged over a four-week period.

2. Continuous on-site duty, including in-house call, must not exceed 24 consecutive hours for PGY-2 and above residents. Residents may remain on duty for up to four additional hours to participate in didactic activities, transfer care of patients, conduct outpatient clinics, and maintain continuity of medical and surgical care. PGY-1 residents are restricted to 16 hours of continuous duty with no exceptions.

3. No new patients may be accepted after 24 hours of continuous duty.
   a) A new patient is defined as any patient for whom the surgery service or department has not previously provided care.

4. At-home call (or pager call) for PGY-2 and above residents
   a) The frequency of at-home call is not subject to the every-third-night, or 24+4 limitation. However at-home call must not be so frequent as to preclude rest and reasonable personal time for each resident.

b) Residents taking at-home call must be provided with one day in seven completely free from all educational and clinical responsibilities, averaged over a four-week period.
c) When residents are called into the hospital from home, the hours residents spent in-house are counted toward the 80-hour limit.

Moonlighting

1. PGY-1 residents are not permitted to moonlight.

2. Moonlighting must not interfere with the ability of the resident to achieve the goals and objectives of the educational program.

3. All moonlighting must be considered part of the 80-hour weekly limit on duty hours.

4. The Program Director must give written permission before moonlighting activities will be permitted for any resident.

CALL SCHEDULES

Surgical resident call assignments are based on rotation assignments and the need for adequate in-house coverage. Call assignments and duty hours are in keeping with Residency Review Committee guidelines. Changes in call schedules are disruptive to all concerned and should be made well in advance. Special needs such as interview time or meetings **must** be discussed with your Program Director and Chief Resident. Residents are advised to devote off - call nights to rest, families, and reading. Moonlighting is discouraged. Minor illness or prolonged lack of sleep should be brought to the attention of attending physicians so that patient care responsibilities may be adjusted accordingly. Arrangements are available for post-call status residents who feel too fatigued to drive home.

Backup Call

Senior residents are assigned to be available by beeper and serve as backup to the junior resident in-house. This schedule varies according to rotation assignments and number of residents available. The call schedule has a Chief Surgical Resident (CSR) always on call to serve as a backup for the in-house resident if he/she is unable to fulfill their call duties.

Chief Resident's Call

The CSR is on call for unattached Emergency Room patients on a regular basis. In addition, the CSR on call each day is to be available by beeper for the Surgical Staff Service patients. The in-house resident or CSR may be reached through the operators by dialing zero.

ORGAN DONATIONS AND AUTOPSIES

Federal law requires that the families of all patients dying in the hospital be offered the opportunity to donate organs and tissues if certain requirements are met. Each nurses' station will provide the necessary forms and procedures to follow. Donation of organs or tissues is counted as an autopsy.

A significant percentage of all hospital deaths must go to necropsy to maintain program accreditation. Additionally, the post-mortem examination is a valuable learning experience. **All residents are to advise the designated team to request permission for an autopsy on all patients dying in–hospital**. The Chaplain Service is aware of the need for these studies and may be helpful to you when dealing with the families in this difficult circumstance. For the terminally-ill patient, it may be appropriate to seek permission for post-mortem studies in advance especially if the legal next-of-kin may be difficult to contact later. **All autopsies on your patients should be attended by you and reviewed with the pathology attending or resident**.

GENERAL DISCUSSION OF OTHER RELATED AREAS

Residents are expected to participate in the risk management activities of BHS. Incidents or situations having medico-legal significance should be promptly reported to attending physicians or Program Directors. Residents and staff are urged to

cooperate in the risk management and risk reduction efforts of the hospital program, as well as all quality improvement activities. Residents participate via assigned hospital committees which you are required to attend.

Secretarial help is available to residents for things such as fellowship applications, professionally related referral letters, etc. through the Surgical Education Program Director's office.

The Program Director will meet with all residents individually to discuss career plans.

SCHEDULES

Yearly schedules are prepared by the Program Director. They may be changed only under special circumstances. Residents desiring special consideration for specific rotations should discuss these needs with the Director well in advance.

EVALUATION OF PERFORMANCE

Members of the full-time and volunteer faculty and senior residents evaluate the performance of Surgery residents, both on inpatient services and in the outpatient setting upon completion of each rotation. These evaluations are reviewed together by the Program Director and the individual resident twice each year in conformance with RRC requirements.

Surgery residents are asked to complete an evaluation form regarding the faculty and the educational value at the end of each rotation. These should be completed promptly.

VACATION

All vacations must be scheduled with the Program and Associate Program Directors. Vacations are generally not permitted during one-month-long subspecialty rotations or during away rotations. Each resident must submit a list of at least three vacation choices. Every effort will be made to give the resident his/her top choice.

PATIENT HANDOFFS

1. Resident assignments will be organized to minimize transitions of care to facilitate patient safety and continuity of care.

2. Attending physicians will periodically monitor resident to resident patient handoffs.

3. Patient handoffs should be a scheduled event at a time and place with ample opportunity for discussion, questions and answers regarding the patient's condition. HIPPA guidelines remain in force regarding exchange of information and the paper list generated.

4. Patient handoffs should be accomplished face-to-face with both a verbal and written component; this should occur twice daily with other checkouts as needed.
   Example:
   a. the day service resident checks out to the night service resident;
   b. as the night service resident leaves he checks out to the day service.

5. Information to be included at patient handoff includes: Patient name, date of birth, medical record number, room number, admission date, attending service, diagnoses, pertinent medications and allergies, pertinent procedures and anticipated patient course.

SUPERVISION OF RESIDENTS

1. ACGME guidelines are followed.

2. Supervision:
    a. Each patient has an identifiable attending physician.
    b. Residents are always supervised by the following classifications of supervision:
        i. Direct - the supervising physician is physically present.
        ii. Indirect -
            a) Immediately available - the attending physician is on the physical site either in the hospital, clinic or campus.
            b) Available - the attending physician is not physically on site, but reachable by standard paging systems such as beepers, phones or text.
            c) Oversight - review and feedback after care is delivered in a discussion fashion.
    c. Supervision may be provided by an upper level resident.

3. PGY-1 residents - supervision is "Direct" until procedural and patient management skills are achieved
    a. Procedural Competency
        i. Central Venous Lines
        ii. Swan Ganz
        iii. Arterial Lines
        iv. Chest tubes (tube thoracostomy)
        v. Drain removal
        vi. Cuffed catheter removal
        vii. Closure of Surgical wounds
        viii. Closure of Lacerations
        ix. Endotracheal Intubation
        x. Excision lesions of skin and SQ
        xi. Bedside debridement
        xii. Paracentesis
    b. Patient Management Competency
        i. Urgent situations - Trauma, ER consults, ICU consults, Critically ILL patients
        ii. Post OP complications - BP problems (hypo/hypertension), UOP problems (oliguria, anuria), cardiac arrhythmias, hypoxemia, neuro changes, compartment syndromes
        iii. Cardiorespiratory Arrest

PGY-2 and above residents - supervision is at the attending physicians discretion based on ACGME guidelines of progressive graded authority and responsibility.

CIRCUMSTANCES REQUIRING FACULTY INVOLVEMENT

The following circumstances require faculty involvement and/or notification:

1. ICU care such as transfers in or out of the ICU or patients admitted directly to ICU.
2. Patients requiring unplanned intubation or ventilatory support.
3. DNR/DNI decisions not previously known.
4. Code status to include cardiorespiratory events where a code is called or other profound changes in major body systems are noted.
5. Blood transfusions which are not planned.
6. Operative intervention or return to the operating room.
7. Transfer requests from outside facilities.

RESIDENCY PROGRAM IN ANATOMIC AND CLINICAL PATHOLOGY

GOALS AND OBJECTIVES

The residency-training program in pathology is intended to provide the resident physician with a strong educational base from which to enter the practice of pathology or to pursue further training at the fellowship level. The objectives of the program are to produce physicians who:

1. Have a broad and deep understanding of pathology combined with the knowledge of basic medicine needed to apply the concepts of pathology to human patients.
2. Are proficient in surgical and autopsy diagnosis and in the evaluation of laboratory data.
3. Can provide accurate, understandable, and clinically-relevant information to other physicians in a timely manner.
4. Understand the philosophies and methodologies of anatomic and clinical laboratories and can provide management of these laboratories, including their integration into the hospital administrative structure.
5. Have the credentials and intellectual preparation necessary to obtain combined certification by the American Board of Pathology.
6. Are capable of continuing to expand and refine their own education after they complete this program.

GENERAL INFORMATION FOR THE PATHOLOGY RESIDENT

The pathology residency program is accredited for training a total of eight residents in years one through four.

The combined APCP program consists of eighteen months of clinical pathology and thirty months of anatomic pathology. During the training period, the residents are exposed to managerial problems, hospital committees, and educational obligations. Residents are encouraged to participate in teaching activities throughout their residency in addition to the required conferences. They are encouraged to become involved in research projects within the department or in cooperation with other divisions and are required to engage in at least one research project each year with the assistance of a faculty mentor.

ROTATION STRUCTURE

The following is a general rotation structure for pathology residents during years one through four of residency training. Rotations are scheduled at Baptist Princeton or Trinity except as noted:

ANATOMIC PATHOLOGY

General Anatomic Pathology (25 months) consists of combined surgical and autopsy pathology with incorporation of neuropathology and immunopathology.

Cytopathology (two and one-half months) includes two-week rotation at Grady Hospital in Atlanta for fine needle aspiration experience.

Pediatric Pathology (six weeks) rotation occurs at Children's Hospital of Alabama.

Forensic Pathology (one month) rotation occurs at State Forensic Science Laboratory in Montgomery.

Dermatopathology (two weeks) rotation occurs at University of Alabama at Birmingham.

CLINICAL PATHOLOGY

Microbiology (three months) includes bacteriology, mycobacteriology, mycology, parasitology, and infectious serology.

Immunology (three months) includes basic concepts of immunology, autoimmune diseases, immunodeficiency states, radioimmunoassays and flow cytometry.

Blood Banking/Transfusion Medicine (two and one-quarter months) includes three months didactic course at UAB and exposure to blood collection, donor recruitment, and component preparation at Birmingham Chapter of American Red Cross.

Chemical Pathology (three months) includes basic chemical and principles of automated instrumentation as well as electrophoresis and therapeutic drug monitoring.

Hematology (three months) includes medical microscopy, coagulation laboratory, principles of automated and manual examination of blood and bone marrow, biopsy and aspiration performance and evaluation, and lymph node and spleen pathology.

Cytogenetics (two weeks) includes karyotype performance and analysis, and molecular diagnostic techniques, such as FISH. Rotation takes place at Cytometry Specialist, Inc., Alpharetta, Georgia and contains exposure to flow cytometry as well.

Flow Cytometry (two weeks) rotation occurs at the University of Alabama in Birmingham.

HLA Typing and Stem Cell Donor Work-Ups (two weeks) occurs at University of Alabama at Birmingham.

Clinical Pathology Electives (two months)

DUTY HOURS AND ON-CALL ACTIVITIES

Duty Hours

Duty hours are defined as all clinical and academic activities related to the program; i.e., patient care (both inpatient and outpatient), administrative duties relative to patient care, the provision for transfer of patient care, time spent in-house during call activities, and scheduled activities, such as conferences. Duty hours do not include reading and preparation time spent away from the duty site.

1. Duty hours must be limited to 80-hours per week, averaged over a four-week period, inclusive of all in-house call activities and all moonlighting.

2. Residents must be scheduled for a minimum of one day free of duty every week (when averaged over four weeks). At-home call cannot be assigned on these free days.

3. Adequate time for rest and personal activities must be provided. Duty periods of PGY-1 residents must not exceed 16 hours in duration. Duty hours of PGY-2 residents and above may be scheduled to a maximum of 24 hours of continuous duty in the hospital. A period of 4 hours maximum for transition of patient care may occur in house following a 24-hour duty period.

4. PGY-1 and PGY-2 residents should have 10 hours, and must have 8 hours, free of duty between scheduled duty periods. PGY-3 and PGY-4 residents should preferably have at least 8 hours between duty periods.

On-Call Activities

1. Continuous on-site duty, must not exceed 24 consecutive hours. Residents may remain on duty for up to four additional hours to participate in didactic activities, transfer care of patients, and maintain continuity of medical and surgical care.

2. At-home call (or pager call):
   a) The frequency of at-home call is not subject to the every-third-night, or 24+4 limitation. However at-home call must not be so frequent as to preclude rest and reasonable personal time for each resident.
   b) Residents taking at-home call must be provided with one day in seven completely free from all educational and clinical responsibilities, averaged over a four-week period.
   c) PGY-1 residents may not take at-home pager call, and must always have direct supervision or indirect supervision with immediate supervision available.
   d) When residents are called into the hospital from home, the hours residents spend in-house are counted toward the 80-hour limit.

INITIAL SUPERVISION OF SPECIAL PROCEDURES

Each PGY-1 resident must be directly supervised during the performance of at least his/her three initial procedures in the following areas: autopsies (complete or limited), gross dissection of surgical pathology specimens by organ system, frozen sections, bone marrow performances, apheresis, and fine-needle aspirations and interpretation of the aspirate. A PGY-3 or PGY-4 resident, pathology assistant or attending pathologist may directly supervise the gross dissection of surgical specimens and autopsies. A PGY-3 or PGY-4 level resident or attending pathologist may directly supervise the remaining procedures.

EVALUATIONS

Residents are informally evaluated on a continuous basis throughout their training. In addition, short evaluation forms are completed monthly for each resident and reviewed by the Program Director. Formal evaluations are conducted twice each year. The information is gathered by collecting evaluation forms from each faculty member or supervisor of a rotation who has been responsible for instructing the resident during the preceding six months. The forms are reviewed by the Program Director, and their contents are made available to the resident during the formal evaluation session, which is a private meeting between the resident and the Program Director. These evaluations are used primarily to guide the residents in their efforts to become good pathologists. If serious and repeatedly uncorrected deficiencies were to be uncovered in this fashion, the forms would also provide documentation for the resident's remediation or dismissal, in accordance with the established policies of the Department of Medical Education outlined in the Resident Handbook. Other types of resident evaluations include the 360° evaluation, Grand Rounds evaluation, and evaluations of senior residents by junior residents with regards to their teaching skills and level of supervision.

Residents have the opportunity to anonymously evaluate each preceptor and each rotation on a form provided yearly. These forms are compiled and reviewed by the Program Director and used to provide feedback to faculty regarding their performance/rotation as appropriate.

PATIENT HANDOFFS

The provision of seamless transitions of patient care is extremely important to the faculty and staff of the Pathology Residency Program, as well as to clinicians, fellow residents in other programs, hospital personnel and, above all, to the patient and family. To ensure that the pathology residents provide the best transition of patient care possible, the following procedures should be followed:

1. Residents scheduled for vacation, meeting attendance, or rotating off service (especially to another facility) should not cut gross the day before leaving the rotation. In the unusual event that all residents will be leaving the following day, one resident should cut gross, notify faculty pathologists of the situation, and be available by beeper/telephone the following day for any questions that may arise regarding appearance or sectioning of specimens.
2. Residents should consult with faculty pathologists before grossing an unusual or extremely complex specimen and follow the instructions of the faculty. Diagrams and photographs may be useful in these situations.
3. Residents should not perform an autopsy on the day before departing to another rotation location or leaving for vacation/meeting unless they are able to discuss the case with the responsible pathologist and complete the Provisional Anatomic Diagnoses that same day. This is to ensure that the PAD is on the patient's chart within 48 hours and that the resident can be physically present should the responsible pathologist have questions regarding the case.
4. Residents scheduled to complete training or to permanently depart from the program for any reason should not perform a hospital autopsy within 60 days from their scheduled departure date. This ensures ample opportunity for the resident to sign out the autopsy with the responsible faculty pathologist and to answer any questions that may arise regarding the autopsy.
5. Should a patient care issue arise that cannot be resolved before the resident begins another rotation or leaves for vacation/meeting, the resident should inform the faculty pathologist of the issue (preferably face-to-face) and should communicate to the pathologist that he/she will be off rotation the following day. Before the end of the final day of rotation, the resident should thoroughly brief the incoming resident (preferably face-to-face) about the patient care issue and supply the name of the faculty pathologist familiar with the case. Communication with the faculty member and the incoming resident should occur before the resident leaves the rotation.

SUPERVISION OF RESIDENTS

Residents are supervised in all their medical activities by the faculty of the BHS Department of Pathology and its affiliated laboratories. The PGY1 resident is directly supervised during the performance of at least his/her first three autopsies (all steps from chart review to final sign-out), first three frozen sections, first three gross dissections by organ system, and first three bone marrow biopsies/aspirations. Direct supervision during performance of frozen sections, autopsies and bone marrows is provided by a senior resident (PGY3 or PGY4) or a faculty pathologist. Direct supervision for grossing of the first three specimens by organ system is provided by a physician's assistant, a senior resident, or a faculty pathologist. Following the performance of at least three frozen sections, three autopsies, three bone marrows, and three specimens grossed from each organ system, the PGY1 resident is supervised indirectly with direct supervision immediately available from a senior resident or a faculty pathologist. Faculty pathologists review diagnostic pathologic material and all surgical, cytological, hematological, and autopsy reports prepared by residents of all levels of training. Work performed on the clinical pathology rotations, including consultative reports, is under the supervision of the doctoral scientist or faculty pathologist supervising the laboratory and is ultimately the responsibility of the Chairman of the Pathology Department at the hospital where the laboratory is located. The Pathology Residency Program Director bears final responsibility for the quality of the residents' supervision while on intradepartmental and extra departmental rotations and monitors their supervision with the aid of the evaluation forms submitted by the residents. Education in the signs of fatigue, sleep deprivation, and strategic napping is provided through periodic conferences offered by the BHS Department of Medical Education.

CIRCUMSTANCES REQUIRING FACULTY INVOLVEMENT

PGY 1:

1. Residents must be directly supervised by a senior resident (PGY 3 or PGY 4), physician's assistant or faculty pathologist during the first three specimens grossed form each organ system. Thereafter, PGY 1 residents may gross specimens under indirect supervision with direct supervision immediately available.
2. Resident must be directly supervised by senior resident (PGY 3 or PGY 4) or a faculty pathologist during all phases of the first three autopsies performed. Following this, the PGY 1 resident may perform autopsies under indirect supervision with direct supervision immediately available.
3. Resident must be directly supervised by senior resident (PGY 3 or PGY 4) or a faculty pathologist during the performance of at least their first three frozen sections and must be indirectly supervised with direct supervision immediately available for frozen.
4. Residents must alert the responsible faculty pathologist upon receipt of a frozen section in the laboratory. The pathologist must be notified before any inking, cutting, or manipulation of the specimen occurs.
5. The responsible faculty pathologist and physician of record should be notified before the beginning of any autopsy.
6. Residents should notify the faculty pathologist of any discrepancy of questions regarding autopsy permits, grossing of specimens, ordering of special stains, issues regarding mismatched paperwork with specimen labels, or absence of tissue in specimen containers.
7. Before communication of diagnoses to clinicians, the resident must receive approval of the diagnosis from the responsible faculty pathologist for all frozen sections, surgical pathology diagnoses, and cytopathologic diagnoses.

PGY 2, 3, 4:

1. Unless otherwise advised by the responsible faculty pathologist, the resident should notify the responsible faculty pathologist upon receipt of a frozen section in the laboratory. In all cases, the faculty pathologist must approve the diagnosis before it is communicated to the surgeon/clinician.
2. The physician of record should be notified before the beginning of an autopsy. In cases where the resident has any question about the correct protocol or procedure to follow regarding the autopsy, the responsible faculty pathologist should also be notified and consulted before the beginning of the autopsy.
3. Residents should notify the faculty pathologist of any discrepancy or questions regarding autopsy permits, grossing of specimens, issues regarding mismatched paperwork with specimen labels, or absence of tissue in specimen containers.
4. Before communication of diagnoses to clinicians, the resident must receive approval of the diagnosis from the responsible faculty pathologist for all frozen sections, surgical pathology diagnoses, and cytopathologic diagnoses.

RESIDENCY PROGRAM IN DIAGNOSTIC RADIOLOGY

PRINCIPAL OBJECTIVES

An opportunity for the development of the knowledge and technical skills necessary for the practice of diagnostic radiology is provided with emphasis on the ACGME competencies in an environment that reflects the clinical practice of radiology. Providing the credentials, case material and didactic education necessary for certification by the American Board of Radiology are paramount considerations of the program.

Although based in a private practice atmosphere, the basic and physical sciences of radiology are also emphasized. Clinical and basic science research is also encouraged. This combination affords residents the opportunity to pursue academic fellowships and other academic positions in radiology if desired.

Because radiological diagnosis is important to essentially all physicians, the program provides an opportunity for medical students and residents in non-radiological disciplines to learn the fundamentals of radiological interpretation and to participate in the daily activity of radiological practice.

DIAGNOSTIC RADIOLOGY

There are three residents at each level of training in the program. In the past, and perhaps in the future, exceptions have been made by the ACGME to allow additional residents at any given time under extraordinary circumstances. Over the four-year program, 41 months of clinical diagnostic radiology rotations are provided at BHS Hospitals, equally divided between Baptist Princeton and Trinity Medical Center. These rotations provide training in mammography, vascular and interventional radiology, neuroradiology, nuclear medicine, diagnostic ultrasound, gastrointestinal radiology, genitourinary radiology, chest radiology and skeletal radiology. Five months of clinical diagnostic radiology rotations are performed outside of the BHS Hospitals at affiliated institutions. Four of these months are at The Children's Hospital of Alabama for pediatric radiology, and one of these months is at the University of Alabama Hospital for cardiac radiology. One month is provided for the American Institute for Radiologic Pathology's Radiologic Pathologic Correlation Course, and one months is provided for an elective rotation. Didactic courses in radiologic physics are offered at the University of Alabama Hospital as one or two hour lectures over approximately fifteen weeks of the PGY-2-PGY-3 year. Residents are required to take the American College of Radiology In-Training Examination each year. Residents are required to acquire and maintain Advanced Cardiac Life Support and BLS certification. The program provides an ACLS course each year for residents.

SUMMARY OF SUBSPECIALTY DISTRIBUTION

Mammography	3.0 Months
CV Radiology (UAB)	1.0 Months
Interventional Radiology	6.0 Months
Neuroradiology	6.0 Months
Pediatric Radiology (Children's)	4.0 Months
Nuclear Medicine	5.0 Months
Ultrasound	3.0 Months
GI Radiology	5.0 Months
GU Radiology	4.0 Months
Chest Radiology	4.0 Months
Skeletal Radiology	5.0 Months
AIRP	1.0 Month
Elective	1.0 Months
Total	**48 Months**

A Radiology Curriculum Handbook is given to each radiology resident and includes details of rotations, reading lists and learning objectives for each subspecialty area.

DUTY HOURS

The ACGME program requirements for Diagnostic Radiology state that duty hours are defined as all clinical and academic activities related to the program; i.e., patient care (both inpatient and outpatient), administrative duties relative to patient care, the provision for transfer of patient care, time spent in-house during call activities, and scheduled activities, such as conferences. Duty Hours also include all moonlighting. Duty hours do not include reading and preparation time spent away from the duty site.

1. Duty hours must be limited to 80 hours per week, averaged over a 4-week period, inclusive of all in-house call activities.

2. Residents must be provided with 1 day in 7 free from all educational and clinical responsibilities, averaged over a 4-week period, inclusive of call.

3. Adequate time for rest and personal activities must be provided. This should consist of a 10-hour time period provided between all daily duty periods and after in-house call.

CALL SCHEDULE

The ACGME program requirements for Diagnostic Radiology state the following relative to on-call activities:

1. In-house call must occur no more frequently than every third night, averaged over a 4-week period.

2. Continuous on-site duty, including in-house call, must not exceed 24 consecutive hours. Residents may remain on duty for up to 4 additional hours to participate in didactic activities, transfer care of patients, conduct outpatient clinics, and maintain continuity of medical and surgical care.

3. No new patients may be accepted after 24 hours of continuous duty.

4. At-home call (or pager call)
   a. The frequency of at-home call is not subject to the every-third-night, or 24+6 limitation. However, at-home call must not be so frequent as to preclude rest and reasonable personal time for each resident.
   b. Residents taking at-home call must be provided with 1 day in 7 completely free from all educational and clinical responsibilities, averaged over a 4-week period.
   c. When residents are called into the hospital from home, the hours residents spend in-house are counted toward the 80-hour limit.

CONFERENCES

Daily morning conferences begin at 7:00 a.m. either at Princeton Baptist Medical Center or at Trinity Medical Center. Twice monthly Pediatric conference is held at UAB. Each Monday there are Tumor Board conferences held at both campuses - Princeton BMC and Trinity Medical Center. Attendance is mandatory. Journal Club is held once per month. Afternoon Show and Tell Conferences are held once a week.

PHYSICS

Physics, radiation biology, and radiation protection are taught in a review course at UAB. The courses are taught during the summer of the resident's PGY-2-PGY-3 year of training under the direction of Dr. Gary Barnes.

COURSES

Second-Year Courses

Physics Board Review
60 hours of course work over 15 weeks
Includes 5 hours radiation biology review

LIBRARIES

Department libraries are located adjacent to the reading rooms at Princeton and Trinity. These are supplemented by the hospital medical libraries. In addition to textbooks and journals, ACR film and DVD teaching files are available as well as the department teaching file. A number of videotape lectures are available.

BHS RADIOLOGY TEACHING FILE

The Department of Radiology Teaching File is the most important educational tool available to residents at BHS. A searchable database is maintained on our computer network. Residents are required to submit 2 cases per month during normal rotations and a minimum 50 cases per month for the four months assigned to the Research and Float Rotation. Cases can be stored in files at both campuses. The database will allow retrieval of all case material for research purposes.

MEETINGS, CONFERENCES, POST-GRADUATE COURSES AND INTERVIEWS

One week (5 week days) of conference time is allotted during the PGY-2 year, and two weeks (10 week days) are allotted during the subsequent post-graduate years. Certain meetings and courses may be subject to the approval of the Program Director and are reimbursable.

Residents who present papers or exhibits at national meetings are not charged additional conference time for this meeting. BHS pays additional expenses associated with presenting papers at these meetings as well.

Time for interviews may be substituted for meeting time. Additional interview time may be granted with the approval of the Program Director.

AMERICAN INSTITUTE FOR RADIOLOGIC PATHOLOGY'S RADIOLOGIC PATHOLOGIC CORRELATION COURSE

Residents spend one month at the AIRP during their third year of radiology training. BHS reimburses the resident for course tuition. Additional funding is provided for lodging, travel and other expenses.

VACATION

Vacation and meeting time are scheduled by the Program Coordinator at Trinity Medical Center.

Vacation time is two weeks (10 days) per year for PGY-1 residents and three weeks (15 week days) per year at the PGY-2 level and above. Note: All Radiology residents start at the PGY-2 level. Two weeks should be taken in blocks of one week. The other five days may be taken as desired. In order to maintain a core group for conferences and other educational activities, at any given time, only two residents may be off for vacation or meetings. Special consideration may be given for some meetings, but any changes must meet with the approval of the Program Director and respective department chairmen. Time off should not be scheduled during angiography rotations or the last week of June. Vacation is also discouraged during outside rotations. Residents assigned to Cardiac Radiology and Pediatric Radiology must coordinate their schedule and obtain permission from the respective department chairman.

EVALUATION OF RESIDENTS AND FACULTY

RESIDENT EVALUATION

Resident evaluation forms are completed by the faculty evaluator after each one-month rotation. A designated faculty person is assigned to provide the evaluation for a specific rotation. This person receives input from other faculty regarding resident performance at monthly meetings. Thus, the submitted evaluation form represents a consensus of the faculty regarding that resident's performance. A copy of our current resident evaluation form is available in the Program Coordinator's office.

Resident evaluation forms are reviewed by the Program Director each month. Any specific problems are discussed with the resident. A notebook with all of the resident's evaluations is available for review by the resident. Resident conferences are

held in six-month intervals with each resident and their mentor following up with the Program Director, where the resident's progress is discussed. These conferences also provide feedback for the Program Director regarding rotation and faculty evaluation. At these meetings procedure logs are reviewed, and performance on the ACR in-service exam is discussed when appropriate. Minutes of the conferences are submitted for the resident's file. A final letter of resident performance from the Program Director is submitted for the institutional file upon the completion of the resident's training. Any recurring resident concerns are documented such that a resident will know well in advance of any problems that could lead to disciplinary action.

ROTATION AND FACULTY EVALUATION

Residents evaluate the educational experience of each rotation upon the conclusion of each rotation. A copy of our current rotation evaluation form is available in the Program Coordinator's office. These forms are initially reviewed by the Program Director and filed by rotation. Copies are submitted to the department chairmen at each institution. They in turn distribute the form to the faculty evaluator for that rotation. Rotation evaluations are discussed among the faculty at departmental meetings and education committee meetings.

Anonymous evaluation of faculty by residents is accomplished by an individual evaluation of each faculty member by residents in each year of training every six months. For example, all of the third year residents individually fill out an evaluation form for each faculty member every six months. A copy of the faculty evaluation form is available in the Program Coordinator's office. These evaluations are reviewed by the Program Director. Copies are submitted to the department chairmen at each institution. They in turn distribute the form to the faculty member being evaluated. Faculty evaluations are not widely discussed among the faculty; rather problems are discussed with individual faculty members through the Program Directors or department chairmen.

PATIENT HANDOFFS

Protocol for Transfer of Patient Care Upon Completion of Rotation or Upcoming Absence from Rotation -- The provision of seamless transition of patient care is extremely important to the faculty and staff of the Radiology Residency Program, as well as to clinicians, fellow residents in other programs, hospital personnel and, above all, to the patient and family. To ensure that the radiology residents provide the best transition of patient care possible, the following procedures should be followed:

1. A resident who is scheduled for vacation, meeting attendance, or rotating off service (especially to another facility) should notify his/her attending on service and notify the resident covering the service of any outstanding patient care information (interventional radiology, especially). This should be done face-to-face (when possible) 24 hours before vacation, meeting, or rotating off service. The resident should not leave until all of his/her reports are finalized by the attending on service in the event that any questions may arise.
2. The resident shall complete hospital charts before rotating off service.
3. A resident scheduled to complete training or to permanently depart from the program for any reason shall complete hospital charts at all primary sites and provide the health information departments with forwarding contact information in the event that any further charting is necessary. This resident should also check out with his/her attending face-to-face before leaving in order to document that all dictated reports have been finalized.
4. The primary call resident shall contact the attending on call by 6:00 pm in order to confirm seamless coverage of any emergency department and STAT examinations performed.
5. If the primary call resident is unable to provide preliminary interpretations within a reasonable or expected amount of time based on the volume of cases, he/she is to contact the secondary call resident for assistance. If there is an emergency requiring an interventional procedure or other additional assistance, the back-up resident shall contact the attending on call.

SUPERVISION OF RESIDENTS

Residents are supervised in all their medical activities by the faculty of the Department of Radiology at all of the affiliated sites. The resident is directly supervised during the performance of any invasive procedure including myelography, lumbar puncture, thoracentesis, paracentesis, needle biopsy, drainage procedure, any angiographic study, vertebroplasty, kyphoplasty, nephrostomy, percutaneous transhepatic cholangiography, etc. The graded supervision based on number of procedures performed and mastery of skills is described in detail as part of the procedure log

document. However, an attending does physically observe the critical portions of all invasive procedures performed.

During performance of noninvasive procedures and day-to-day preliminary interpretation of imaging studies, the attending is immediately available to review cases but may not always be in the same room with the resident. This is qualified in that the resident must be able to demonstrate that he/she can perform said procedure under indirect supervision (based on procedure log document). The Radiology Residency Program Director bears final responsibility for the quality of supervision while on intra and extradepartmental rotations and monitors their supervision with the aid of the evaluation forms submitted by the residents. Education in the signs of fatigue, sleep deprivation, and strategic napping is provided through periodic conferences offered by the BHS Department of Medical Education.

CIRCUMSTANCES REQUIRING FACULTY INVOLVEMENT

As above, faculty involvement is indicated in any invasive procedure performed during the day or night. There may be a rare occasion that a resident on call is asked to perform a fluoroscopic barium procedure, joint injection, lumbar puncture, thoracentesis, or paracentesis without an attending radiologist present in the hospital. In these cases, the resident will have already documented mastery of those indicated procedures. If, however, the primary resident requires assistance, the secondary (upper level) resident is available for assistance as is the on-call attending. Any other procedure performed requires direct faculty involvement. Additionally, the on-call resident will contact the attending radiologist on call for any request of attending-level interpretation from another attending physician. Finally, for the specific care of patients following an interventional radiology procedure, the secondary call resident will be contacted by the primary call resident. The secondary call resident will then contact his/her attending for questions regarding any complication or change in therapy.