## Table of Contents

<table>
<thead>
<tr>
<th>Block Schedule Rotations</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>IM, EM/IM, Transitional, and Osteopathic Schedule</td>
<td>4</td>
</tr>
<tr>
<td>General Medicine Teaching Service Core Schedule/ Night Colored Teaching</td>
<td>7</td>
</tr>
<tr>
<td>Hospitalist Core Schedule/ Night Hospitalist Teaching - Description, Organization, Responsibilities</td>
<td>11</td>
</tr>
<tr>
<td>MICU Core Schedule - Description, Organization, Responsibilities</td>
<td>14</td>
</tr>
<tr>
<td>CCU Core Schedule - Description, Organization, Responsibilities</td>
<td>21</td>
</tr>
<tr>
<td>Medicine Consults - Description, Organization, Responsibilities</td>
<td>24</td>
</tr>
<tr>
<td>Bone Marrow Transplant Service- Description, Organization, Responsibilities</td>
<td>24</td>
</tr>
<tr>
<td>Oncology - Description, Organization, Responsibilities</td>
<td>26</td>
</tr>
<tr>
<td>Subspecialty Electives - Description, Organization, Responsibilities</td>
<td>26</td>
</tr>
<tr>
<td>Neurology Elective</td>
<td>27</td>
</tr>
<tr>
<td>Emergency Room Rotation</td>
<td>27</td>
</tr>
<tr>
<td>Geriatrics</td>
<td>28</td>
</tr>
<tr>
<td>Away Elective</td>
<td>38</td>
</tr>
<tr>
<td>Continuity Clinic Guidelines</td>
<td>28</td>
</tr>
<tr>
<td>Medical Ambulatory Elective</td>
<td>32</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>General Responsibilities</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Professionalism</td>
<td>34</td>
</tr>
<tr>
<td>Daily Responsibilities</td>
<td>34</td>
</tr>
<tr>
<td>Patient Care</td>
<td>35</td>
</tr>
<tr>
<td>Dress Code</td>
<td>35</td>
</tr>
<tr>
<td>Sign Out</td>
<td>35</td>
</tr>
<tr>
<td>Working Hours</td>
<td>36</td>
</tr>
<tr>
<td>Paging Policy</td>
<td>36</td>
</tr>
<tr>
<td>Email Policy</td>
<td>37</td>
</tr>
<tr>
<td>Change in Call Schedule</td>
<td>37</td>
</tr>
<tr>
<td>Lectures and Conference</td>
<td>37</td>
</tr>
<tr>
<td>Order Writing Policy</td>
<td>37</td>
</tr>
<tr>
<td>Procedure Policy</td>
<td>38</td>
</tr>
<tr>
<td>Arrest Teams</td>
<td>39</td>
</tr>
<tr>
<td>Medical Records</td>
<td>40</td>
</tr>
<tr>
<td>Death Certificates</td>
<td>40</td>
</tr>
<tr>
<td>Coroner's Cases</td>
<td>41</td>
</tr>
<tr>
<td>Sabbath Program</td>
<td>41</td>
</tr>
<tr>
<td>Resident Supervision</td>
<td>41</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Admission &amp; Discharge Policies</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Requirements for admission to the teaching services</td>
<td>47</td>
</tr>
<tr>
<td>Topic</td>
<td>Page</td>
</tr>
<tr>
<td>--------------------------------------------------------------</td>
<td>------</td>
</tr>
<tr>
<td>Limits on admission to the Teaching Services</td>
<td>42</td>
</tr>
<tr>
<td>Requirements for Discharge from the Teaching Services</td>
<td>53</td>
</tr>
<tr>
<td><strong>ADVANCEMENT</strong></td>
<td></td>
</tr>
<tr>
<td>USMLE Step 3</td>
<td>45</td>
</tr>
<tr>
<td>Clinical Competency Exams</td>
<td>45</td>
</tr>
<tr>
<td>Procedure Credentials</td>
<td>45</td>
</tr>
<tr>
<td>Criteria for Advancement</td>
<td>45</td>
</tr>
<tr>
<td><strong>EVALUATIONS</strong></td>
<td></td>
</tr>
<tr>
<td>Resident Evaluation</td>
<td>46</td>
</tr>
<tr>
<td>Faculty Evaluation</td>
<td>48</td>
</tr>
<tr>
<td><strong>DIDACTICS</strong></td>
<td>48</td>
</tr>
<tr>
<td><strong>VACATION</strong></td>
<td></td>
</tr>
<tr>
<td>Sick Days</td>
<td>50</td>
</tr>
<tr>
<td>Maternity Leave</td>
<td>50</td>
</tr>
<tr>
<td>Interviews</td>
<td>51</td>
</tr>
<tr>
<td>Personal Time</td>
<td>51</td>
</tr>
<tr>
<td>Special Rules</td>
<td>51</td>
</tr>
<tr>
<td>Vacation</td>
<td>52</td>
</tr>
<tr>
<td>Jeopardy</td>
<td>52</td>
</tr>
<tr>
<td><strong>RESIDENT MISCONDUCT</strong></td>
<td></td>
</tr>
<tr>
<td>Due Process</td>
<td>53</td>
</tr>
<tr>
<td>Disciplinary Action</td>
<td>54</td>
</tr>
<tr>
<td>Appeal Process</td>
<td>62</td>
</tr>
<tr>
<td><strong>RESIDENT FATIGUE</strong></td>
<td>62</td>
</tr>
<tr>
<td><strong>MOONLIGHTING POLICY</strong></td>
<td></td>
</tr>
<tr>
<td><strong>HIPAA POLICY</strong></td>
<td></td>
</tr>
<tr>
<td><strong>MISCELLANEOUS</strong></td>
<td></td>
</tr>
<tr>
<td>Assignment of On-Call Rooms</td>
<td>65</td>
</tr>
<tr>
<td>Attending Rounds Conference Rooms</td>
<td>65</td>
</tr>
<tr>
<td>Library</td>
<td>65</td>
</tr>
<tr>
<td>AGH Human Resources Employee Assistance Program</td>
<td>65</td>
</tr>
</tbody>
</table>
Block Scheduling Requirements

Internal Medicine and Emergency Medicine/Internal Medicine Schedules
- The following are the block schedule requirement for each PGY level for the Internal Medicine and Emergency Medicine/Internal Medicine residency programs.
- One block equals 1 month duration.

**Internal Medicine –**

<table>
<thead>
<tr>
<th>R1 Categorical Intern Requirements</th>
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</tr>
</thead>
<tbody>
<tr>
<td>General Medicine—(hospitalist and colored teaching services)</td>
<td>5 months</td>
</tr>
<tr>
<td>Medical ICU</td>
<td>2 months</td>
</tr>
<tr>
<td>Emergency Medicine</td>
<td>1 month</td>
</tr>
<tr>
<td>Ambulatory</td>
<td>1 month</td>
</tr>
<tr>
<td>Electives</td>
<td>2 months</td>
</tr>
<tr>
<td>Night Teaching</td>
<td>1 month</td>
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<table>
<thead>
<tr>
<th>R1 Categorical Osteopathic Intern Requirements</th>
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</thead>
<tbody>
<tr>
<td>General Medicine</td>
<td>5 months</td>
</tr>
<tr>
<td>Medical ICU</td>
<td>2 months</td>
</tr>
<tr>
<td>Night Teaching</td>
<td>1 month</td>
</tr>
<tr>
<td>Emergency Medicine</td>
<td>1 month</td>
</tr>
<tr>
<td>Family Medicine</td>
<td>1 month</td>
</tr>
<tr>
<td>Elective</td>
<td>1 month</td>
</tr>
<tr>
<td>Anesthesia</td>
<td>2 weeks</td>
</tr>
<tr>
<td>Radiology</td>
<td>2 weeks</td>
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<table>
<thead>
<tr>
<th>R1 Preliminary Intern Requirements</th>
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</thead>
<tbody>
<tr>
<td>General Medicine</td>
<td>6 months</td>
</tr>
<tr>
<td>Medical ICU</td>
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</tr>
<tr>
<td>Emergency Medicine</td>
<td>1 month</td>
</tr>
<tr>
<td>Ambulatory</td>
<td>1 month</td>
</tr>
<tr>
<td>Electives</td>
<td>2 months</td>
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</table>

<table>
<thead>
<tr>
<th>R2 Categorical Resident Requirements</th>
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</thead>
<tbody>
<tr>
<td>General Medicine</td>
<td>3 months</td>
</tr>
<tr>
<td>Medical ICU</td>
<td>1 month</td>
</tr>
<tr>
<td>CCU</td>
<td>1 months</td>
</tr>
<tr>
<td>Ambulatory</td>
<td>2 months</td>
</tr>
<tr>
<td>Neurology</td>
<td>2 weeks</td>
</tr>
<tr>
<td>Oncology/ Bone Marrow Transplant</td>
<td>1 month</td>
</tr>
<tr>
<td>Electives</td>
<td>2 ½ months</td>
</tr>
<tr>
<td>Night Teaching</td>
<td>1 month</td>
</tr>
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<table>
<thead>
<tr>
<th>R3 Categorical Resident Requirements</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>General Medicine</td>
<td>2 months</td>
</tr>
<tr>
<td>Medical ICU</td>
<td>1 month</td>
</tr>
<tr>
<td>Requirement</td>
<td>Duration</td>
</tr>
<tr>
<td>-------------------------------------------------</td>
<td>-----------</td>
</tr>
<tr>
<td>Ambulatory / Ambulatory Selective</td>
<td>2 months</td>
</tr>
<tr>
<td>Geriatrics</td>
<td>1 month</td>
</tr>
<tr>
<td>Patient Safety</td>
<td>2 weeks</td>
</tr>
<tr>
<td>Night Teaching or Medical Officer of the Day</td>
<td>2 weeks</td>
</tr>
<tr>
<td>Oncology</td>
<td>1 month</td>
</tr>
<tr>
<td>Electives</td>
<td>3 months</td>
</tr>
<tr>
<td>Medical Consults</td>
<td>1 month</td>
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</table>

**Internal Medicine/Emergency Medicine –**

<table>
<thead>
<tr>
<th>Requirement</th>
<th>Duration</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>EM/IM R1 Categorical Intern Requirements</strong></td>
<td></td>
</tr>
<tr>
<td>General Medicine Floor Months</td>
<td>4 months</td>
</tr>
<tr>
<td>Medical ICU</td>
<td>1 month</td>
</tr>
<tr>
<td>Ambulatory</td>
<td>1 month</td>
</tr>
<tr>
<td><strong>EM/IM R2 Categorical Resident Requirements</strong></td>
<td></td>
</tr>
<tr>
<td>Medical ICU (considered R1 level)</td>
<td>1 month</td>
</tr>
<tr>
<td>CCU</td>
<td>2 months</td>
</tr>
<tr>
<td>Ambulatory</td>
<td>1 month</td>
</tr>
<tr>
<td>Sports Medicine</td>
<td>1 month</td>
</tr>
<tr>
<td>Neurology</td>
<td>½ month</td>
</tr>
<tr>
<td>Elective</td>
<td>½ month</td>
</tr>
<tr>
<td><strong>EM/IM R3 Categorical Resident Requirements</strong></td>
<td></td>
</tr>
<tr>
<td>General Medicine Floor Months</td>
<td>2 months</td>
</tr>
<tr>
<td>Medical ICU</td>
<td>1 month</td>
</tr>
<tr>
<td>Medicine Consults</td>
<td>1 month</td>
</tr>
<tr>
<td>Ambulatory</td>
<td>1 month</td>
</tr>
<tr>
<td>Elective</td>
<td>1 month</td>
</tr>
<tr>
<td><strong>EM/IM R4 Categorical Resident Requirements</strong></td>
<td></td>
</tr>
<tr>
<td>Geriatrics</td>
<td>1 month</td>
</tr>
<tr>
<td>Emergency Medicine</td>
<td>1 month</td>
</tr>
<tr>
<td>Ambulatory</td>
<td>1 month</td>
</tr>
<tr>
<td>Mini Fellowship</td>
<td>3 months</td>
</tr>
<tr>
<td><strong>EM/IM R5 Categorical Resident Requirements</strong></td>
<td></td>
</tr>
<tr>
<td>General Medicine Floor Months</td>
<td>3 months</td>
</tr>
<tr>
<td>Medical ICU</td>
<td>1 month</td>
</tr>
<tr>
<td>Ambulatory</td>
<td>1 month</td>
</tr>
<tr>
<td>Elective</td>
<td>1 month</td>
</tr>
</tbody>
</table>

Note:
- The medicine elective months for EM/IM residents must include at least 4 subspecialty medicine rotations.
- General medicine rotations for EM/IM residents include color teaching, hospitalist, or oncology service.
The Osteopathic Rotating Internship addresses all AOA requirements and accommodates individuals' learning needs and interests. Interns must work with the Director of Osteopathic Medical Education to develop their rotation schedule in a way that best addresses their learning needs and interests.

<table>
<thead>
<tr>
<th>Rotation</th>
<th>Blocks required</th>
<th>Vacation Allowed</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Osteopathic Categorical Internship</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family Practice</td>
<td>1 month</td>
<td>No</td>
</tr>
<tr>
<td>Anesthesia/Radiology</td>
<td>2 weeks/2 weeks</td>
<td>Yes, only 1 week</td>
</tr>
<tr>
<td>ER</td>
<td>1 month</td>
<td>No</td>
</tr>
<tr>
<td>MICU</td>
<td>2 months</td>
<td>No</td>
</tr>
<tr>
<td>IM day wards</td>
<td>5 months</td>
<td>No</td>
</tr>
<tr>
<td>IM night float</td>
<td>1 month</td>
<td>No</td>
</tr>
<tr>
<td>Elective</td>
<td>1 month</td>
<td>Yes, 2 weeks</td>
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</table>

<table>
<thead>
<tr>
<th><strong>Osteopathic Traditional Rotating Internship: PM&amp;R</strong></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Family Practice</td>
<td>1 month</td>
<td>No</td>
</tr>
<tr>
<td>Anesthesia/Radiology</td>
<td>2 weeks/2 weeks</td>
<td>No</td>
</tr>
<tr>
<td>ER</td>
<td>1 month</td>
<td>No</td>
</tr>
<tr>
<td>MICU</td>
<td>2 months</td>
<td>No</td>
</tr>
<tr>
<td>IM day wards</td>
<td>2 months</td>
<td>No</td>
</tr>
<tr>
<td>IM night float</td>
<td>1 month</td>
<td>No</td>
</tr>
<tr>
<td>Ambulatory</td>
<td>1 month</td>
<td>No</td>
</tr>
<tr>
<td>Elective</td>
<td>3 months</td>
<td>Yes</td>
</tr>
</tbody>
</table>

Electives must be at least 4 weeks in specialty or subspecialty; i.e. no 2 week electives. These may include: Cardio, Pulm, GI, Rheum, ID, Renal, Endo, Neuro, Ortho, PM&R.

<table>
<thead>
<tr>
<th><strong>Osteopathic Traditional Rotating Internship: Diagnostic Radiology</strong></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Family Practice</td>
<td>1 month</td>
<td>No</td>
</tr>
<tr>
<td>Anesthesia/Radiology</td>
<td>2 weeks/2 weeks</td>
<td>No</td>
</tr>
<tr>
<td>ER</td>
<td>1 month</td>
<td>No</td>
</tr>
<tr>
<td>MICU</td>
<td>2 months</td>
<td>No</td>
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<tr>
<td>IM day wards</td>
<td>2 months</td>
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</tr>
<tr>
<td>IM night float</td>
<td>1 month</td>
<td>No</td>
</tr>
<tr>
<td>Ambulatory</td>
<td>1 month</td>
<td>No</td>
</tr>
<tr>
<td>Elective</td>
<td>3 months</td>
<td>Yes</td>
</tr>
</tbody>
</table>

Electives for Diagnostic Radiology may include: Cardio, Pulm, GI, Rheum, Neuro, Orthopedics, Neurosurgery, Anatomic Pathology, and/or Radiology.

*No more than two months Radiology electives.
General Medicine Teaching Services

**Color Teaching Services at AGH**

<table>
<thead>
<tr>
<th>Time</th>
<th>Monday</th>
<th>Tuesday</th>
<th>Wednesday</th>
<th>Thursday</th>
<th>Friday</th>
</tr>
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<tbody>
<tr>
<td>7:00AM</td>
<td>Sign-in Resident Lounge</td>
<td>Sign-in Resident Lounge</td>
<td>Sign-in Resident Lounge</td>
<td>Sign-in Resident Lounge</td>
<td>Sign-in Resident Lounge</td>
</tr>
<tr>
<td>7:00AM</td>
<td>Morning Report</td>
<td>Morning Report</td>
<td>Morning Report</td>
<td>Morning Report</td>
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</tr>
<tr>
<td>7:00AM-8:30AM</td>
<td>Pre Round</td>
<td>Pre Round</td>
<td>Pre Round</td>
<td>Pre Round</td>
<td>Pre Round</td>
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<tr>
<td>8:30AM-10:00AM</td>
<td>Work Rounds</td>
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<td>Work Rounds</td>
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<td>Work Rounds</td>
</tr>
<tr>
<td>10:15AM-11:30AM</td>
<td>Teaching Rounds</td>
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<td>Teaching Rounds</td>
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<tr>
<td>11:30AM-12Noon</td>
<td>Lunch</td>
<td>Lunch</td>
<td>Lunch</td>
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<tr>
<td>12 Noon-1:00PM</td>
<td>Lecture</td>
<td>Lecture</td>
<td>Medical Grand Rounds</td>
<td>Board Review</td>
<td>Lecture/ M&amp;M</td>
</tr>
<tr>
<td>1:00PM-4:00PM</td>
<td>Patient Care</td>
<td>Patient Care</td>
<td>Patient Care</td>
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<td>Patient Care</td>
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<tr>
<td>4:00PM</td>
<td>Earliest time to Sign out</td>
<td>Earliest time to sign-out</td>
<td>Earliest time to sign out</td>
<td>Earliest time to sign out</td>
<td>Earliest time to sign out</td>
</tr>
</tbody>
</table>
General Medicine Teaching Service Guidelines

- Description
  - Patients located on the regular nursing floors are divided among five services designated by colors – blue, red, yellow, green, and purple.
  - Teams consist of one attending physician, one R2 or R3 serving in a supervising capacity, and two to three R1 residents who assume primary responsibility for patient care. Additionally, third and fourth year medical students are assigned to each team.

- Admitting Schedule
  - From Monday through Friday, there will be three admission cycles per day.
    - One team (designated overnight) will be responsible to taking admissions done by the night float team from the night prior. The night float team will round with this team at 8:30am and leave by 10:00am.
    - One team will be assigned to an admission period from 7am-4pm.
    - One team will be assigned to an admission period from 4pm-10pm.
    - Night Float will arrive at 9:30pm to get sign-out and admit until 7am, followed by rounding with the team assigned to take the overnight admissions, for a total shift of approx. 12.5 hours
    - Night Float will be assigned shifts from Sunday night through Thursday night.
    - On Friday, the R3 assigned to the Patient Safety rotation for 2 weeks will cover for the Senior assigned to admitting call on Saturday. This resident will cover the team for the day and stay for the overnight admitting shift with the senior assigned to the Friday 4p-7a shift. The Patient Safety senior will leave at 7am.
    - The team assigned to Friday 4p-10p will continue admitting patients until 7am on Saturday. The interns will leave on Friday at 10pm and the senior will stay overnight with the Patient Safety senior and round with one intern returning on Saturday. This senior will follow the rules of a 24+4 shift. After this senior signs out, the intern will be supervised by the Saturday admitting senior.
    - The team assigned to admit Saturday will admit from 7a-7a. The senior will follow a 24+4 shift. One intern will be assigned to work 7a-10p on Saturday and then have Sunday off. The other intern will be off from Friday into Saturday, and then work from 8pm Saturday to 12pm on Sunday and be able to round.
    - The team assigned to admit Sunday will admit from 7a-10p. One intern will be assigned to a 7a-10p shift and will have had Saturday off. The other intern will have rounded on Saturday and will work on Sunday from 2pm-10pm, thus having a 24h period off from Saturday into Sunday.
    - Admitting shifts will continuously rotate through all 5 teaching services, and for the average month, each team should be assigned to no more than 1 Friday and 1 Saturday admitting shift.
    - Days off for both interns and seniors would be based on the call schedule, with the only “work week” day off being the Saturday call senior off on Friday. This would help to eliminate conflicts with clinic and potentially help with clinic scheduling.
Night Teaching and the team accepting overnight admissions are expected to attend morning report. The team admitting from 7a-4p would be excused from performing work rounds, which would occur once per week.

- **Pre Rounds**
  - Interns should see and examine their patients.
  - Determine any overnight events
  - Collect relevant data (vitals, labs, etc.)
  - Develop a problem list and plan

- **Work Rounds (Daily, except when the team accepts overnight admissions)**
  - To be led by the senior resident.
  - The resident and the interns will gather at patient bedside before attending rounds to discuss their patients.
  - This will allow senior residents to see all of the patients and to examine sick, unstable, or patients with a change in status directly with the intern.
  - They will also review pertinent physical findings, labs, and develop and plan for the patients.
  - Senior residents should also be actively teaching clinical pearls and practicing evidence-based medicine during work rounds.
  - PGY-1’s will learn how to succinctly present their patients to the senior resident.

- **Teaching Attending Rounds**
  - Led by the teaching attending to discuss patient management issues and provide dedicated teaching.
  - At least 3 times per week, bedside rounds are conducted to promote physical diagnosis and communication skills. Attendings are expected to demonstrate and to observe diagnostic skills at the bedside.
  - During dedicated teaching time, or during patient management discussions, reading assignments may be discussed as they relate to the specific patient care issues. Residents and medical students (on color teaching services) will be expected to contribute to literature reviews and didactics.
  - Goals of teaching rounds include development of history-taking and physical examination skills, case-presentation skills, and analytic skills. Medical knowledge is also improved by detailed discussions of the diseases encountered in the patients on the inpatient services.

- **Responsibilities**
  - **Supervising Resident (R2 and R3) Responsibilities:**
    1. Supervise R1 daily work rounds.
    2. Supervise patient admissions and ongoing care for 2 R1’s and up to 20 patients in total.
    3. Ensure that tasks are completed, studies followed-up on, and consultants called when appropriate.
    4. Serve as primary teacher and resource for interns.
    5. Organize rounds such that patient care and teaching are optimized and efficient.
    6. Actively participate in daily teaching and patient management rounds.
    7. Lead case management rounds recognizing patient’s short term and long term care needs.
    8. Keep attending updated of any change in patient status during the day and night and formulate patient care plans.
    9. Review daily progress notes written by the intern and provide feedback.
   10. Be intimately familiar with patients’ medical diagnoses and assist with R1 assessment and daily plan.
   11. Prepare and present a teaching lecture at least once per month on a Core Topic in inpatient medicine to rounding teams.
   12. On color teaching service, prepare and present evidence-based topic discussion at least weekly.
   13. Assign short topics to medical students and sub-interns to present during teaching rounds.
   14. Set example for team with appropriate work ethic, professionalism, and dedication.
   15. Set tone for the team with enthusiastic, evidence-based, and professional approach to patient care and intern education.
   16. Attend radiology rounds.
17. Attend noon lectures presented by the Department of Medicine.
18. Attend Grand Rounds weekly presented by the Department of Medicine.
19. Complete formal written evaluation for R1’s, attending physician and medical students within 24 hours of end of rotation.
20. Ensure that proper sign out of patients has been performed by themselves and their interns before leaving the hospital.
21. Review and co-sign all MSIII & MSIV progress notes.
22. Carry the 8181 pager and delegate patients to the correct service when on-call.

- **R1 Responsibilities:**
  1. Perform an independent and comprehensive history and thorough physical examination on each patient at the time of admission.
  2. Perform daily problem-focused medical history and physical.
  3. Develop a management plan sequentially, first under direction of a senior medical resident and subsequently or concurrently by the hospitalist or colored teaching attending.
  4. Round daily on admitted patients and formulate assessment and plan of care.
  5. Document findings and provide an assessment of the patient’s problems in daily notes.
  6. A problem list should be formulated that includes ALL documented medical problems (active and inactive).
  7. Daily notes MUST include differential diagnosis, work-up, and plans for each active problem.
  8. Assessments are documented in the chart after being discussed with the supervising senior resident and/or attending physician.
  9. Write all admission orders based on plans discussed with the resident and attending physician.
  10. In subsequent follow-up of their patients, PGY1s are expected to be knowledgeable about the details of their patients’ problems and the results of diagnostic studies and therapeutic interventions. They should be able to present this information orally in a concise manner during work rounds and in discussions with attendings and consultants.
  11. Keep electronic sign-out up-to-date and provide appropriate verbal and typed sign-out to colleagues when transferring care, especially overnight.
  12. Perform procedures on their patients (with appropriate supervision as necessary).
  13. Provide daily progress notes on weekdays and cross cover notes on the weekends.
  14. Attend daily management rounds with attending hospitalist and teaching rounds with colored teaching attending.
  15. Participate actively in daily teaching and patient management rounds.
  16. Keep senior resident abreast of any changes in patient status and review new management plans prior to discussion with attending.
  17. Establish discharge plans early in the hospital course.
  18. Review discharge planning with case managers early and often to identify patients’ short term and long care needs.
  19. Dictate all discharge summaries within 24 hours.
  20. Create concise and comprehensive transfer of service notes when leaving a service or when the patient is transferred to a different service.
  22. Attend radiology rounds.
  23. Attend noon lectures presented by the Department of Medicine.
  24. Attend Grand Rounds weekly presented by the Department of Medicine.

**Night Colored Teaching**

- **Night Color Teaching Team**
  - Retains responsibility for patients admitted overnight until 8:30 a.m. but **does not** write the daily progress note for them.
- From 8:30 a.m. to 10 a.m. there will be combined work/attending rounds for all admissions done overnight by the night float team with the night float team and the accepting color teaching team and attending.
  - The night float team is dismissed no later than 10 a.m.
- Night Teaching (R1)
  - 2 Interns will be scheduled for night float in one month blocks.
  - One Intern will be responsible for up to 5 admissions per night (supervised by the senior resident or hospitalist attending) and the other intern will be responsible for cross-coverage of the color teaching teams' patients.
- Night Teaching (R2-3)
  - Resident will be scheduled for night float in 15 day blocks. Hours are from 10:00PM-10:00AM.
  - Resident will supervise the interns at night for five admissions per intern. They will also perform admissions for the cardiology service, oncology service, hospitalist service, new consults at night, and unreferred teaching patients over the cap.
  - Total patients admitted for the Night Float R2/R3 is 10 per night.
  - Supervision and teaching at night is provided by the hospitalist attending on nights and the unreferred teaching attending who will be assuming care of the patients on the following day.
  - Resident will provide cross coverage from 10:00PM-7:00AM for oncology, hospitalist, cardiology and the consult services during the shift.
  - All residents will meet for sign-out in the resident lounge before morning report except MICU and CCU residents.
  - Night float seniors are responsible for seeing and discussing with Attendings any new house medicine consults during the night.
  - Night float senior should call the Oncology fellow on call with all new oncology admissions to the oncology hospital group or call the private oncology attending for admissions to their service.

- If the night float resident has capped at 10, the hospitalist attending admits any over the cap patients (referred or unreferred).

All seniors on night Teaching are required to attend morning report

### Hospitalist Teaching Service and Core Schedule

**Hospitalist Core Resident Schedule**

<table>
<thead>
<tr>
<th>Monday</th>
<th>Tuesday</th>
<th>Wednesday</th>
<th>Thursday</th>
<th>Friday</th>
</tr>
</thead>
<tbody>
<tr>
<td>7:00AM-8:00AM</td>
<td>Morning Report/Post Call Cases</td>
<td>Morning Report/ Post call cases</td>
<td>Morning Report/Post Call Cases</td>
<td>Morning Report (prepared case discussion)</td>
</tr>
<tr>
<td>9:00AM-9:15AM</td>
<td>Senior Resident attends Case Management Rounds</td>
<td>Senior Resident attends Case Management Rounds</td>
<td>Senior Resident attends Case Management Rounds</td>
<td>Senior Resident attends Case Management Rounds</td>
</tr>
<tr>
<td>Time</td>
<td>Work Rounds</td>
<td>Work Rounds</td>
<td>Work Rounds</td>
<td>Work Rounds</td>
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<tr>
<td>------------</td>
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<td>-------------</td>
</tr>
<tr>
<td>9:15AM-10:00AM</td>
<td>Work Rounds</td>
<td>Work Rounds</td>
<td>Work Rounds</td>
<td>Work Rounds</td>
</tr>
<tr>
<td>10:00AM-11:30AM</td>
<td>Attending Teaching Rounds</td>
<td>Attending Teaching Rounds</td>
<td>Attending Teaching Rounds</td>
<td>Attending Teaching Rounds</td>
</tr>
<tr>
<td>11:00AM-11:30AM</td>
<td>Patient Care</td>
<td>Patient Care</td>
<td>Patient Care</td>
<td>Patient Care</td>
</tr>
<tr>
<td>11:30AM-NOON</td>
<td>Lunch</td>
<td>Lunch</td>
<td>Lunch</td>
<td>Lunch</td>
</tr>
<tr>
<td>NOON-1:00PM</td>
<td>Lecture</td>
<td>Lecture</td>
<td>Medical Grand Rounds</td>
<td>Board Review</td>
</tr>
<tr>
<td>1:00PM-8:00PM</td>
<td>Patient Care</td>
<td>Patient Care</td>
<td>Patient Care</td>
<td>Patient Care</td>
</tr>
</tbody>
</table>

- Two Hospitalist teams will be assigned to accept new admissions for each day.
- Senior residents on the Hospitalist teams will alternate with either 7AM-6PM or 7AM-8PM shifts Monday through Thursday on their admitting days, according to the Amion schedule.
- For Monday through Thursday, interns from each admitting team will alternate Short Call and Long Call assignments according to the Amion schedule. Short Call interns accept new admissions from 7AM-2PM and Long Call interns accept new admissions from 2PM-8PM.
- Hospitalist Night Float will cover the Hospitalist teams and admit Hospitalist patients from Sunday night through Friday morning from 8pm-7am each night. Admissions completed by the Night Float team will be distributed to the teams admitting from the day prior.
- On Friday, one admitting Hospitalist team, whose senior resident is assigned to 7AM-6PM shift, will follow the same rules for Short Call and Long Call interns Monday-Thursday.
- On Friday, one admitting Hospitalist team will be assigned to admit until 7am Saturday. This senior resident will perform admissions from 7AM Friday until 7AM Saturday and remain for up to 4 additional hours to round for their team. One intern will work from 7AM until 9PM on Friday. The other intern will work 7AM-12PM Friday, leave the hospital and return from 10PM Friday until 12PM Saturday.
- On Saturday, two teams are again assigned to take new admissions. One team, whose senior resident is scheduled to admit from 7AM-7PM, will have one intern present from 7AM-7PM and one intern present from 12PM-7PM. The other admitting team will have one intern present and accepting new admissions from 7AM-9PM. A covering senior will be present on Saturday morning for rounding purposes only. This team’s senior resident will be admit from 7PM until 7AM on Sunday and remain for up to 4 hours to round for their team. This team’s other intern will arrive at 9PM and take admissions until 7AM Sunday and stay until 12PM for rounding purposes.
- On Sunday, two teams are again available to accept new admissions. One team will have a senior resident present from 7AM-8PM, one intern present from 7AM-7PM, and another intern present from 2PM-8PM. The other team will have one intern present from 7AM and available to accept admissions. These admissions will be precepted by the Hospitalist attending, as a covering senior will be assigned to this team in the morning and not responsible for new admissions.
- Admission caps for any period designated as Short Call or Long Call are 4 admits per intern. All other admitting periods from Friday through Sunday will be capped at 5 admits per intern.
- All shift periods and days off are assigned as per the Amion schedule.
- Night float residents work from 8:00M-7:00AM. They are responsible for the Hospitalist admissions, Oncology admissions and coverage, and consult service coverage as well as completing any STAT and Pre-op consults during their shift. Senior resident caps are 10 new patient encounters.

**Hospitalist Medicine Teaching Service Guidelines**
• Description
  o Patients of Allegheny General Hospital Internal Medical Practice (AGHIM) will be preferentially admitted to this service that will be supervised by full-time in-house Attending Physicians. Any AGH physician designated to admit to the Hospitalist service and clinic patients will be admitted to this service as well. In addition, any unrefereed patient admitted after the Color Teaching service has capped will be admitted to the Hospitalist service.

• Organization
  o There will be four teams, designated as Team 1, Team 2, Team 4, and Team 5 (Team 3 is the Hospitalist Consult service). Each team consists of one attending and one senior resident and two interns.
  o Admitting schedule for interns:
    1. Intern admitting schedules are described above under the Hospitalist Core Resident Schedule description.
    2. All Intern shifts and admitting periods will assigned according to the Amion schedule.
    3. Intern caps follow rules outlined in the ACGME Internal Medicine Program Requirements. No intern can accept more than 5 new patients plus 2 medical service transfers in 24 hours or 8 new patients in a 48 hour period
  o Teaching Attending Rounds
    1. Teaching rounds are primarily intended for training and education and general oversight of patient management issues as they pertain to insuring the quality of patient care and education.
  o Patient Management Rounds
    1. Management rounds will be inclusive of many levels of care providers, including nurses, case managers, pharmacists and physicians, reflective of integrated care management appropriate to this population.

• Responsibilities R1
  o Initial complete history and physical examinations.
  o Complete differential diagnosis.
  o Diagnostic and therapeutic care plan.
  o Communication daily with the senior resident and Attending of Record.
  o Communication daily with the patients and their families.
  o Enter all orders.
  o Procedures (under appropriate supervision).
  o Daily progress notes.
  o Transfer notes on leaving or beginning service and when the patient is transferred to a different service.
  o Discharge summary dictation within 24 hours of patients discharge.
  o Provide adequate sign out to the covering intern before leaving the hospital.
  o While on call, cross cover the other hospitalist patients.
  o Attend all conferences except morning report.
Responsibilities of the R2-3

- Admission note on all patients admitted to the service.

1. Supervise work rounds.
2. Evaluate all patients assigned to the service.
3. Complete progress notes when the patient’s condition changes or when there is a major change in management.
4. Supervise acting interns assigned to the service.
5. Supervise procedures performed by R1’s.
6. Participate with the hospitalists attending in discussion of cases for teaching attending rounds.
7. Complete formal written evaluation for R1’s and attending within 24 hours of end of rotation.
8. Ensuring proper sign out of by themselves and their interns to the covering team before leaving the hospital.
9. Attend Morning Report and all conferences.
10. Senior hospitalist resident assigned to 7A-8P shift will be responsible for stat consult coverage from 5:00 PM-8:00 PM and signing off consults to the night float senior.
11. Night-float hospitalist seniors are responsible for cross-coverage and admissions to the hospitalist teams, cross coverage and admissions to oncology, STAT and Pre-op consults overnight and cross coverage for the Consult services. Consults count as an admission, and all stat consults must be seen and discussed with the consult attending and followed up over night and signed out to the daytime consult senior.
12. All stat consults over the cap should be directed to the hospitalist attending.

Hospitalist Night Teaching

- The hospitalist night teaching team consists of one senior resident and two first year residents.
- Senior residents spend 15 days on night teaching and interns spend one month on night teaching.
- The night teaching team runs from Sunday night through Thursday night.
- The senior resident can admit patients to the hospitalist and oncology services. He/she should also perform STAT consults.
- The cap for all patient encounters (admissions for hospitalist, oncology, and consults) is 10.
- There are two interns on night teaching. One intern admits patients and the other intern cross-covers admitted patients and can admit MICU transfers.
- Intern admissions are supervised by a senior resident or attending.
- The night teaching shift is from 8PM- 8AM.
- Senior residents should attend morning report.

MICU Core Schedule

Table 3

<table>
<thead>
<tr>
<th>MICU Intern Schedule at AGH</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monday</td>
</tr>
<tr>
<td>6:00AM</td>
</tr>
<tr>
<td>7:00AM-9:00AM</td>
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<tr>
<td></td>
</tr>
<tr>
<td>Time</td>
</tr>
<tr>
<td>--------------</td>
</tr>
<tr>
<td>9:00AM-11:00AM</td>
</tr>
<tr>
<td>11:00AM-11:30AM</td>
</tr>
<tr>
<td>11:30AM-12:00PM</td>
</tr>
<tr>
<td>12:00PM-1:00PM</td>
</tr>
<tr>
<td>1:00PM-5:00PM</td>
</tr>
<tr>
<td>3:30PM</td>
</tr>
</tbody>
</table>

- Post long call interns must sign out by **NOON OR within 29 hours** from their start time.
- Interns will be on a Q5 call in the MICU, and are supervised by MICU seniors 6:00AM-6:00PM and the MICU night float senior 6:00PM-0600AM. Interns must sign out the care of their MICU patients to appropriate intern and senior post call.

**MICU Core Schedule**

**R2 and R3 MICU Resident**

<table>
<thead>
<tr>
<th>Time</th>
<th>Monday</th>
<th>Tuesday</th>
<th>Wednesday</th>
<th>Thursday</th>
<th>Friday</th>
</tr>
</thead>
<tbody>
<tr>
<td>0600</td>
<td>MICU Sign in</td>
<td>MICU Sign in</td>
<td>MICU Sign in</td>
<td>MICU Sign In</td>
<td>MICU Sign In</td>
</tr>
<tr>
<td>0600-0900</td>
<td>Pre Rounds/MICU Lecture Series</td>
<td>Pre Rounds/MICU Lecture Series</td>
<td>Pre Rounds/MICU Lecture Series</td>
<td>Pre Rounds/MICU Lecture Series</td>
<td>Pre Rounds/MICU Lecture Series</td>
</tr>
<tr>
<td>0900-1100</td>
<td>Attending Rounds</td>
<td>Attending Rounds</td>
<td>Attending Rounds</td>
<td>Attending Rounds</td>
<td>Attending Rounds</td>
</tr>
<tr>
<td>1100-1200</td>
<td>Patient Care/Lunch</td>
<td>Patient Care/Lunch</td>
<td>Patient Care/Lunch</td>
<td>Patient Care/Lunch</td>
<td>Patient Care/Lunch</td>
</tr>
<tr>
<td>1200-1300</td>
<td>Lecture (optional)</td>
<td>Lecture (optional)</td>
<td>Medical Grand Rounds (optional)</td>
<td>Board Review (optional)</td>
<td>Lecture (optional)</td>
</tr>
<tr>
<td>1300-1800</td>
<td>Patient Care</td>
<td>Patient Care</td>
<td>Patient Care</td>
<td>Patient Care</td>
<td>Patient Care</td>
</tr>
</tbody>
</table>
Medical Intensive Care Unit Guidelines at AGH

- **Description**
  - Patients who are critically ill are located in the MICU. Overflow patients may be located in other specialty units (SICU, CCU, Trauma ICU, Neuro ICU)

- **Organization**
  - The service consists of four senior residents (R2 or R3) who serve in a supervisory capacity over the 8 R1 residents per MICU month. The R1 resident will assume primary responsibility for his/her patients.
  - Fourth year medical students rotate on the unit as assigned by the Clerkship Director.
  - The service will be divided into three teams. There will be two teams consisting of one senior resident and two interns that will be responsible for admissions and patient care during the day. There will be one senior and two interns responsible for patient care and admissions at night.
  - There will also be a third senior resident that will serve at a “float senior” who will admit to the MICU and transfer patients out of the MICU while the day teams are rounding.
  - Each day team will have its own attending and rounds.

**Admitting and on-call schedule.**

<table>
<thead>
<tr>
<th>Time</th>
<th>Schedule</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Admissions Cycle: MICU week days</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6AM</td>
<td>NF admissions accept team</td>
<td>Team 1 accepts admissions from night float</td>
</tr>
<tr>
<td></td>
<td><strong>(NF interns stay to present their admissions to the accept team during rounds)</strong></td>
<td></td>
</tr>
<tr>
<td>6AM-Noon</td>
<td>AM Admission Team</td>
<td>Float Senior completes admissions then hands them over to Team 2 after their rounds</td>
</tr>
<tr>
<td>Noon-6PM</td>
<td>PM Admission Teams</td>
<td>Float takes the call about the admissions then notifies team 1 OR 2 of the admission. The team will accept admissions on a rotating basis. If Team 1 and 2 are busy with other admissions or urgent patient matters, Float will supervise an intern from either team to complete the admission in a timely manner.</td>
</tr>
<tr>
<td>6PM-5:30AM</td>
<td>Night Float Team</td>
<td>NF team completes admissions</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Time</th>
<th>Schedule</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Saturday 6AM-Rounds</td>
<td>NF Admissions accept team</td>
<td>Team 1 accepts admission from night float</td>
</tr>
<tr>
<td></td>
<td><strong>(NF interns stay to present their admissions to the accept team during rounds)</strong></td>
<td></td>
</tr>
<tr>
<td>Saturday 6AM-Noon</td>
<td>AM Admissions Team</td>
<td>Team 2 completes admissions (there is no designated Float Senior; therefore, Team 2 senior carries the Float pager for the entirety of the day Saturday 6AM-Sunday 6AM)</td>
</tr>
<tr>
<td>Saturday Noon-6PM</td>
<td>PM Admissions Teams</td>
<td>Team 1 and 2 complete admissions in an alternating fashion (Team 2 senior carries the Float pager--8651)</td>
</tr>
<tr>
<td>Saturday 6PM-6AM</td>
<td>Saturday Overnight</td>
<td>Team 2 senior continues their 24 hour call and carries the Float pager (8651)</td>
</tr>
<tr>
<td>Sunday 6AM-Rounds</td>
<td>There was no Night float team to hand admission over to an accept team; but, Team 2 is “post call”</td>
<td></td>
</tr>
</tbody>
</table>
### MICU Rotation Guidelines

- It is imperative that the 30 hour duty limitation be adhered to on the MICU rotation.
  1. In the interest of ensuring compliance with this regulation, interns will be limited to 29 hours of duty on their call day.
  2. Compliance will be facilitated by the MICU attending.
  3. On MICU rounds, the post call interns will present the new patients first such that they can be released from rounds and attend to the tasks necessary for patient care in a timely fashion.

- **The intern admission cap over a 24 hour period is 5 patients. The intern census cap is 10 patients.**
  The intern may not be over the limit at any point in time.

- **The junior and senior resident admission cap is 10 patients per 24 hours. The junior and senior resident census cap is 15 patients per resident.**
  The resident may not be over the limit at any point in time.

- As per agreement of the teaching faculty, the **service census cap for the entire MICU teaching service will be established at 30.** This is to be considered a hard cap, and all patients admitted over this cap are to be cared for by the MICU attendings and fellows on an overflow service.

- During normal working hours, the MICU fellows will be first call on the patients on the overflow service. During off hours the MICU intern on-call will be first call for the overflow service. It is essential that the interns receive a detailed sign-out on all overflow patients such that they can provide reasonable overnight coverage.

- When the cap of 30 is exceeded, it is the senior’s responsibility to identify less complicated patients that can be transferred to the private service. (However, the attending can make ultimate decision about who goes to the private service)

- Teaching rounds will be completed at Noon.

- The MICU faculty will provide a structured didactic lecture schedule with specific times for lectures to be given to the MICU interns and residents. These lectures are to be given by the MICU attendings and fellows.

### R1 Responsibilities Include

- Completing the initial history and physical exam.
- Formulating a complete and well thought out differential diagnosis.
- Designing a diagnostic and therapeutic care plan.
- Communicating daily with senior resident, attendings, consultants, patients, and families.
- Entering all orders (except in emergency situations when supervising fellow or senior resident may write orders) (see order writing policy).
- Performing or observing procedures (under appropriate supervision).
Preparing a sign out for your patients that the R1 will review with the on-call intern before that R1 departs for the day

Completing daily progress note:
1. R1 residents must collect all the data and complete the daily progress notes with assessment & plans prior to attending work rounds.
2. R1 residents may carry his/her progress note during rounds to aid with presentation fluency.
3. R1 residents must complete an addendum note in the event any of a change in the treatment plan, a patient’s code status, family discussions, procedures performed, or consultant recommendations, etc.
4. R1 residents must ensure that all progress notes are stamped with the patient’s name and MRN.

Sign-out rounds:
1. R1 residents must be present during 6:00AM daily sign-out rounds in the MICU. At this sign-out, the overnight intern has an opportunity to update his/her fellow R1 of issues regarding patient care, as well as discuss these major issues with the supervising senior resident.
2. R1 residents must be present for sign-out rounds at 3:30PM daily to discuss their patients’ care plan.
3. R1 residents must ensure that the computer sign out sheets are updated daily.

Daily Routine:
1. 6:00AM—R1 residents should arrive in the MICU each day. He/she must check overnight issues, speak to nurses, examine your patients, check labs, culture data, chest X-rays, check med list, day of antibiotics, line days, ET tube days, vitals, I&Os etc. Gather, and interpret all clinical data before 9:00AM.
2. 8:15-9:00 AM- MICU lectures given by the PCCM Attendings and Fellows.
3. 9:00AM to 11:30AM— Attending rounds.
   • Work rounds and teaching rounds.
   • All the old patients are discussed thereafter.
4. 11:30AM-3:30PM—Patient care; complete lines, procedures, consult follow ups, admit new patients, eat lunch.
5. 3:30PM—Sign-out rounds of the MICU team: Give one line summary about the patients daily updates, please mention the upcoming possibilities and plan to address them. Whole team must be present for sign-out rounds.
6. R1 residents are to order routine labs and chest x rays (when intubated) on your patients, daily.
7. Residents are the first response for new admissions unless they are involved with attending rounds or in a code situation.
8. If a patient is unstable, residents must physically stay with the patient until they are stabilized.
9. Residents are to notify the attending about new admissions, major issues, like code status change, invasive procedures, and all deaths.
10. If your patient is ready to be transferred out please write a comprehensive transfer note, highlighting in details about the events during the MICU stay.

MICU on call intern:
1. R1 resident is to cross cover all the patients in the MICU for any acute issue that occurs.
2. R1 resident is to carry the code pager and respond to codes.
3. R1 resident is to be the first line to see new admissions, along with the senior resident.
4. R1 residents are responsible for transfer of patients to the floors. This includes a verbal sign out to the admitting team and attending assuming the care of the patient, as well as a written transfer summary in the progress note section.

Responsibilities R2-3- Day Residents
1. See General Medicine Teaching Service.
Daily Progress note:
1. Supervising residents must provide an orientation to the interns advising them on how to write the progress note.
2. Supervising resident must provide read the MICU interns’ progress note and provide them with feedback.
3. Supervising resident must include addendums when appropriate to the patients’ charts about changes in treatment plans, patients’ code status, family discussions, procedures performed, etc.

Sign-out rounds:
1. Supervising resident must be present at morning sign-out rounds starting at 6:00 AM with the night senior, fellow, and both day-seniors (+/- overnight intern).
2. Supervising residents organize sign-out rounds at 3:30 PM.
3. Supervising resident must ensure that the computer sign out is updated daily.
4. Supervising resident must reassign the “day off” intern’s patients to another intern by 6:00 AM.

Daily Routine:
1. 6:00AM—Supervising resident must arrive in the MICU. Check overnight issues, speak to nurses, examine your patients, check labs, culture data, chest X-rays, check med list, vitals, I&Os etc. Touch base with interns about any urgent issues. Make management decisions.
2. 9:00AM-11:30AM—Attending rounds: Work rounds and teaching rounds. Post call intern should present all his/her patients first. All the old patients are discussed thereafter. Post call intern is allowed to break from rounds and complete his work so that he is out of the hospital before 1200 hours.
3. 11:30AM-3:30PM—Patient care; complete lines, procedures, consult follow ups, new admissions.
4. 3:30PM—Sign-out rounds of the MICU team: Give one line summary about the patient with daily updates, please mention the upcoming possibilities and plan to address them. Whole team must be present for sign-out rounds.
5. Supervising residents must make sure that interns are the first line to see a new admission unless they are in attending rounds or in a code situation.
6. Supervising residents must aid the intern with the care of a very sick patient who is in need of stabilization.
7. Supervising resident must notify the attending about new admissions, major issues such as change in a patient’s clinical status, changes in code status, invasive procedures, and all deaths.
8. Supervising residents must aid interns with daily family communication that may include an update of daily progress plans, consent for procedures, etc. All patients in the MICU must have code status clarified with the patient’s family.

Responsibilities of Night Float Team:
- Cross-cover all of the patients in the MICU (private and non-private). One intern cross covers and the other intern admits new patients.
- The senior resident supervises and assists with whatever is needed.
- Ensure that there are only 30 patients on the teaching service. The resident should identify less complicated patients and transfer them to the private service, so when the MICU team arrives in the morning, everyone is clear on who they are supposed to see. (However, the attending can make ultimate decision about who goes to the private service)

Responsibilities of the MICU senior covering for the weekend:
- Supervising residents who are covering for the weekend have the same responsibilities as the weekday MICU senior.

Pulmonary & Critical Care fellow’s responsibility
- Allow the internal medicine resident to be the patient’s primary provider.
- Actively participate during daily teaching rounds (9:00AM-11:00AM).
- Document (e.g. admission note, consultation note, daily note, informed consent, procedure note) in the patient’s medical record.
- Evaluate and manage (with appropriate documentation in the medical record) a group of patients daily. Review of the treatment plan will be performed with the faculty member on a daily basis.
• MICU Transfers
  o As a general principle, the Intensivist service is not expected to continue as the primary attending service for patients who are transferred off of the MICU service.
  o In the event that a patient admitted to the MICU service has a primary care physician from outside of the AGH system, it remains essential that the resident staff identify and notify this primary care physician. It is also essential that efforts be made by the discharging service to notify the primary care physician of the patient’s discharge and hospital course.
  o In the interest of orderly transition of patient care, the following guidelines are to be applied for the transfer of patients from the MICU teaching service.
    1. Primary care physicians who do not have teaching service admission privileges may not wish to accept transfers onto their private service from the MICU. Early on in the MICU admission, the resident staff should inquire as to whether the non teaching attending would prefer to have the patient transferred to the unreferring teaching service attending at the time of transfer from the MICU service.
    2. Primary care physicians who have teaching service admission privileges may elect to serve as the primary attending at the time of MICU admission. Primary care physicians who do not have teaching service privileges may not serve as the primary attending for patients who are on the MICU teaching service. All primary care physicians will receive a mandatory consult when their patient is admitted to the MICU service.
    3. Prior to the physical transfer of a patient out of the MICU area, it is essential that an accepting physician be notified of the transfer and agrees to transfer the patient to his/her service. In the

o Assist the internal medicine residents with patient evaluation and management.
o Perform or assist the Medical Intern or Resident in specialized procedures. This includes, but may not limited to central line and pulmonary artery catheter insertions, thoracentesis, chest tube insertion, and bronchoscopy.

o Coordinate the care of patient receiving mechanical ventilation
o Attend conferences associated with intensive care medicine (e.g. housestaff conferences, ICU conferences, care coordination conferences, etc).

o Begin sign over rounds with the medical residents at 6:00AM. This should occur in the intensive care unit on the 4th floor. Discussions of previous night’s admissions and any difficulties encountered should be discussed at this time. A review of the expected management plans with the residents should be done at this time. If the medical residents are not present immediately at 6:00AM, a page for those residents not in attendance should be performed.

o From 6:30AM-8:00AM, begin evaluation and management of patients with emphasis on those patients who require the most attention.

o From 8:00AM-9:00AM, make rounds with the respiratory therapy staff who is present in the MICU. The fellow should page the RT staff and then review with them the plans for those patients who are receiving mechanical ventilation or others who require emergent RT care.

o From 9:00AM-11:00AM, formal learning rounds will be done with the faculty, pulmonary fellow, internal medicine residents, pharmacy staff, and nursing staff.

o During the afternoon hours, the pulmonary fellow will discuss individual patient issues with each internal medicine residents. Evaluation and management decisions and appropriate documentation in the patient’s medical record will be made.

o From 5:00PM-6:00PM, sign out rounds will be conducted with the pulmonary fellow and internal medicine residents. During these rounds, patient care activities for that day will be discussed and plans made for subsequent ongoing patient management throughout the evening.

o At 6:00PM, conduct face to face sign over rounds with the fellow who is on call that evening.

o From 6:00PM-6:00AM, the fellow on call will be responsible for the evaluation and management of patients who are admitted to the MICU as well as attend to any emergent problems that arise. He/she should also provide ongoing care for those patients requiring such care during the overnight hours.

o Throughout the day, direct contact with the faculty should be performed to review the management plans for those patients in the MICU. This should be performed on multiple occasions throughout the day and also when a patient’s condition has changed significantly.
unlikely situation that the attending does not accept the transfer, the patient will remain on the service of the MICU attending. Every effort will then be made by the Section Chief of the division of Internal Medicine, (and as a last line, the Chairman of Medicine), to assign this patient to an attending physician as soon as possible when this occurs.

4. When the resident speaks with the accepting attending, the conversation should be documented in the chart and include the date and time.

5. For each patient, interns must document the name of the PCP and the service to which the patient will be transferred. Interns must do this when the patient is admitted to the MICU. That way, if the intern is not present, there will be no confusion for the covering residents as to who the patient should be transferred to.

6. Patients who are located in remote ICU locations, (neuro IU, TICU, SICU), should have an order written in Sunrise to notify the resident when the patient receives a floor bed (before the patient is sent to that floor bed), so the resident has the opportunity to obtain an accepting physician before the patient is transferred out of the ICU.

7. The primary care physician is expected to make an effort to become involved in the patient’s care in the MICU such that he/she is sufficiently familiar with the patient’s condition to accept the patient in transfer on short notice.

8. Timely identification of the patient’s primary care physician by the admitting MICU resident team is essential. Timely notification of the primary care physician when his/her patient is admitted to the MICU is likewise essential.

9. When the resident has found an accepting physician, it is the resident’s responsibility to change the name of the attending in the computer.

10. When conflicts arise as to the appropriate attending assignment for a patient being transferred from the MICU service, conversations to discuss the issue should be on an attending to attending basis rather than on a resident to attending basis.

**CCU Core Schedule**

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<tr>
<th>Time</th>
<th>Monday</th>
<th>Tuesday</th>
<th>Wednesday</th>
<th>Thursday</th>
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<tbody>
<tr>
<td>7:00AM</td>
<td>CCU Sign In</td>
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<tr>
<td>7:00AM-9:30AM</td>
<td>Pre Rounds</td>
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<tr>
<td>9:30AM-11:00AM</td>
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<td>11:00AM-NOON</td>
<td>Patient Care/Lunch</td>
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<tr>
<td>NOON-1:00PM</td>
<td>Lecture</td>
<td>Lecture</td>
<td>Medical Grand Rounds</td>
<td>Board Review</td>
<td>Lecture</td>
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<tr>
<td>1:00PM-6:00PM</td>
<td>Patient Care</td>
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Coronary Care Unit Guidelines

- Description
  - Patients who are critically ill with cardiovascular problems are located in the CCU. Overflow patients may be located in the MICU or other specialty units (i.e. SICU, Trauma ICU, Neuro ICU).
  - Organization
    1. The service consists of one attending cardiologist, one Cardiology Fellow, and two or three second year medical residents, and one to two second year emergency medicine resident for a total of four residents in the CCU. Fourth year medical students rotate on the unit as assigned by the Clerkship Director.
    2. The cap for CCU residents is 10 patients.
    3. Vacation for medicine residents cannot be scheduled during this rotation.

- Call schedule
  1. Residents will rotate through an internal night float system.
  2. There will be one resident present from 6pm-6am.
  3. Prior to the resident’s week of nights, he/she will take call for 24 hours on Sunday and will be due back 6PM Monday night.
  4. The day time residents will rotate between staying until 3, 4, or 6PM.

- Responsibilities
  - R2 is responsible for:
    1. Completing the initial history and physical exam.
    2. Formulating a complete and well thought out differential diagnosis.
    3. Designing a diagnostic and therapeutic care plan.
    4. Communicating with family members and attending of record.
    5. Entering all orders (except in emergency situation when supervising fellow may write orders. See order writing policy).
    6. Performing procedures (under appropriate supervision).
    7. Completion of daily CCU progress notes.
    8. Completing a transfer note when a patient leaves/transfers to another service as a means of communication to the next care team or accepting service.
      - For example: at the end of the each month or when a patient is transferred to a critical care unit.
      - All transfers of care within the hospital must include both a written (transfer note) and verbal sign-out.
    9. If an attending is arranging transfer of a patient from another hospital to a special care unit or a patient from the ED for evaluation, he/she will contact the Fellow during the normal working hours and the CCU Resident at night and on weekends.
    10. The resident will be responsible for patient evaluation for transfer from the CCU if there is a critical bed shortage. The resident must contact the attending physician of record for approval of transfer. The Senior Teaching Resident or the Hospitalist at night must also be contacted for appropriate assignment of patients transferred to a teaching service team.
    11. Completing a code note on all arrests and pronouncement note when the patient does not survive the arrest. (see below)
    12. Assisting in evaluation of critically ill patients being considered for transfer to CCU.
    13. Being immediately available to the Fellow or nursing staff should they need your assistance for patient care responsibilities. (i.e. Resident should not spend long periods off the unit)
14. Residents in CCU are exempt from morning report.

- Cardiology Fellows Responsibilities in the CCU:
  1. The primary role of the Fellow on the Coronary Care Unit rotation is to assist in the care of critically ill patients located in the CCU.
  2. While the minute-to-minute responsibilities for patients in the Coronary Care Unit belong to the residents and nursing staff, the cardiology fellow is the senior supervisor. He/she provides oversight for the care of all Coronary Care Unit patients and must be notified of sudden changes in patients’ conditions.
    - He/she supervises and/or performs all cardiologic procedures (i.e., elective and semi-urgent cardioversion, insertion of pacing electrodes, insertion of Swan-Ganz catheters and arterial lines for hemodynamic monitoring, emergency pericardiocentesis, etc.) and assists with insertion of aortic balloon pumps. It is particularly important that the fellow make certain that the resident understands the hemodynamic information obtained from patients in the Coronary Care Unit, and its diagnostic and therapeutic implications.
    - He/she participates in the decision-making processes required for weaning patients from major elements of therapy and radiotelemetry, and for the selection of low-risk patients for triage, progressive care and early discharge. It is essential that the fellow maintains ongoing dialogue with house staff, attendings and surgical staff with regard to appropriate utilization of beds. Fellows on the Coronary Care Unit rotation should be available until 5 PM, and it is anticipated that he/she will remain in the area as needed. At AGH, there is an in-house fellow available twenty four hours per day.
    - Fellows must make formal work rounds with house staff each day. These rounds take place Monday through Sunday. They begin at 0700 hours and are generally separate from the daily teaching rounds. The fellow’s opinion will be solicited for the majority of cases discussed and presented by the house staff. It is expected that the Coronary Care Unit fellow will have the opportunity to engage in background reading so that he/she is able to intelligently discuss various patient problems and other information of a didactic nature. The fellow should view him/herself as a senior member of the health care team. With that title, comes the responsibility of ensuring that prudent care is administered to all patients, and that house staff and students are taught state-of-the-art cardiology. On a regular basis, a member of the cardiology staff will conduct teaching rounds with the house staff. It is anticipated that the Coronary Care Unit fellow will not only attend these rounds, but also select patients and make any necessary preparations to ensure that this is a valuable experience for everyone.
    - Admissions: The fellow will assist residents in facilitating admissions to the Coronary Care Unit. Every effort should be made to admit patients with acute myocardial infarction or unstable angina to the Coronary Care Unit. Any issues regarding non-CCU location of a critically ill patient must be discussed with the patient’s attending physician or the CCU Director. The fellow is to be notified of all emergent admissions to the Unit, and is expected to play a prominent role in planning the initial management of such patients.
    - Percutaneous Intra-Aortic Balloon Pumping: Many patients in the Coronary Care Unit require intraaortic balloon support. Such procedures should be performed under fluoroscopic guidance. Depending on the clinical condition, this may occur in the catheterization laboratory or at the bedside with portable fluoroscopy. When a patient is being considered for this procedure, a second year cardiology fellow should first be called for preliminary evaluation. If he concurs with the house office initiating the request, the patient’s attending cardiologist should be consulted. While the nursing staff
will be responsible for the timing and day to day management of the IABP, the fellow should be thoroughly familiar with the equipment and its principles of operation.

House Consult Service Guidelines

- **Description**
  - R3 will perform house general medicine consults for one month. This rotation exposes senior residents to pre and post operative evaluations. The resident will work closely with the consult attending.

- **Organization**
  - Resident will work under direct supervision of the Red Teaching Service attending or a Hospitalist attending.

- **Responsibilities of the Consults Resident include:**
  - Performing all emergent and non-emergent consults to house medicine from 7:00AM-5:00PM Sunday through Saturday.
  - Writing daily progress notes and medicine orders in collaboration with the medicine attending.
  - Rounding with the Red Teaching or Hospitalist attending on the new and old consult patients daily.
  - Communicating with the consulting physician.
  - Signing out the hospitalist senior daily is mandatory. This sign out can occur as early as 5:00PM. The hospitalist senior will sign out to the Hospitalist Night float senior that will cross cover these patients from 7:00PM to 7:00AM. The hospitalist senior (from 5-7 PM) and the night float senior (7PM-7AM) will only do STAT or Pre-Op consults overnight. Routine consults are expected to be done by the house consult resident the following day.
  - Attending morning report and all conferences is mandatory.

Bone Marrow Transplant: R2/R3 at WPH

<table>
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<tr>
<th>R2 BMT Resident</th>
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<tbody>
<tr>
<td><strong>Monday</strong></td>
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<td>7:00AM</td>
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<td>7:00-9:00AM</td>
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<td>9:00AM-NOON</td>
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Family and PCP update | Family and PCP update | Family and PCP update | Family and PCP update | Family and PCP update
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5:00PM-7:00PM | Alternating Days early dismissal/Sign out | Alternating Days early dismissal/Sign out | Alternating Days early dismissal/Sign out | Alternating Days early dismissal/Sign out
7:00PM | Sign out to night resident | Sign out to night resident | Sign out to night resident | Sign out to night resident

- **Description**
  - Patients with Hematology or Oncology related medical problems will be admitted to the BMT Unit. These issues include but are not limited to induction chemotherapy, neutropenic fever and other oncologic emergencies.
  - Patients with an Oncologist as the primary attending or as a consultant may be admitted to the specialist teaching service.

- **Organization**
  - The BMT rotation consists of a Hematology/Oncology Fellow and 3 second year residents.
  - Patients will mainly be located on T7, the BMT Unit.
  - You will be involved in the BMT pathological and teaching conference meetings.

- **Admitting Schedule for Residents**
  - PGY-2s: Admissions from 7am – 7 pm; alternating as your fellow deems appropriate.
  - The resident and fellow sign out at 4:30 pm or when you’re finished with daily work and follow-up. The resident assigned to stay until 7pm, will do the admissions from 4:30 until 7pm. The night resident/moonlighter will sign out to the R2 at 7 am the following day.

- **BMT Attending Rounds**
  - Teaching rounds are primarily intended for training, education, and management issues as they pertain to Hematology/Oncology. These will occur on a daily basis from 9 to 11:30 am

- **Responsibilities**
  - Resident (R2) is responsible for:
    1. Initial complete history and physical examinations.
    2. Complete differential diagnosis.
    3. Diagnostic and therapeutic care plan.
    4. Communication daily with the Attending of Record.
    5. Communication daily with the patients and their families.
    6. Enter all orders (except in emergency situation when supervising residents/fellow may write orders).
    7. Procedures ( if certified and with Attendings approval, or under appropriate supervision)
    8. Daily progress notes.
    9. Transfer notes on leaving or beginning service and when the patient is transferred to a different service.
    10. Dictated discharge summary on the day of discharge.
    11. Oversee activities of and teach medical students if they are assigned to the service.
    12. BMT residents must participate in continuity clinic.

  - BMT Fellow is responsible for:
1. Acting in a supervisory role of 2 R2 residents rotating through BMT at WPH
2. Performing all specialized procedures on BMT patients, such as Bone Marrow Biopsies, (or supervising the resident, when appropriate)
3. Preparing chemotherapy orders under the direct supervision of a BMT attending. No resident shall prepare chemotherapy orders.
4. Allowing the internal medicine resident to be the patient’s primary provider.
5. Actively participating during daily teaching rounds.
6. Discussing management and plan with the residents during admissions and daily care of patients.

Oncology Rotation at AGH

- Organization
  - The Oncology Rotation consists of 3 senior residents.
  - Patients will mainly be located on 11C, the Oncology Ward.
  - The census cap is 10 patients per senior resident.
  - Admitting Schedule:
    1.

- Oncology Attending Rounds
  - Teaching rounds are primarily intended for training, education, and management issues as they pertain to Hematology/Oncology. These will occur on a daily basis from 0900-1130 hours.
  - Teaching rounds will be conducted with one of the two oncology groups on an alternating weekly or biweekly schedule. Residents are not to round with two oncology groups.

- Responsibilities of the R3
  - Perform and write complete histories and physcials on all patients admitted to the service.
  - Daily evaluation of all patients assigned to the service.
  - Complete progress notes when the patient’s condition changes or when there is a major change in management.
  - Attend noon conference.
  - Give proper sign out to the senior on the 0700-1900 shift or the night teaching senior.

  - Oncology Fellow is responsible for:
    1. Acting in a supervisory role of 2 R2 residents rotating through a Oncology at AGH
    2. Performing all specialized procedures on Heme/Onc patients (or supervising the resident, when appropriate)
    3. Preparing chemotherapy orders under the direct supervision of a Heme/Onc attending. No resident shall prepare chemotherapy orders.
    4. Allowing the internal medicine resident to be the patient’s primary provider.
    5. Actively participating during daily teaching rounds
    6. Discussing management and plan with the residents during admissions and daily care of patients.

Subspecialty Electives

- The Subspecialty services are electives for R1, R2, and R3 residents.
- All away rotations must be approved by the Program Director as per GME policy.
- Each categorical resident will do a total of 6 electives throughout their three years of residency (This includes Rheumatology and Endocrinology done during their third year ambulatory rotations.
- Medical Students may participate in these rotations.
• Residents should complete their electives months with core electives.

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<tr>
<th>Core Electives Include</th>
<th>Cardiology</th>
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<td>Nephrology</td>
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<td>Rheumatology</td>
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<td>Electrophysiology</td>
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• Organization
  o Patient population of each service is selected from all departments within the hospital.

• Responsibilities:
  o Complete a **pretest** at the beginning of the rotation and a **post test** at the end of the rotation. On the first day of the rotation, report the Medicine Residency Office to take your pretest before reporting to your elective.
  o On the last day of the month, complete the post test before leaving that day.
  o Consult notes daily on patients admitted to service.
  o Daily evaluation of all patients assigned to the service.
  o Attend Morning Report.
  o Communication with daily fellow or Attending of Record
  o **If residents attend subspecialty morning reports or noon conferences it is the resident’s responsibility to sign the attendance record there and bring a copy to the department of medicine. If this is not done, the resident will not get credit for attendance.**
  o Upon completion of each Subspecialty month, the resident must satisfactorily complete a test covering required material. A syllabus of the required material will be given out at the beginning of each month.

**Neurology Rotation**

• All R2’s are required to complete a **mandatory Neurology rotation.** This will consist of **two weeks** during any elective month.
• Residents can also choose a 4 week neurology elective which will satisfy this requirement.
• During this month, residents will spend two weeks on the Stroke Service or General teaching service to satisfy this Neurology requirement.
• Residents are expected to work Monday through Friday 7:00 AM- 5:00 PM.
• Residents will see new admissions and consults.
• Attend neurology morning report but can attend neurology or medicine noon conference.
• **Residents must sign in officially at neurology morning report and bring a copy to the department of medicine to get credit for attendance.**
• Residents will still have their ½ day clinic scheduled during this rotation
• Vacation cannot be scheduled during this rotation.

**Emergency Medicine Rotation R1**

• Residents are under direct supervision of the Director, Division of Emergency Medicine or appointed staff attending, Division of Emergency Medicine
• The R1 resident will complete 15 shifts over the course of one month.
The R1 resident rotating through the ED will have first contact responsibility for diagnosis and management of ALL types of patients and are not restricted to those adults with complaints of an Internal Medicine nature.

The R1 resident will rotate through ALL shifts in the Emergency Department.

The resident will serve ½ day in Medical Clinic during the rotation.

The R1 resident is responsible for completion of in-house medical records that he/she may have accumulated prior to starting in the Emergency Medicine Rotation.

Geriatrics Rotation R3

- Third year residents will be doing a monthly Geriatric rotation as part of their training.
- Residents are expected to be on duty from 9:00 AM-5:00 PM Monday – Friday.
- Residents are expected to attend morning report but are exempt from noon conferences.

Away Electives

- Requests for a rotation at an outside institution must be submitted to the program director at least 6 months in advance of the rotation start date.
- Requests must include a description of the rotation and an explanation as to why an away rotation is necessary. The request must be co-signed by the outside institution’s rotation director.
- Once the request is received by the program director it will be forwarded to the AGH CGME Committee for approval.
- You may only do any away rotation if the rotation is not available within the WPAHS health system.

Continuity Clinic Guidelines

- Residents must establish long-term therapeutic relationships with a panel of general internal medicine patients.
  - In the medical clinic, each patient is assigned to see a specific medical resident. After the initial visit, this relationship is documented in our computer scheduling system and is used to reschedule future patient visits. For each subsequent follow-up visit over the next three years, the patient is to be scheduled with their resident PCP physician whenever the resident is available. Residents will be expected to keep a list of their patients on the Sunrise medical records system so that they may periodically review patients’ test results and collect personal performance data (see below). This list will be reviewed by the resident’s attending preceptor during biannual evaluation meetings.

- Conflicting inpatient and outpatient responsibilities must be minimized while residents are working in the continuity clinic.
  - All interns are to sign their pagers out to their senior floor resident during their continuity clinic sessions. Senior resident physicians are generally not assigned to clinic on the days that they are on short or long call. When they do receive a page during their clinic hours, residents may return the call, but should quickly determine if the matter can be handled expeditiously. If not, the resident is to direct the caller to an appropriate backup physician, including the attending physician, intern, or chief resident.

- Residents must serve as primary physicians for a panel of patients.
  - Residents are designated as the PCP for a panel of patients in the medical clinic, and this relationship is documented in the computer scheduling system.

- Resident attendance in continuity clinic must not be interrupted by more than a month (not inclusive of vacation).
The chief resident scheduler is to ensure that no resident has consecutive rotations in which they are absent from clinic (e.g. MICU, CCU). The schedule is also reviewed by the Clinic Director as a backup mechanism.

- **Residents must have 130 distinct half-day outpatient sessions extending over a 30-month period in the continuity clinic. These sessions must be devoted to longitudinal care of the resident’s panel of patients.**
  - Residents will have once-weekly, half-day continuity clinic sessions starting in August of their intern year and ending approximately two weeks prior to graduation. During night teaching rotations, residents will not participate in clinic.
  - **The FIRM system**
    - Residents will generally be responsible for following test results, reading consultation notes and other correspondence, filling prescriptions, and updating their patients’ charts at regular intervals. One half-hour of dedicated time will be provided prior to the beginning of clinic sessions in order to complete these tasks. Residents will be expected to review all information related to their patients’ care prior to the end of their clinic, and if necessary, discuss findings or plans with their assigned attending physicians.
    - Although this represents the optimal system for allowing a resident to follow and take responsibility for their patients’ care, there are many instances in which a resident may not be in the clinic to review charts in a timely manner (e.g. during MICU rotations, vacation, post-call, etc.). In the cases in which a resident will not have continuity clinic for more than one week, or in which a critical result cannot wait for the ordering resident’s return, a coverage system will be in place to make sure that issues are addressed and that the resident PCP is updated on their patient’s progress. This will hereby be referred to as the “firm system.”
    - Each firm will consist of one or more attendings, their assigned residents, and a nurse. When it is determined by the triage nurse that a particular result must be addressed prior to the resident PCP’s next clinic session, the chart will be given to one of the other residents in the firm on their clinic day. That resident will then be responsible for reviewing and addressing the information. The covering resident will also be responsible to contact the resident PCP (and attending PCP if necessary) to inform them about any updates in their patient’s status. The contact should be made in the form of a confidential e-mail in Microsoft Outlook through the WPAHS intranet (note: this is the only system approved by WPAHS Compliance for the transmission of confidential patient information). There will be a communication sheet attached to the chart which indicates the result that was addressed, any action taken, and which physicians were notified by e-mail. This will become part of the permanent record.
    - In the event that no firm members are available to cover for an absent physician, the chart will be given to any other available resident physician in clinic. This physician will again be responsible for reviewing the chart and notifying the attending residents and PCPs of the patient’s status. If the ordering resident/attending physicians were not actually the PCPs, the covering resident should notify both the ordering and primary physicians of the patient’s progress and note this on the communication sheet.

- **Continuity Clinic: AGH site**
  Resident continuity clinic will take place Monday through Friday from 8:30 AM- 11:30 AM and 1:30 PM- 4:30 PM.
  - Each session will be with a 3:1 ratio with a faculty preceptor. Most often, each session will include a PGYIII, PGYII, and PGYI.
  - Each 3:1 clinic group will function as a team or “mini-firm” within our system
  - Interns will be limited to 3 patients per session for the 1st 3 months and increase accordingly
  - Residents will have 30 minute appointments for follow up visits and 60 minutes for new patient visits.
  - More time will also be allotted for a patient who requires a translator.
In a particular resident’s absence, the labs/studies, etc will be dealt with by a member of their “mini-firm” and will be precept by the faculty member present.

**Continuity Clinic: WPH site**
- Resident continuity clinics will take place Monday through Friday 1:00-4:30 PM
- Each session will be with a 3:1 ratio with a faculty preceptor. Most often, each session will include a PGYIII, PGYII, and PGYI.
- Each 3:1 clinic group will function as a team or “mini-firm” within our system
- Interns will be limited to 3 patients per session for the 1st 3 months and increase accordingly
- Residents will have 30 minute appointments for follow up visits and 60 minutes for new patient visits
- Non-urgent labs/studies/med refills, etc will be placed in the resident’s mailbox and will be reviewed in a timely fashion in between patient visits with the medicine attending. The resident will be expected to contact the patient with their results, and a review form will need to be completed by the resident to ensure that loop is being closed, i.e. lab result worksheet
- In a particular resident’s absence, the labs/studies, etc will be dealt with by a member of their “mini-firm” and will be precept by the faculty member present
- To ensure patient continuity in a resident’s absence, necessary appointments should be with another member of the “mini-firm” and contact should be made between both residents

**Urgent Care Clinic: AGH site**
- An urgent care clinic will be available for the patients of AGH Internal Medicine on a daily basis. Urgent care will be part of the ambulatory rotation, and the residents selected to staff the clinic will generally have their continuity experience at AGH. The session times may differ on a weekly basis depending on resident availability, and will be determined by the administrator of the ambulatory rotation.
- Patients who call the AGH Internal Medicine triage nurse should have an acute issue that needs to be addressed within 48 hours (e.g. acute sinusitis, poison ivy, etc.). The triage nurse will determine whether the patient should be triaged to the urgent care clinic, the emergency room, or should wait to see their resident PCP. If deemed appropriate by the triage nurse, the patient will be put on the urgent care schedule.
- The urgent care clinics will run from 8:15-11:45 AM and/or 1:15-4:45 PM. The resident will see the patient and address any urgent issues, precepting with the assigned urgent care attending afterwards. Chronic issues should generally be addressed only if they are uncontrolled to the point where the patient is in immediate danger. Furthermore, if the patient is in need of a routine follow-up visit with their PCP in the near future, the urgent care resident may choose to order bloodwork (e.g. diabetic labs) to facilitate the upcoming encounter. Although routine health maintenance does not need to be addressed at the urgent care visit, it may be appropriate in certain young and healthy patients who do not need routine follow-ups.
- The urgent care resident may also be responsible for addressing critical lab results or triage questions during the session if the resident PCP is not available. However, if the result is available before the continuity residents begin seeing patients, it should be dealt with by a resident from the firm system.
- Urgent care residents may occasionally be asked to assist the continuity residents with seeing non-urgent care patients when they are getting behind in their schedule. In such cases, they should inform the resident PCP of the patient’s progress after the visit.
- After any visit, the urgent care resident should ensure that the patient gets appropriate follow-up care with their resident PCP. If the patient has not established a PCP, the urgent care residents should schedule the patients with themselves if they have their continuity experience at AGH. The urgent care resident should
inform the PCP about the visit in the form of a confidential e-mail in Microsoft Outlook through the WPAHS intranet (note: this is the only system approved by WPAHS Compliance for the transmission of confidential patient information). The resident PCP is also responsible for informing the urgent care resident and attending of any follow-up information from the visit so that they may learn from the case.

- **Urgent Care Clinics: WPH site**
  - System-wide, Urgent Care Clinics offer a universal service to each campus site’s patient population.
  - The slight difference at WPH site include:
    1. There will be urgent care clinics Monday through Friday 8:30AM until Noon for those residents on ambulatory rotation
    2. Urgent labs/messages/studies will be handled daily by the urgent care resident and precept by the faculty member in clinic that morning
    3. It is expected that the urgent care resident contact the primary resident for the patient to inform him/her of the patient’s status/lab/studies, etc

- **The program must collect performance data for each resident with respect to chronic disease management and preventive health care.** Residents must have sessions with a faculty member twice a year to review their performance and develop a data-based action plan for performance improvement.
  - During ambulatory block, residents will be expected to review charts from two separate residents’ patient panels for performance data. A resident will not review his or her own chart. Per ambulatory block, each resident will review 30 charts per panel, 60 charts total per resident. This will be completed during allotted Problem-Based Learning (PBL) time. The performance data to be reviewed will be PGY specific, including the following:
    | PGY-I | Cancer Screening |
    |-------|------------------|
    | PGY-II| Immunizations    |
    | PGY-III| Diabetic Care     |
  - If any of the above does not apply to selected charts, residents will review BMI documentation and assess if appropriate dietary and exercise counseling was performed for patients with abnormal BMIs
  - This data will be given to the program coordinator and stored in a database, thus facilitating review for future residents, advisors, and preceptors.

- **Residents must participate in the coordination of care for their panel of patients across different healthcare settings.**
  - When referring a patient to a subspecialist, it will be expected that the resident write or dictate a referral letter to the consultant explaining the reason for consultation and detailing any relevant history, exam, or test results. They will be expected to read letters from consulting physicians and update the chart or follow recommendations as appropriate.
  - Residents are to send letters or clearance forms to surgeons after performing a preoperative evaluation. These letters should detail relevant findings and recommendations for the peri-operative setting.
  - Upon being informed about an admission of their clinic patient to the hospitalist service, the resident is to contact the admitting physician to provide any relevant clinical information. If possible, the resident should also see the patient in the hospital and document a brief note to assist in the overall diagnostic and treatment plan.

- **Faculty must have longitudinal relationships with residents throughout the duration of the resident continuity experience.**
Residents are paired up with an attending preceptor at the beginning of internship, and are to see patients with that attending for the remainder of their residency whenever both are available.

- **Faculty must not have other clinical duties while supervising more than two residents or other learners in the continuity clinic.**
  - Faculty members are solely dedicated to resident teaching when supervising two or more residents in the clinic.

- **Resident-to-faculty ratio in the clinic must not exceed 4:1**
  - The resident-to-faculty ration in the clinic is usually 2:1-3:1, and never exceeds the above ratio.

- **Resident assessment must include direct observation of resident-patient encounters.**
  - Attendings directly observe resident-patient encounters in the clinic in the context of the clinical competency exams. However, attendings are also encouraged to observe specific aspects (e.g. orthopedic exam, counseling skills, etc.) of these interactions on a periodic basis.

**Ambulatory**
Ambulatory Medicine Block rotations will offer each resident the opportunity to experience various subspecialties of both medicine and surgery during their Internal Medicine training. Also, this time affords the chance to take part in adolescent, indigent, and women’s care.

1. **PGY-1**
   a. **Month 1**
      i. Primary Care Offices
      ii. Urgent Care
      iii. Community Clinics
      iv. Simulation Center
         1. 1 day per month
      v. Continuity Clinic
         1. ½ day per week
            a. Categorical residents only
      vi. Ambulatory Day
         1. ½ day a week
      vii. Academic Time
         1. ½ day CQI
         2. ½ day John Hopkins Modules
         3. ½ day Yale/PICO preparation

2. **PGY-2**
   a. **Month 1**
      i. Primary Care Offices
      ii. Urgent Care
      iii. Simulation Center
         1. 1 day per month
      iv. Continuity Clinic
         1. ½ day per week
      v. Ambulatory Day
         1. ½ day a week
      vi. Academic Time
         1. ½ day CQI
         2. ½ day Johns Hopkins
         3. ½ day Yale/PICO preparation

   b. **Month 2**
      i. Subspecialty
1. 2 weeks: subspecialty
   ii. GYN
      1. 2 weeks
   iii. Academic Time
      1. \( \frac{1}{2} \) day Johns Hopkins
      2. \( \frac{1}{2} \) day Yale/PICO preparation
   iv. Continuity Clinic
      1. \( \frac{1}{2} \) day a week
   v. Ambulatory Day
      1. \( \frac{1}{2} \) day a week

3. PGY-3
   a. Month 1
      i. 2 weeks
         1. Subspecialty
      ii. 2 weeks
         1. Primary Care Offices
         2. Urgent Care
      iii. Simulation Center
         1. 1 day a month
      iv. Continuity Clinic
         1. \( \frac{1}{2} \) day per week
      v. Ambulatory Day
         1. \( \frac{1}{2} \) day a week
      vi. Academic Time
         1. \( \frac{1}{2} \) day CQI
         2. \( \frac{1}{2} \) day Johns Hopkins
         3. \( \frac{1}{2} \) day Yale/PICO preparation
   b. Month 2
      i. 2 weeks psychiatry
         1. 1 week inpatient
         2. 1 week outpatient
      ii. 2 weeks
         1. Subspecialty
      iii. Continuity Clinic
         1. \( \frac{1}{2} \) day per week
      iv. Ambulatory Day
         1. \( \frac{1}{2} \) day a week
      v. Academic Time
         1. \( \frac{1}{2} \) day Johns Hopkins
         2. \( \frac{1}{2} \) day Yale/PICO preparation
General Responsibilities

- **Professionalism**
  - Residents will be evaluated on the basis of their professionalism at all levels of their training. The department of medicine holds this competency above all others and expects residents to act in a professional manner at all times. Disciplinary action for professional issues is outlined later in this manual. Professionalism is defined by the following components:
    - Serving the best needs of the patient and placing those needs above the needs of the system or the practitioner.
    - Respecting patient privacy.
    - Respecting patient autonomy.
    - Respecting the dignity of patients and the particular sensitivity to diverse issues.
    - Demonstrating dependability, responsibility and commitment.
    - Demonstrating personal integrity and honesty.
    - Demonstrating compassion and empathy.
    - A commitment to personal excellence and ongoing professional development.
    - Maintaining the highest standards of ethical behavior.

- **Dress Code**
  - Appropriate attire serves as a hallmark of professionalism. Dress and personal hygiene standards are dictated by patient comfort in interacting with their resident-physician.
  - The hospital identification badge must be worn at all times with picture facing out above the waist at all times.
  - All employees not required to wear a uniform are required to wear appropriate business attire that presents a professional appearance. There should be no exposed midriffs and any revealing or sheer clothing such as, but not limited to spandex, open weave or mesh is not permitted.
  - No sweat suits or shorts are permitted.
  - Denim is restricted to Medical Records.
  - Safe, practical, and clean footwear must be worn at all times. For safety purposes, canvas tennis shoes, crocs with holes, sandals and tongs are not permitted. Shoes/clogs with straps are permitted. Open-toed shoes are highly discouraged, but per hospital policy are permitted, but only in the office setting. Socks/hosiery must be worn.
  - Men should wear collared dress shirts at all times when not on call. This is particularly important in the outpatient clinic setting. Otherwise, scrubs can be worn in the intensive care units and when on call.
  - Women’s skirts and dresses and accompanying slits must be a length appropriate to the specific job being performed, but no shorter than the middle of the thigh.
  - In general, clothing should be visible around a buttoned up lab coat (i.e. blouses that extend above the closure of the coat and skirts or pants that extend below the bottom margin of the coat.
  - Men should be clean shaven or maintain a well-kept beard/facial hair.
  - While cultural differences in personal hygiene differ, residents should be mindful of local differences and abide by these standards.

Daily responsibilities

- **Pre-Rounds**: Interns and medical students on General Medicine Inpatient Teaching Services see patients and prepare a concise SOAP note with a complete Assessment and Plan section to present on Work Rounds and
Attending Rounds. (These notes need not be completed in time for teaching rounds, but all the data must be obtained).

1. During this time, patients will be discussed with nursing staff, seen and examined, and SOAP notes will be composed
2. The SOAP note needs to contain
   - Subjective—The overnight events, Nurse’s concerns, Patient’s complaints, etc.
   - Objective—Vital signs, pertinent physical exam findings, laboratory results, radiological results, medication lists.
   - Assessment—best estimated diagnoses or differential diagnoses, acute and chronic
   - Plan—Your approach to improve/optimize that patient’s condition with an understanding of their acuity and disposition

- **Work Rounds:** Conducted by Senior Residents with Interns and Medical Students on General Medicine Services; all patients are seen and discussed as a group then the management approach is determined for that day. Potential discharges are recognized for approval by the attending of record.
- **Attending Rounds:** Conducted by Service Attending with General Medicine Team. There should be an emphasis on both didactic teaching and specific patient management issues. **On night float accept days, rounds begin at 8:30 AM.**
- **Morning Report** is required for all R-2’s and R-3’s, except when scheduled to be in the MICU or CCU, or on away elective. Interns and medical students are invited to attend if their pre-rounding is complete. Night float residents are expected to attend. Interns on night float, electives, and ambulatory are required to attend.
- **Noon Lectures** are required for all interns and residents except for residents on night float or in the MICU. Residents performing off-site Ambulatory or Geriatrics may be excused from noon lectures.
  1. If one is unable to attend noon lecture for any reason, the lectures can be accessed via New Innovations website.
- **Rounds/Discussions with Physician of Record** - except for urgent or emergent patient care needs - these should not occur during core activities.
- **Medical Ambulatory Clinic (MAC):** Residents at each level spend 1/2 day per week seeing patients in the MAC as a Continuity Clinic experience. No resident can miss their Continuity Clinic for more than 1 month. Residents are excused from their Continuity Clinic during their MICU, CCU, and Night Float rotations.
- **No resident will have clinic in the morning while on teaching service** thus avoiding interference with patient care rounds.

**Patient Care**

- Residents bear the major responsibility for patients admitted to the Teaching Services, but must work in concert with the patient’s Attending Physician to assure delivery of both consistent and appropriate medical care. It is recognized that the patient’s Attending Physician has final authority and responsibility for all aspects of care.
- Any resident admitting a patient to either General Medical or Subspecialty Services must inform the Admitting Attending of his/her patient’s condition within 4 hours of admission or immediately upon change in the condition of a hospitalized patient.
- Any death of a patient requires the notification of the attending physician immediately. The resident must inform the patient’s family as well.

**Daily Sign Out**

- Residents are to sign out all their patients at the end of the work day to the night teaching residents for overnight coverage.
- All R1’s will be done utilizing the sign out template via a link on the hospitals physician portal.
- This template must be printed, verbally signed out, and physically given to the on call resident.
- Residents should consult the curricular guide or their orientation notes for instruction on proper verbal and typed sign out.
- The template should be fully updated and kept current at the end of each working day for sign out.
• Evaluations of Sign Outs: Sign out evaluation will be done on all interns by the chief residents. Both verbal and paper sign outs will be evaluated for each intern on teaching service twice monthly.
• Typed Sign Out must include the following information
  o Present patients of highest acuity first
  o Name, MRN, reason for admit, current condition
  o Code status
  o Important meds (cardiac meds, antibiotics etc….)
  o Allergies
  o Current treatments (pt has PE on anticoagulation, pt has CHF receiving diuresis)
  o Abnormal physical findings (pt severely demented, has edema)
  o Recent procedures
  o Tasks (a.k.a. 1310 To-Do List)
  o Use “if….. then” format, and give times for labs to be checked
    1. “if hgb less than 8, give 2 units prbcs and 20 mg lasix IV
    2. “if pt has chest pain repeat the EKG and check enzymes, if enzymes are positive call cardiologist”

Working Hours

• Residents are expected to be in the hospital between the hours of 7:00AM-4:00PM, Monday through Friday. On weekends residents should generally be in the hospital from 7:00AM-12:00NOON. However, the resident is not off duty until the patients assigned to the resident are stabilized and proper transition of care is assured. Earliest sign-out is 4:00PM.
• Resident on long call must leave the hospital no later than 10:00PM.
• Work hours will be tracked with the KRONOS System. All residents are required to swipe in on arrival to the hospital and swipe out when leaving.
• You MUST swipe in and out daily if you are on BMT, Onc, Color teaching, hospitalist, cardiology teaching, ER, MICU, CCU, an in-house elective, or any other in-house rotation.
• Duty hours will be checked bimonthly by the chiefs and if you are not swiped in, it will be counted as a vacation day. If you forget to swipe out and realize later, please email the department of medicine, ie, Patti or one of the Chiefs, so she can correct it, but this cannot be a frequent habit.
• All resident must comply with the work hour rules set forth by the hospital policy which states that residents cannot work more than 80 hours in a week, averaged over a four week period.
• On all services, interns are limited to 16 hours. R2/R3’s are limited to 24 hours of call plus 4 hours of transitioning care of patients on call days.
• Penalty for duty Hour Violation manifest in the form of working over the allotted 80 hour work guidelines or not keeping accurate account of your duty hours by not swiping in and out through KRONOS, include:
  o 1st offense: verbal communication from the chief.
  o 2nd offense: you will have a sit down with the chief regarding the problems, time management, and the absolute necessity that this cannot happen.
  o 3rd offense: You will have a meeting with program director or associate program director regarding why duty hours were violated, time management skills, and to develop a specific action plan as to how to avoid this in the future.
  o 4th offense: A memorandum will be placed in your file documenting your deficiency as related to the competencies of practice-based learning, systems based practice, and professionalism. A formal notification of failure to comply will result in more severe punitive action.

Paging Policy

• The resident is responsible for his/her paging status. Each resident is required to sign out his or her pager to the resident covering his/her patients when he or she leaves the hospital or answer all pages regardless of whether they are on call.
Email Policy

- Each resident is required to check their hospital email on a daily basis. Failure to check email is not an acceptable excuse for not receiving work related communications.

Change in Call Schedule

- Any individual changes made in the call schedule must be approved by all four Chief Residents at least two weeks prior to the change; all requests are subject to approval by the chiefs. All Chief residents must be notified via e-mail of the request.
- Any time off for interviews, Step 3, etc. must be done on your day off for that week when possible. Residents are responsible for finding their own coverage when absence is expected. Again approval must be submitted in writing to the chiefs at least two weeks prior to the expected absence.
- All vacation schedule requests are to be submitted in the spring of each year by a deadline set forth by the incoming chief residents in order to assure that requested days are granted.
- It is up to the resident to arrange coverage if they must be absent on a day other than their scheduled day off. There will not be additional days off for that week. Again, shift switches are subject to the approval of the chiefs.
- Time off will only be granted during electives and ambulatory rotations or at the discretion of the program director.
- Time off will not be granted on a scheduled clinic day. Coverage for clinic is not acceptable and will not be granted. Residents are responsible to assess their clinic schedule and inform any discrepancy such as post call clinic or vacation clinic at least 4 weeks in advance.
- Any resident absent from scheduled duties, or engaged in shift switching without notifying the chiefs in writing will be subject to disciplinary action which may include termination.

Lectures and Conferences (see Didactics for more detail)

- Attendance is required at all core activities. All residents (categorical and preliminary) are expected to attend a minimum 66% of required conferences throughout the year. Categorical residents who do not meet the minimum requirements will not be permitted to advance to the next level of training. Preliminary residents who do not meet the lecture attendance requirements will not be given a certificate of completion for their year. MICU, CCU, ED, away elective, are exempt from morning report and noon lecture. Ambulatory and geriatrics residents are exempt from noon conferences unless you’re in the building.
- Residents not meeting the minimum conference attendance requirements may be subject to disciplinary action at the discretion of the program director.
- If a resident finds themselves under the requirements, they may view the lectures that they missed on New Innovations.
- Attendance is optional for conferences organized by Subspecialty divisions except when rotating on those services.
- There will be an attendance sheets from conferences. It is your responsibility to sign in at each conference.

Order Writing Policy

- For patients admitted on the teaching service writing orders is the responsibility of the PGY-1 intern and/or the PGY2 assigned to the patient. Under the following circumstances the above order-writing policy can be superseded.
  - Emergency patient care situations when the intern is not readily available.
Attempts to communicate the necessary orders and educational rationale have not been successfully achieved in a reasonable time frame. In this setting, the order must be accompanied by a “please clear above with primary service” order.

- Attendings that choose to consistently violate the above policy will no longer be allowed to admit to the teaching service. All situations will be reviewed on a case by case basis.

Procedure Policy

1) Certified Performance of Procedures: (Required by the ABIM and RRC)
   - There are 5 procedures that must be successfully performed at least 5 times each during residency under direct observation of a certified attending, senior level resident/fellow, or appropriate staff member (on other services). The supervisor must sign your procedure log on New Innovations for certification.
     i. ACLS - needs AHA documentation
     ii. Drawing arterial blood
     iii. Drawing of venous blood
     iv. Pap smear and Endocervical culture
     v. Placing a peripheral line

2) Certified Completion of Procedure Manual: (Required by the ABIM and RRC)
   Residents complete a multiple choice test after reading the procedure manual and watching associated videos which review procedural fundamentals.
   - There are 13 procedures for which residents must show knowledge and ability to outline the anatomy, indications, contraindications, and interpretations of the results for the procedure.
     1. Abdominal Paracentesis
     2. Arterial line placement
     3. Arthrocentesis
     4. Central Line placement
     5. Drawing Venous blood*
     6. Drawing arterial blood*
     7. IV placement*
     8. I&D of abscess
     9. Lumbar Puncture
     10. NG Tube
     11. Pap smear and endocervical culture
     12. Pulmonary artery catheter placement
     13. Thoracentesis

3) Certification of Other Procedures
   - It may be necessary to become certified for non-ABIM required procedures. This may be needed for credentialing privileges when you enter fellowships or attending level positions at other hospitals. Remember that although you can become certified in these procedure, you must still be supervised when you perform them at Allegheny General Hospital (except for the procedures marked with an asterisk). Procedures you can become certified include:
     1. Jugular Central Line
     2. Subclavian Central Line
     3. Femoral Central Line
     4. Radial Arterial Line
     5. Femoral Arterial Line
     6. Thoracentesis
     7. Paracentesis
     8. Pap Smear*
     9. Pelvic Exam and Endocervical Culture*
     10. Arthrocentesis
     11. Rectal Exam*
12. Breast Exam*
13. Lumbar Puncture
14. Nasogastric Intubation*
15. PA Catheter Insertion
16. Abscess Incision and Drainage

- Procedures that can be done independently once certified. ALL OTHER PROCEDURES MUST HAVE CERTIFIED ATTENDING OR FELLOW SUPERVISION REGARDLESS OF YOUR CERTIFICATION STATUS.

Central Venous Catheters:
No central line is to be placed unless there is direct supervision from either a Pulmonary/ Critical Care fellow, Cardiology fellow, or qualified attending physician. No resident will be permitted to supervise the placement of a central line by another resident, regardless of the number of lines placed by the supervising resident or their certification status.

With regards to the procedures below, all procedures must be supervised by a certified fellow or attending (except the procedures that have an asterisk attached to them). You must be supervised during these procedures regardless of your certification status. Once you are certified in the procedures that have an asterisk than you may perform these independently.

- Please see procedure manual for full details.

**Arrest Teams – Code Teams and MET teams at AGH**

- The Medical Residents are responsible for aiding in the management of all in-house arrests and must be ACLS certified appropriately. In house arrests will be supervised by an attending physician. Arrest teams at AGH consist of the CODE team and the MET teams.

  - CODE TEAM
    1. Organization
      - The R1 long-call residents for General Medicine Teaching Service, R1 and R2/R3 on night float, R1 MICU, R2 Resident on call for CCU will serve on the Arrest Team for a 24 hour period beginning at 7 am on their call days.
      - Code beepers are worn at all times by these residents during the 24 hour period and are not to be turned off.
      - There is preset protocol for positioning during a code which all residents must familiarize themselves with. The person directing the code may change roles as felt appropriate (see handouts for code protocol)

  - CCU Senior Arrest Team Responsibilities
    1. Carry the Code and MET pager
    2. Transfer pager to on call person at 7am
    3. Any Code patient:
      - You must sign the code log that the nurse records
      - You must document a note in the progress notes portion of the chart
      - Call attending
      - Transfer patient to next service (MICU, CCU, SICU) depending on attending
      - Call family (ask attending if they want you to call)
      - If a patient dies the resident must document the death note (includes time of death, examination findings, and whether family was notified)
    4. Any MET patient:
      - The CCU resident and the Hospitalist attending responds to the MET. This exercise serves as a learning opportunity for the CCU resident.
      - Interns from the internal medicine residency program are not responsible for responding to the MET However, if they are in the vicinity of a MET, they should offer assistance.
      - The ancillary staff that usually responds to a CODE also responds to the MET.
5. During Codes:
   - Present staff should include: CCU Resident, 2-3 medical residents [1-2 from teaching service and MICU intern], surgery resident [if central venous access is needed], anesthesia, 2 MICU nurses, bedside nurse, EKG tech, IV team, MHO, and an attending physician.
   - CCU resident can be in charge under supervision of the attending.

Medical Records

- Residents are responsible for the timely completion of medical records.
- Residents should visit medical records once a week.
- Charts must be completed within 30 days of discharge according to hospital policy.
- All orders and notes must be signed legibly if done manually on paper.
  - Signatures must include your printed name AND pager number.
  - Orders on Sunrise are automatically signed if you enter them, but house-staff must log on and sign off any verbal orders requiring their electronic signature for release or completion.
- A complete history and physical examination must be performed on every patient admitted to the hospital.
- All teaching patients will have a note written by the house staff daily in a timely manner.
- Verbal orders must be signed within 24 hours on the Sunrise system.
- Discharge summaries must be dictated within 24 hours of a patient’s discharge.
- Every week of the month a pending suspension letter will be delivered to the mailboxes of the house staff responsible for any outstanding medical records. This letter will inform the house staff of which records are in danger of becoming delinquent.
  - Delinquent medical records policy:
    - You will be considered in violation of our medical record policy if any record comes up delinquent (first warning-email).
    - If ANY of the SAME delinquent records come up a second week (2nd warning, meet with chiefs).
    - If any of the SAME delinquent records come up a third week (3rd warning-meet with Dr. Sealey).
    - 4th time a letter goes in permanent file documenting lack of professionalism.
    - If you receive a 2nd warning three times in a year (July-June), then you will have to meet with Dr. Sealey (will count as a 3rd warning).
    - ANY subsequent delinquency will result in a letter being placed in your permanent file documenting lack of professionalism.

- Death Certificate at AGH
  - Residents are responsible for completion of part 23a-26 of death certificates for who he/she has been directly responsible or is cross covering.
  - Whoever is responsible for pronunciation of death is required to write and dictate a pronouncement note in the chart. In the event of a code, termination of a code constitutes a clinical judgment of death. Therefore, the resident running the code is responsible for a pronouncement note and completion of the death certificate.
Coroner’s Cases

- It is the legal responsibility of the resident pronouncing the patient deceased to notify the coroner if the patient died as a result of any of the following:
  - **Sudden death** not caused by readily recognizable disease; or herein the cause of death cannot be properly certified by a physician on the basis of prior medical attendance.
  - Death occurring under suspicious circumstances, including those where alcohol, drugs, or other toxic substances may have a direct bearing on the outcome.
  - Death occurring as a result of violence or trauma, whether apparently homicidal, suicidal, or accidental (including those due to mechanical, thermal, chemical, electrical, or radiation injury, drowning, cave-in and subsidence); regardless of the time elapsing between time of injury and time of death.
  - Any death in which trauma, chemical injury, drug overdose or reaction to drugs or medication or medical treatment, was a primary or secondary, direct or indirect, contributory, aggravating or precipitating cause of death.
  - Deaths known or suspected to be due to contagious disease and constituting a public hazard.
  - Fetal death, stillbirth, sudden infant death syndrome, or death of any baby within 24 hours after its birth, where the mother has not been under the care of a physician.
  - Therapeutic and criminal abortions, regardless of the length of pregnancy; and spontaneous abortions beyond 15 weeks of gestation.
  - Operative and peri-operative deaths in which the death is not readily explainable on the basis of prior disease.
  - Death wherein the body is unidentified or unclaimed.
  - Death of a prison inmate from any cause whatsoever.
  - Any death within 24 hours of hospital admission.

Sabbath Program

- The AGH Internal Medicine Residency Program has a Sabbath Observant schedule for up to 1 resident per year. This program is designed to accommodate Sabbath observant Jewish residents.
- These residents are exempt from hospital duties on the Jewish Sabbath (Friday evening to Saturday evening), as well as, certain Jewish Holidays. This schedule allows the observant Jewish resident to acquire medical training while not violating the Sabbath.
- The Sabbath Observant resident will work with the Associate Program Director and Chief Residents to accommodate specific scheduling issues.

Resident Supervision and Communication

- General Supervision
  - Faculty supervision will be provided for all resident care including the outpatient clinics, emergency room, inpatient units, and intensive care units.
  - All residents will have a close daily personal interaction with attending staff for each patient under their care.
  - Based on resident performance evaluations, it is expected that each resident will assume progressively more responsibility for patient care as he/she advances through the residency.
  - An important part of the process of supervision is adequate documentation by the residents in the charts of history and physical examinations, treatment plans and complications. This includes the timely completion of medical records.
  - At the bedside, under the direct supervision of a cardiology or pulmonary fellow, or qualified attending physician, internal medicine residents are allowed to insert venous lines and Swan Ganz catheters, insert arterial lines, and remove venous and arterial catheters.
Clinic Supervision
- In all clinics in which the residents participate, their activities will be directly supervised by attending faculty.
- During the early aspects of residency training, faculty will work closely with the resident to establish diagnostic skills, treatment plans and follow-up care practices. As the resident’s skill’s increase, greater responsibility will be given in a gradual, progressive manner.

Admission and Discharge Policies

- Objective
  - The objective of the inpatient component of the Internal Medicine Teaching Services is to provide superior medical care for patients and fulfill education and training goals of the Internal Medicine Residency Program.
  - Provide meaningful patient care responsibility and the appropriate environment for resident training.
  - Ensure the appropriate number of patients for the training experience.

Requirements for Admission to Teaching Services

- All patients admitted to the Medical Intensive Care Unit and the Coronary Care Unit will be admitted to the Resident-covered services.
- ICU transfers should always be placed on teaching unless otherwise specified by the attending or if the attending is not a member of a teaching service.
- Designation of service can be made by consulting the listing of Attending Admission Privileges which make up the pool of attendings with admitting privileges. This is housed in binders in each of the medicine call rooms, and the Emergency Department. It is the Admitting Senior Resident’s responsibility to place patients on the appropriate service.
- If a resident goes down to the ED at AGH to admit a patient, and after evaluation decides to change the location of the admission (ex: RNF to MNF or MNF to MICU), the ED attending must be informed. The secretary must also be informed, so she can put in for a bed change.
- Only patients of attending physicians with teaching service privileges will be admitted to the teaching services. Patients of physicians who do not have teaching services privileges but who require admissions to the Medical Intensive Care Unit or Coronary Care Unit will be cared for by the ICU teaching service until such time that they are discharged from the ICU.
- Patients who do not have a primary care physician will be admitted to the unreferred attending teaching service.
- All other admissions, refer to the admitting attending pool (an attending excel spreadsheet) to decide whether it is a hospitalist or unreferred patient.
- All patients cared for in the Medical Ambulatory Clinic will be admitted to the hospitalist Service.

Limits or “Caps” on admission to the Teaching Service

- In the interest of resident education, patient safety and compliance with upcoming changes in the RRC Guidelines the following changes will be made concerning census caps and the distribution of overflow admissions to the color teaching services. These changes will become effective January 3, 2011.
  - A first year resident / intern / PGY1 must not be assigned more than five new patients per admitting day; an additional two patients may be assigned if they are in-house transfers from the medical services;
  - A first year resident / intern / PGY1 must not be assigned more than eight new patients in a 48-hour period;
  - A first year resident / intern / PGY1 must not be responsible for the ongoing care of more than 10 patients;
When supervising more than one first year resident/intern/PGY1, a supervising resident/PGY2 or 3 must not be responsible for the supervision or admission of more than 10 new patients and four transfer patients per admitting day or more than 16 new patients in a 48-hour period;

When supervising one first year resident/intern/PGY1, the supervising resident must not be responsible for the ongoing care of more than 14 patients;

When supervising more than one first year resident/intern/PGY1, the supervising resident must not be responsible for the ongoing care of more than 20 patients.

Color Teaching Services
1. The census cap per intern is 10 patients
2. The census cap per teaching team is 20 patients
3. Overflow admissions will be distributed in the following manner:
   - On weekdays the short call team may accept up to 4 overflow unreferred admissions if the night float team does more than 6 unreferred admissions.
   - If any call team caps prior to completion of their shift, all overflow goes to hospitalist until the next color teaching admitting shift starts.
   - Caps for admitting shifts are subject to change at the discretion of the program director within the caps given by ACGME guidelines.

Hospitalist Service (AGH)
1. The census cap per intern is 10 patients
2. The census cap per supervising residents is 20 patients

CCU
1. The census cap is 10 patients per resident

MICU
1. The census cap is 10 patients per intern
2. The census cap is 15 patients per supervising resident
3. The overall census cap for the MICU teaching service is 30 patients.

Oncology Service
1. The census cap is 10 patients per intern/resident

Interns on any medicine service cap at 10 patients.
Residents on any medicine service cap at 20 patients.

Specific limits on admissions to General Medicine Service, Hospitalist and MICU

- Each PGY-1 resident is limited to a maximum of 5 admissions during a 24 hours weekday admitting period. They may take an additional 2 MICU transfers on the weekend (Saturday or Sunday) call on general medicine and hospitalist. A PGY-1 will be responsible for the ongoing care of no more than 10 patients.
- In the MICU, any patient admitted after the intern reaches his/her cap of 5 will be admitted by the Senior MICU Resident and care is handed over the next morning to an R1.
- Each senior resident is limited to a maximum of 10 admissions during a 24-hour weekday admitting period and may take an additional 4 extra MICU transfers during a weekend (Saturday or Sunday) call on the general medicine service.
- In 48 hours the maximum admission for an R1 in 48hours is 8 and for an R2-3 is 16.

Requirements for Discharges from the teaching services
• Discharge summaries should be **done on the same day of discharge**

• Patients can only be discharged after that decision is made with the patient’s attending.

• A “discharge” order must be entered in Sunrise before patients can be discharged from the hospital.

• A written discharge sheet must be completed before a patient is discharged. This will be found in the chart. It must include the patient’s discharge medications reconciliation form and appropriate follow up.

• Discharge Summary Template-The purpose of a DC summary is for the outpatient doctor to be able to treat a patient after their hospital course and have a good understanding of what happened in the hospital.

• If a person is going to a nursing home or another hospital, the discharge summary is emergent.
  o Dial 3990.
  o You will then say- “This is Internal Medicine Resident (Your Name) dictating a discharge/transfer summary on (patient name); Medical Record Number (patients #); for attending physician/hospitalist on (Date admitted and discharged) PERIOD. Please forward a copy of this summary to (the PCP of record and any consultants) PERIOD. End paragraph”
  
  o **Principal Diagnosis** - (ONLY 1-what the patient was admitted and treated for)…**end paragraph**
  (e.g. Acute Exacerbation of chronic systolic CHF)
  
  o **Secondary diagnosis**—(other medical problems the patient has.) e.g. #1—chronic systolic heart failure secondary to non-ischemic cardiomyopathy; #2—hypertension, #next—hyperlipidemia, #next—anemia, etc.…**end paragraph**
  
  o **Consultations** - any physician you consulted during the stay and their specialty…**end paragraph**
  (e.g Dr. Garret of Cardiology)
  
  o **Procedures** - Listed with dates and results (e.g #1—echocardiography on 6/12 which showed EF of 25%; # next—CT scan abdomen was within normal limits. You do not need to included bloodwork or CXR (unless there is a very significant finding)
  
  o **Complications** - List of any complication that was incurred during that hospital stay. Hopefully there will be none. (e.g. #1—pneumothorax after central line placement or other possible procedure related complication)
  
  o **Adverse Reactions** - List of any adverse reaction that was incurred during that hospital stay. Hopefully there will be none. (e.g. Patient with CAP was treated with Ceftriaxone and developed a diffuse rash.)
  
  o **Brief Hospital Course**—Brief summary of what happened during the stay that was significant. Not a complete HPI. Not a day to day occurrence log, anything **pertinent** should be listed.
  
  o **Discharge Instructions**—Explain any new instructions, diet and follow-up appointments for anyone consulted-if you do not know you should find out prior to discharge.
  
  o **Discharge Medications**—with dosages and frequencies. Specify changes from admission meds, specify if any stop dates (e.g 7 days Avelox - last dose 4/12)
  
  o End dictation this is medical resident (your name) dictating a discharge summary on (patients name) on (date).
  
  o **Key points** - **hit star after the summary (which signifies a “stat” dictation)** if it’s a transfer to a nursing home so that it will be available when the patient is seen.
  
  o If you don’t say period at the end of sentences there may not be a period there-each transcriptionist is different with this, so saying period is recommended.
Advancement

- **USMLE/COMLEX Step III**
  - Step 3 must be taken by August 1st of your second year of residency in order to continue in the program.
  - You must have taken the test that gives you a passing score by January 31st of your second year.
  - Interns are strongly encouraged to take Step III by June, in case of a failing score and the need to retake the test. Interns MUST take Step III during either their elective, ambulatory, or ED month. They must find coverage for the exam if it is not taken during these months.
  - This policy includes categorical internal medicine and internal medicine/emergency medicine residents

- **Clinical Competency Exam**
  - Interns are required to satisfactorily pass a clinical competency evaluation by an assigned attending. They will be asked to perform a full history & physical on a patient and develop an assessment and plan. Advancement to their senior year is dependent upon a passing score. Refer to Clinical Evaluation Exercise for details. (See attached Clinical Evaluation Exercise Form).
  - R2-3 must complete and pass four mini-cex exams during the last two years of residency. This entails short focused history and physical exams done mostly in the medical clinic.
  - All the above clinical competencies are supervised by an attending physician.

- **Procedure Credentials**
  - All R3 residents must complete the procedure validation worksheet before graduation. This consists of a procedure manual which must be read carefully and a multiple choice test which must be completed and handed in to the Department of medicine.
  - Procedures for which all residents must develop knowledge competencies are arterial line insertion, arthocentesis, central line insertion, I&D abscess, lumbar puncture, NG intubation, PA catheter insertion, paracentesis, and thoracentesis. These are included in the procedure manual mentioned in (a) above.
  - Procedures for which all residents must develop both knowledge and performance competencies are ACLS, draw arterial blood, pap smear and endocervical culture, draw venous blood, and placing IV lines.
  - Procedures for which all residents must have the opportunity to achieve competency include all in (a) and (b) above in addition to cryosurgical removal of skin lesions, skin biopsies, elective cardioversion, endotracheal intubation, soft tissue and joint injections, temporary pacemaker insertion, and treadmill exercise testing.
  - Residents must achieve a score of 80% to receive credit for the knowledge competency section of the procedure validation.
  - The chief residents will assist in scheduling the training sessions with the appropriate staff to learn these competencies.

**Criteria for Advancement**

- **Advancement from R1 to R2**
  - Successfully completed R1 rotations.
  - The Clinical Competency Committee will be responsible for reviewing any unsatisfactory evaluations and for determination of any necessary remediation.
  - Need to pass the Clinical Evaluation Exercise as determined by assigned Department of Medicine faculty.
  - Competent to supervise R1 residents and medical students per Department of Medicine faculty.
  - Able to perform resident duties with limited independence per Department of Medicine faculty.
- Has demonstrated sufficient progress in the components of clinical competence that he/she is capable of functioning as a team leader. Specifically, the resident has the necessary skills in data gathering, medical knowledge, clinical insight, and critical thinking to assume a team leadership role. He/she demonstrates elements of practice-based learning and system-based learning in clinical encounters.

**Advancement from R2 to R3**
- Successfully completed R2 rotations.
- The Clinical Competency Committee will be responsible for reviewing any unsatisfactory evaluations and for determination of any necessary remediation.
- Has taken USMLE Step 3 examination (see above)
- Competent to supervise R1 and R2 residents and medical students per Department of Medicine faculty evaluation.
- Seeks appropriate consultation when indicated.
- Able to perform resident duties with minimal supervision per Department of Medicine faculty evaluation. The resident is capable of making independent decisions based on previous clinical experiences. He/she has the ability to recognize and manage “new” clinical problems (scenarios not previously encountered) skillfully.

**Advancement of R3**
- Successfully completed R3 rotations. The Clinical Competency Committee will be responsible for reviewing any unsatisfactory evaluation and for determination of any necessary remediation.
- Able to perform independently in the practice of general internal medicine per Department of Medicine faculty evaluation
- Has the sufficient medical knowledge base, problem-solving skills, and clinical judgment that enable him/her to provide satisfactory patient care.
- Has demonstrated practice-based learning and system-based learning in clinical encounters.
- At every level of advancement and at the time of completion of training, the resident must demonstrate the following:
  1. Interpersonal and communication skills are satisfactory or superior, as documented by evaluators in inpatient and ambulatory settings.
  2. Works well with patients, fellow residents, faculty, consultants, ancillary staff and other members of the health care team in a manner that fosters mutual respect and facilitates the effective handling of patient care issues as demonstrated by satisfactory staff and faculty professional behavior evaluations.
  3. Absence of impaired function due to mental or emotional illness, personality disorder, or substance abuse. Any disciplinary actions or treatment programs implemented per the WPH/AGH policies on impaired function must have been successfully completed and reinstatement approved by the Internal Medicine Program Director.

**Evaluation**

**Policy for Resident Evaluation**

- Introduction:
  1. Formative and summative evaluations are important elements in the process to educate residents. They provide the feedback which enhances learning and offer guidance for improvement of future performance. Feedback is a very critical component of the resident program because it provides residents with information about the quality of their clinical performance and fund of knowledge, assists the faculty in determining whether learning objectives were achieved, provides the opportunity to change and improve clinical rotations, and most importantly, it provides the constructive criticism and praise for residents at all levels in the program.
1. In order to apprise residents of their didactic and clinical progress in the program, formative and summative evaluation will be competed by the teaching faculty.

- Procedure
  - At the completion of each clinical rotation or rotation period, the resident’s performance will be evaluated by an electronic evaluation process (New Innovations) by the teaching faculty.
  - Residents will be provided copies of the evaluation instrument in order to fully understand the evaluation process and formative evaluation criteria.
  - Criteria for evaluation include:
    1. Patient Care
    2. Medical Knowledge
    3. Clinical Judgment
    4. Teaching Abilities
    5. Practice Base Learning and Improvement
    6. Interpersonal and Communication Skills
    7. Professionalism
    8. System Based Learning
    9. Over All Clinical Competence
  - At the completion of each clinical rotation or rotation period, or at any time thereafter upon request of the resident, he or she will have an opportunity to review his or her evaluations with a faculty member.
  - The resident will meet with the Program Director or faculty member, at least semiannually, to receive counseling and structured feedback on overall performance. When necessary, a written plan will be developed to address areas requiring remediation.
  - The Program Director will be responsible for preparing a detailed consensus evaluation for each resident annually, and also at the completion of the program. The Program Director will meet with each resident, at least annually, and more frequently as requested by the resident or the Program Director.
    - The evaluation will describe the degree to which the resident has mastered each component of clinical competence as outlined in the program’s curriculum.
    - It will also include evaluating conference attendance, in service exam score, career planning, and self evaluation.
    - The resident will be fully apprised of his or her areas of strength and those specific areas requiring improvement. With input from the teaching faculty, the Program Director will develop a plan of remediation to facilitate the resident’s improvement.
      1. Residents will also get the opportunity to evaluate the faculty after every rotation. This will be made available on the new innovation system.
      2. Residents will also evaluate themselves so that a comparison can be made between their expectations and the expectations of the program.
      3. Residents will also evaluate co-residents whom they worked with for a certain rotation. Residents’ anonymity will be protected.
      4. The program will be responsible for maintaining complete evaluation records in each resident’s file. The records will be made available to the resident for review.
      5. Monthly resident rotation evaluations provide the program with important information on the performance of individual residents. Nevertheless many instances of excellent or unacceptably poor resident performance go unreported. Resident performances in cross coverage situations are particularly likely to go unreported. Observations of faculty members serving in a consultative role also are frequently unreported. As a result the program may be missing important pieces of information on the performances of
individual residents. The program has not provided the faculty with consistent mechanisms for reporting instances of exceptional (good or bad) resident performance. We would like to suggest the following mechanisms for reporting exceptional performance:

- Page chief residents for phone conversation
- Page program director for phone conversation
- Direct email to program director. This is the most effective reporting mechanism.

6. Please be assured that reports of poor performance will be used in a constructive educational fashion rather than a punitive fashion.

- Policy for Faculty Evaluation
  - Policy:
    1. In order to facilitate ongoing evaluation of educational quality all residents must be provided the opportunity to evaluate the effectiveness of faculty teaching.

- Procedure:
  - At the completion of each clinical rotation residents will evaluate the effectiveness of faculty clinical teaching.
    1. Residents will be evaluating the faculty through an electronic evaluation system (**new innovations**) Residents’ anonymity will be protected.
  
  - At the completion of a didactic segment or at the end of the academic year all residents will evaluate the effectiveness of faculty didactic teaching.
    1. Residents will be provided written forms to utilize when evaluating the faculty. Residents’ anonymity will be protected. Completed forms will be submitted to the residency coordinator or program secretary.
  
  - The Program Director will be responsible for compiling a consensus evaluation for each clinical and didactic faculty member.
    1. The Program Director will provide each didactic and clinical teaching faculty member an annual written evaluation of his or her teaching performance. Meetings to discuss the evaluation will occur at the request of the faculty member and/or the Program Director.
    2. The faculty member will be apprised of areas of strength and those areas requiring improvement. When improvement is needed, the Program Director and the faculty member will jointly develop a plan to assist the faculty member with improving teaching skills. In addition, the Program Director and the faculty member will jointly review, revise and develop teaching goals and objectives for the faculty member.

**Didactics**

- The Department of Medicine has created various didactic exercises to fulfill its mission of delivering a comprehensive curriculum intended to expose residents to the totality of internal medicine and prepare them for the internal medicine board exam at the end of residency training. This includes:
  - **Morning Report**
    1. On Monday thru Thursday at 7:10-8:00 AM assigned residents present admissions that they completed on a previous call.
    2. General medicine and hospitalist residents present on Monday, Wednesday, and Thursday, and the MICU or CCU resident present on Tuesdays in an alternating schedule.
    3. Admissions are critically analyzed and appropriate management is discussed in detail.
    4. This is attended by the housestaff, chief residents, and a medicine attending physician.

- **Friday Morning Report (Prepared Case PowerPoint Presentation)**

48
On Friday at 7:10-8:00 AM, an assigned resident presents a scholarly power point presentation of a medicine topic.

This exercise involves critical analysis of the medical literature in preparation of the presentation.

This is attended by the housestaff, chief residents, and a medicine attending.

Goals of presentation:

To become the expert on the information you are speaking about

To deliver an excellent presentation of Grand Rounds quality and of board relevance.

Have a subspecialty expert in the field come to your presentation

BE professional: Be on time. Make sure your presentation works the week prior on the laptop. Be presentable.

You are the teacher, we are to learn from you

Outline:

1. Case presentation (generally lasts at maximum 15 minutes) (case presentation would be presentation of the case on the topic you are presenting
2. Epidemiology
3. Etiology
4. Presentation
5. Diagnosis
6. Treatment
7. Evidence Based Medicine (always look in NEJM and Annals at the least)

Tips:

1. Be organized
2. Develop specific teaching points/objectives
3. You may include images. Echocardiograms can be downloaded from the echo lab (make sure they work on our computer before you present)
4. X-rays, CT, MRI – will not be taken from portal during your presentation. These images can be downloaded to CD format in the radiology film room.
5. Pathology—give path some time in advance to make slides and possibly even come to describe the path (residents even)
6. Include MKSAP questions relevant to your topic.
7. Practice your talk
8. Know your topic extremely well
9. Use primary literature sources
10. Keep your topic clinically and board relevant

Overall:

1. If you perform this task well, you will leave knowing more than you knew before, and teaching more than you have before.

2. Remember:
   
   ▪ Pick a case that you found interesting (4-8 weeks prior)
   ▪ Let the chiefs know what case you will be presenting (5 weeks prior)
   ▪ Research that topic (4 weeks prior)
   ▪ Put together slides of your presentation (3 weeks prior)
   ▪ Inform subspecialty attending of your presentation and ask if they could come (2 weeks prior)
   ▪ Finalize presentation (1.5 weeks prior)
   ▪ Run on departmental laptop (1 week prior)
   ▪ PRESENT (day of)

Grand Rounds

Once weekly from 12:00-1:00 PM, Medical Grand Rounds is scheduled.

This usually is given by faculty within divisions of the department of medicine and occasionally, by an outside speaker.
• Board Review
  o Once weekly during the first six months of the academic year from 12:00-1:00 hours, Board Review is scheduled and then, in addition, daily at morning report for the second six months.
  o Didactic questions are critically analyzed under the supervision of a medicine attending physician.

• Journal Club
  o Will take place once every month.
  o Residents will read the article before the scheduled session and discuss the article at each session.
  o This is attended by the housestaff and various attendings.

• Morbidity/Mortality
  o On the last Friday of every month from 12:00-1:00 PM hours M/M is scheduled.
  o A resident presents one- two cases which are thoroughly discussed by the housestaff. This is moderated by a medicine attending physician.
  o A combined EM/IM M/M conference is also held on Thursday at 7:00 AM-8:00 AM every other month.
  o An EM/IM resident presents a case that involved care between the two services.

• R1 Intern Report
  o On Thursday, between 12:00-1:00 PM, an assigned intern will present a prepared case.
  o The case is discussed beforehand with the chief resident to offer guidance in the preparation of the case.
  o This is attended by the housestaff and the chief residents.

• Core Medicine Lecture Series
  o Daily from 12:00-1:00 PM, a core medicine lecture series is scheduled for all housestaff.
  o This lecture series covers general topics in Internal Medicine for preparation for the Boards in Internal Medicine.
  o The lectures are given by core medicine and subspecialty attendings.

• CPC (Clinical Pathologic Correlation)
  o Once per month, the MICU resident from the previous month will discuss an interesting case from their month in the MICU.
  o They will present the case, look up the pathology related to that case, and have a pathologist at the conference to aid in explaining the pathology.
  o They will also give a presentation about the disease process.

Vacation/Sick Leave/Maternity Leave/Personal Time/Interview Days/Jeopardy

• According to AGH GME policy, residents will have 15 days of paid time off each academic year. This time may be used for vacation, conferences, personal business, or sick time. Requests for unpaid time off (i.e. maternity leave, medical LOA, etc.) must be submitted for approval by the resident’s Program Director.
• According to the ABIM, up to one month per academic year is permitted for time away from training, which includes vacation, illness, parental or family leave, or pregnancy-related disabilities. Training must be extended to make up any absences exceeding one month per year of training. Vacation leave is essential and should not be forfeited or postponed in any year of training and cannot be used to reduce the total required training period. ABIM recognizes that leave policies vary from institution to institution and expects that program director to apply his/her local requirements within these guidelines to ensure trainees have completed the requisite period of training.
- Each resident who takes emergent sick days for personal illness or emergent family illness over the course of their three years of residency, will be covered by the Jeopardy call system (please see below).
  - These days may not be used in June or over the holiday break without a written excuse from a physician. The program reserves the right to request a physician excuse for any of these sick days.
  - Sick time will not be paid out at the end of a resident’s tenure.
  - The program reserves the right to investigate the authenticity of the resident’s illness. The program director may request that the resident be evaluated by a physician or the Employee Assistance Program. Residents will be charged a vacation day and may be subject to disciplinary action if they are not truly ill.
  - Residents are responsible for letting the chief medical residents know about all time taken off (for illness, physician appointments, etc.)

**Interviews**

- The following guidelines are used when it is necessary for residents to take time off for interviews:
  - The chief residents must be notified at least four weeks in advance of the interview date. In the event that a last minute interview opportunity arises, exceptions may be made.
  - Resident is expected to provide his/her own coverage for clinic and clinical responsibilities. In the event that the resident is unable to provide such coverage, it is essential that the chief residents be informed of the need for the use of jeopardy system in a timely fashion.
  - 5 interview days can be taken without the lose of vacation time.
  - All requests must be accompanied by a travel itinerary and interview schedule to justify the duration of absence.
  - Absences which total greater than five working days will necessitate the use of vacation time to cover the absences. It is the responsibility of the resident to be certain that vacation time is set aside for this potential need.

**Personal Time**

- Residents who need time to relocate at the end of the year will need to use vacation time.

**Special Rules**

- Specific Rules - R3 Level
  - Vacation cannot be taken while assigned to ambulatory, cardiology teaching service, House Consult, MICU, Oncology, Night Float, Hospitalist, or any color teaching service rotation.

- Specific Rules - R2 Level
  - No vacation may be taken while on any colored teaching service rotation, CCU, MICU, Night Float, Hospitalist, ambulatory, or cardiology teaching service.

- Specific Rules – R1 Level
  - Vacations should be taken during the electives only. The only exception to this is during the osteopathic intern year in which vacation can be taken during the family practice rotation. No more than 7 vacation days can be taken in the ER. Such vacation days must be approved EARLY with both departments’ chiefs (IM and EM).
Vacation

- Vacations must be scheduled for the entire year and changed only at the discretion of the chief residents.
- Vacation requests are obtained in the spring prior to the year block schedule being created.
- Requests must be delivered via email or amion and include specific dates. If there is no documented request, then it was never made (i.e. verbal request may not be recognized). There is no guarantee that a vacation request can be granted do to the complexity of the schedule.
- Vacation cannot be granted during general medicine, MICU, CCU, hospitalist, oncology, consults, the month of neurology elective, and non-medical specialty ambulatory month.

The Jeopardy System

- When on jeopardy call you must assume you will be working. It is an assigned rotation without payback.
- Residents are encouraged to make their own coverage arrangements whenever possible. Be sure to let the chiefs know of the switch.
  - Extenuating circumstances include acute illness or injury, serious illness or death of a family member, and any other urgent circumstance as deemed appropriate by the program director and chief residents. A vacation day may be deducted for calling jeopardy at the discretion of the Program Director and chief residents.
  - Jeopardy call may also be used at the discretion of the program director and chief residents to cover residents who have to attend specific conferences during a teaching month and are unable to find their own coverage. This does not apply to a routine educational conference, which should be attended during a non-teaching month.
  - Jeopardy Call may also be activated at the discretion of the program director, to cover residents who must attend urgently scheduled interviews during a teaching month. Again, residents are encouraged to schedule all interviews during a non-teaching month and arrange own coverage.
  - The Internal Medicine Jeopardy System applies to non-medicine residents rotating on medicine services. For example, the jeopardy resident may be called to cover an ED resident who calls off on a medicine rotation.
  - Jeopardy will not be used for relocating at the end of the year.
  - Whenever possible, efforts will be made to cover the resident without having to call in the jeopardy person.
  - Only residents at any level will be assigned to Jeopardy Call.
  - At the beginning of the year, every resident will be assigned approximately 2 weeks of Jeopardy Call while on a non-teaching month.
  - All call-offs and schedule changes must be reported to one of the Chief Residents.
  - Residents must be available 24 hours a day for their scheduled jeopardy call (i.e. no moonlighting).
  - The decision of the Program Director regarding the use of the Jeopardy Call is final.
    1. Days used for jeopardy may qualify as the resident’s 24 hour period off for that week.
    2. Greater than three days absence requires a doctor’s excuse for resident and family member illness in accordance with hospital policy.
    3. Any apparent abuse of the jeopardy call off system will have consequences judged by the chief resident and program director, whose decision is final on the matter.
    4. Residents who miss their jeopardy service due to any reason will have to pay back per the chief residents. Residents are responsible for being available in town and fit to work for their jeopardy coverage.

Resident Misconduct

- Resident Due Process Flow Sheet
  - The goal of the Program Director and faculty is to support each resident so that they can successfully complete the training program.
  - The faculty will provide additional teaching, supervision and support for any resident who is struggling.
• **Evaluation Process:**

1. Program Director is notified of Resident problem, or receives a poor evaluation of the Resident.

2. Program Director and Chief Residents meet to discuss the problem.

3. Chief Residents interview the Resident and the complainant or faculty member reporting the problem.

4. Chief Residents and Program Director reconvene to discuss the facts and determine the appropriate action. Options include:

   - Complaint of no basis or consequence and the matter is ended.

   - Complaint has merit but little consequence and is managed with a meeting of the Program Director, Chief Residents and the Resident. The course of action arrived at in this meeting is noted in the residents administrative file.

   - Complaint has merit and moderate consequence and is managed with a meeting of the Program Director, the Chief Residents and the Resident. Remedial action is determined and a follow-up review date is set. After the follow-up meeting a summary of the episode is included in the residents administrative file and the Residency Training Committee is notified. The Residency Training Committee is composed of the Program Director, the Chairman of the Department of Medicine, a Vice-Chair of the Department of Medicine, three (3) Associate Program Directors and the Chief Residents.

   - Complaint has merit and is of significant consequence. The Program Director, Chief Residents and Resident meet to discuss the problem. The Program Director decides upon an appropriate remedial action and presents the problem and remedial action to the Residency Training Committee. The Program Director and the Residency Training Committee develop a consensus decision as to the appropriate remedy (education, probation, dismissal etc.). The Program Director meets with the Resident to inform him/her of the Committees decision. The Resident is informed by the Program Director that he/she may select a faculty advocate to assist in the appeal of this decision if he/she desires. If the Resident elects to appeal the decision the Program Director reconvenes with the Residency Training Committee, the Resident and the Advocate for further discussion. Following this discussion the Resident and Advocate are dismissed from the meeting and the appeal is considered with the following options for action:

     - Committee amends plan of remedial action.

     - Committee does not amend plan of remedial action and Resident is informed of this decision. The Resident is informed that further appeal can be made to a Department of Medicine Grievance Committee.

     - If the Resident appeals a Residency Training Committee action an Ad hoc Department of Medicine Grievance Committee is appointed. This Committee is to be composed of three (3) faculty members who do not sit on the Residency Training Committee and one (1) resident physician. One faculty member will be appointed as Chairman of the committee. The Committee is to be appointed by the Chairman of the Department of Medicine.
The Department of Medicine Grievance Committee will convene within two weeks of the appeal. The Resident may have an Advocate present at this meeting. The Program Director will present the case and the recommendations of the Residency Training Committee. The Program Director may call witnesses and present documents as appropriate. The Resident and the Advocate will be allowed to present his/her case and call witnesses as necessary. The Chairperson of the Grievance Committee will then dismiss the Resident and his/her Advocate along with the Program Director. The Department of Medicine Grievance Committee will deliberate, come to a decision and notify the Resident and the Program Director as to their decision. Both the Resident and Program Director can appeal this decision to the Council of Graduate Medical Education (CGME) of Allegheny General Hospital.

The Director of Graduate Medical Education of Allegheny General Hospital should be notified immediately of any action that includes probation or dismissal.

- **Disciplinary Action**
  - **Introduction**
    1. Allegheny General is committed to creating an educational environment based upon principles of contemporary adult education and congruent with high humanistic and ethical standards. This environment will foster educational achievement, professional growth and development, the pursuit of new knowledge, and will be an environment which fosters graduate medical education.
  - **Policy**
    1. The hospital will provide an equitable and uniform procedure for administering disciplinary action. This policy allows for variation of the disciplinary action depending on the nature, frequency and gravity of the offense and on the resident’s past record of performance and behavior. The disciplinary action may range from a verbal or written reprimand to a termination.
  - **Procedure**
    1. **Definitions**
      a. **Violation**
        - A violation is defined as any behavior by a resident which conflicts with policy or accepted conduct, or any other behavior deemed unacceptable by the residency program faculty and the Administration of Allegheny General Hospital.
      b. **Verbal Reprimand**
        - A verbal reprimand is defined as a form of counseling in which the Program Director verbally presents a warning to the resident following a violation.
      c. **Written Reprimand**
        - A written reprimand is defined as a written notice presented by the Program Director to a resident following a violation.
      d. **Suspension Pending Investigation**
        - A suspension pending investigation is defined as the act of placing a resident on an indefinite suspension while the alleged violation is being investigated. The Program Director verbally informs the resident that he or
she is suspended without pay pending investigation and that he or she may be disciplined depending on the outcome of the investigation.

e. **Suspension**
   - Suspension is defined as the act of placing a resident on disciplinary time off without pay following a serious or repeated violation. The Program Director presents a written notice to a resident which identifies the period of suspension.

f. **Final Written Reprimand**
   - A final written reprimand is defined as a written notice presented by the Program Director to a resident following a serious or repeated violation. This form of discipline may be used in addition to, or rather than a suspension, to notify a resident that termination will occur if the violation is repeated.

g. **Termination**
   - Termination is defined as the act of permanently terminating a resident from the program and The Western Pennsylvania / Allegheny General Hospital Graduate Medical Education Consortium in response to a violation or repeated violations.

h. **Medical Record Suspension**
   - Should a resident fail to complete medical records for which he or she is responsible in a timely manner, the resident may be suspended without pay until such time as the delinquent records are completed. In case of such suspension, the resident will not be entitled to the procedural rights provided in this policy.

i. **Temporary Relief of Duties Under Fatigue or Duty Hours Policy**
   - Temporarily relieving a resident of duties under the fatigue or duty hours’ policies, or the reduction of the resident’s clinical privileges, or the imposition of a requirement that some or all of the resident’s clinical privileges be performed under supervision will not constitute a suspension for purposes of this policy and the resident will not be entitled to the procedural rights provided in this policy.

2. **Responsibilities**
   - **A. Resident**
     - The resident is responsible for insuring that he or she maintains an acceptable level of performance, attendance, and conduct; for observing and complying with all program and Hospital policies, procedures, rules and regulations; and for correcting behavior which results in disciplinary action.

   - **B. Program Director**
     - The Program Director is responsible for administering fair, uniform and impartial discipline in accordance with this policy. In addition, the Program Director is responsible for reinforcing a resident’s understanding of the policies, procedures, rules and regulations. Prior to the issuance of any written disciplinary action, the Program Director will contact Human Resources for consultation and review.

   - **C. Council on Graduate Medical Education**
     - The Council on Graduate Medical Education is responsible for the interpretation
of this policy. The Council will consult the Human Resources Department for necessary clarification. The Council on Graduate Medical Education is also responsible for reviewing disciplinary actions for consistency in application and for assisting, when appropriate, with the investigation and analysis of the violation. The Council on Graduate Medical Education may serve as a liaison between a resident and the Program Director.

D. Designated Institution Official (DIO)
The Designated Institutional Official is the individual at the institution who has the authority and responsibility for the oversight and administration of the hospital’s graduate medical education programs.

3. Regulations
A. Stipulations, Limitations, and Exclusions
The stipulations set forth in this policy pertain to all residents regardless of their length of training or position in the residency program.

B. Review Process
The Council on Graduate Medical Education will review all disciplinary actions that result in a written reprimand, suspension or termination.

Prior to imposing a final written reprimand, suspension or termination, the Program Director will follow the established review process set forth in Section V. C. of this Policy.

C. Resident Acknowledgment
A resident will have the opportunity to provide a written statement of facts as he or she sees them and/or note any commitment to make corrections.

A resident’s signature on a disciplinary action form will certify that the resident has been informed of the violation and the consequences of continued violation(s).

Should a resident refuse to sign the disciplinary action form, the Program Director may call another faculty member to witness the refusal to sign.

A resident who disagrees with the disciplinary action and desires to have the matter reviewed will follow the procedure set forth in Section V.C. of this Policy.

D. Records
A verbal reprimand is documented and maintained by the Program Director. Verbal reprimands are not placed in the resident’s personnel file unless the violation is repeated and an additional disciplinary action is imposed.

A written reprimand, final written reprimand, suspension and/or termination are documented on a disciplinary action form which is available in the Human Resources Department. The disciplinary action form becomes a part of the resident’s personnel file.

Upon request, a resident will receive a copy of the disciplinary action form.

4. Procedures
A. Investigation
The Program Director will promptly commence an investigation to verify any suspected, reported, or observed violation.

The Program Director will complete the fact finding and document the conclusions.

The Program Director will notify the resident when the matter requires further investigation and the decision on the disciplinary action is pending.

B. Analyzing Disciplinary Problems
The Program Director will analyze the disciplinary problem and review such relevant factors including but not limited to: seriousness of the problem, frequency and nature of the problem, resident’s performance in the program, and consequences of the violation.

A suspension pending investigation may be imposed when the violation jeopardizes the safety or welfare of patients, employees, or another individual, or when the violation is of a serious nature and may result in a final reprimand, suspension or termination.

Serious or repeated violations, which may result in a suspension or termination, will be reviewed with the Department Chairperson and the Designated Institutional Official (DIO). When the Program Director is the Department Chairperson, the resident’s serious repeated violations will be discussed with the DIO and the vice President responsible for Graduate Medical Education.

Disciplinary Action: Procedure
1. Verbal Reprimand
a. The Program Director investigates and analyzes the disciplinary problem.
b. The Program Director meets with the resident and verbally communicates the following:
   i. Notice that the resident is receiving a verbal warning
   ii. The current violation
   iii. The rule/policy, if any, which was violated
   iv. When appropriate, a plan to assist the resident in correcting the problem
   v. The consequences of continued violation(s)
c. The resident has the opportunity to state the facts as he or she sees them.
d. The Program Director maintains a record of the verbal reprimand for follow-up action.

2. Written Reprimand
a. The Program Director investigates and analyzes the disciplinary problem.
b. The supervisor meets with the resident and presents the written reprimand, which includes:
   i. Notice that the resident is receiving a warning
   ii. Any previous discipline for similar violation(s)
   iii. The current violation
   iv. The rule/policy, if any, which was violated.
v. When appropriate, a plan to assist the resident in correcting the problem.
vi. The consequences of continued violation(s)
c. Resident Acknowledgment
i. A resident will have the opportunity to provide a written statement of facts as he or she sees them and/or note any commitment to make corrections
ii. A resident’s signature on a disciplinary action form will certify that the resident has been informed of the violation and the consequences of continued violation(s).
iii. Should a resident refuse to sign the disciplinary action form, the Program Director may call another faculty member to witness the refusal to sign.
iv. A resident who disagrees with the disciplinary action and desires to have the matter reviewed will follow the procedure set forth in Section V.C. of this Policy.
d. The Program Director forwards the original written reprimand to the Department Chairperson and the DIO. When the Program Director is the Department Chairperson, the original written reprimand will be sent to the DIO and the Vice President responsible for Graduate Medical Education
e. The Program Director maintains the copy of the written reprimand for follow-up action
f. The written reprimand will be forwarded to the Council on Graduate Medical Education.

3. Suspension Pending Investigation
a. The Program Director verbally informs the resident that he or she is suspended pending investigation for an indefinite period and that discipline may be issued depending on the outcome of the investigation.
b. The Program Director conducts a detailed investigation of the problem and documents the facts.
c. The Program Director reviews the findings with the Department Chairperson and the DIO. If the Program Director is the Department Chairman, the findings will be reviewed with the DIO and the Vice President responsible for Graduate Medical Education.
d. The Program Director meets with the resident and reviews the outcome of the investigation
e. If the investigation exonerates the resident, no further action is required. If, as a result of the investigation, disciplinary action is warranted, the Program Director will impose and record disciplinary action.

4. Suspension
a. The Program Director investigates and analyzes the disciplinary problem.
b. The Program Director prepares the suspension notice which includes:
   i. Notice that the resident is receiving a suspension
   ii. Any previous discipline for similar violation(s)
   iii. The current violation
   iv. The rule/policy, if any, which was violated
v. When appropriate, a plan to assist the resident in correcting the problem
vi. The consequences of continued violation(s)
vii. The period of suspension and the date the resident is required to return to their program.
c. The Program Director reviews the suspension notice with the DIO. When the Program Director is the Department Chairperson, the resident’s suspension notice will be reviewed with the DIO and the Vice President responsible for Graduate Medical Education.
d. The Program Director presents the suspension notice to the resident.
e. Resident Acknowledgment
   i. A resident will have the opportunity to provide a written statement of facts as he or she sees them and/or note any commitment to make corrections.
   ii. A resident’s signature on a disciplinary action form will certify that the resident has been informed of the violation and the consequences of continued violation(s).
   iii. Should a resident refuse to sign the disciplinary action form, the Program Director may call another faculty member to witness the refusal to sign.
   iv. A resident who disagrees with the disciplinary action and desires to have the matter reviewed will follow the procedures set forth in Section V. C. of the Policy.
f. The Program Director forwards a copy of the suspension notice to the Department Chairperson and the DIO. When the Program Director is the Department Chairperson, a copy of the suspension notice will be sent to the DIO and the Vice President responsible for Graduate Medical Education.
g. The Program Director maintains the original copy of the suspension for follow-up action.
h. A copy of the suspension will be sent to the Council on Graduate Medical Education.

5. Final Written Reprimand
   a. The Program Director investigates and analyzes the disciplinary problem.
   b. The Program Director prepares the final written reprimand which includes:
      i. Notice that the resident is receiving a final written warning
      ii. Any previous discipline for similar violation(s)
      iii. The current violation
      iv. The rule/policy, if any, which was violated.
      v. When appropriate, a plan to assist the resident in correcting the problem
      vi. The consequences of continued violation(s)
   c. The Program Director reviews the final written reprimand with the Department Chairperson and the DIO. When the Program Director is the Department Chairperson, the final written reprimand will be reviewed with the DIO and the Vice President responsible for Graduate Medical Education.
d. The Program Director presents the final written reprimand to the resident
e. Resident Acknowledgment
   i. A resident will have the opportunity to provide a written statement of facts as he or she sees them and/or note any commitment to make corrections.
   ii. A resident’s signature on a disciplinary action form will certify that the resident has been informed of the violation and the consequences of continued violation(s).
iii. Should a resident refuse to sign the disciplinary action form, the Program Director may call another faculty member to witness the refusal to sign.

iv. A resident who disagrees with the disciplinary action and desires to have the matter reviewed will follow the procedure set forth in Section V.C. of this Policy.

f. The Program Director forwards a copy of the final written reprimand to the Department Chairperson and the DIO. When the Program Director is the Department Chairperson, a copy of the final written reprimand will be sent to the DIO and the Vice President responsible for Graduate Medical Education.

g. The Program Director maintains the original copy of the suspension for follow-up action.
h. A copy of the final written reprimand will be sent to the Council on Graduate Medical Education.

6. **Termination**

a. The Program Director investigates and analyzes the disciplinary problem.

b. The Program Director prepares the termination notice which includes:
   i. Notice that the resident is being discharged.
   ii. Any previous discipline for similar violation(s)
   iii. The current violation
   iv. The rule/policy, if any, which was violated

c. The Program Director reviews the discharge notice with the Department Chairperson and the DIO. When the Program Director is the Department Chairperson, the discharge notice will be reviewed with the Chairman, Council on Graduate Medical Education, the Vice President responsible for Graduate Medical Education and the President and CEO of the Hospital.

d. After obtaining approval of the President and CEO of the Hospital, the Program Director presents the discharge notice to the resident.

e. **Resident Acknowledgment**
   i. A resident will have the opportunity to provide a written statement of facts as he or she sees them and/or note any commitment to make corrections.
   ii. A resident’s signature on a disciplinary action form will certify that the resident has been informed of the violation and the consequences of continued violation(s).
   iii. Should a resident refuse to sign the disciplinary action form, the Program Director may call another faculty member to witness the refusal to sign.
   iv. A resident who disagrees with the disciplinary action and desires to have the matter reviewed will follow the procedure set forth in Section V.C. of this Policy.

   f. The disciplinary discharge is without notice. A resident is paid up to the time that the discharge is imposed.
   g. The Program Director forwards the original discharge notice and other related documentation to the Department Chairperson. When the Program Director is the Department Chairperson, the original discharge notice and other related documentation will be sent to the Chairman, Council on Graduate Medical Education.

7. **Request for Hearing**

   Within ten (10) calendar days of written notification of a final written suspension and/or termination, a resident may request a hearing before a Committee. The resident’s request will be in writing and submitted to the applicable Program Director. The written request will include the resident’s current telephone number and address.

8. **Hearing Committee**
1. The committee will consist of a minimum two (2) members of the teaching faculty from the resident’s department, three (3) faculty members from another department, and the administrative director of GME who shall be ex-officio and serve as staff to the Committee. The Committee will elect a member from the group to serve as the Chairman at the hearing. An Ad Hoc Committee will be appointed by the Chairman, Council on Graduate Medical Education for each hearing requested.

2. The Committee will convene the hearing within fifteen (15) calendar days of the resident’s written request and will notify the resident in writing of the date, time, and place for the hearing as soon as reasonably possible.

3. The resident and the Program Director or his/her designee will be present at the hearing, and each will present information or materials (oral or written) that they wish to support their case. Each party will be permitted to review all materials to be submitted to the Committee prior to and during the hearing.

4. A majority vote of the five-member Committee will decide the issue(s). The Committee will render a decision, affirming, reversing, or modifying the proposed suspension/termination.

5. The Program Director or his/her designee will not be permitted to vote or to participate in the Committee’s deliberations.

6. The Committee will provide the resident and the Program Director with a written statement of its decision and the reason(s) for the decision within ten (10) calendar days from the date of the conclusion of the hearing. If written materials are submitted to the Committee, such materials will be appended to the Committee’s report as deemed necessary by the presiding members of the Committee.

7. The resident or the Program Director may appeal the Committee’s decision to the Council on Graduate Medical Education with fifteen (15) calendar days of receipt of the Committee’s decision. The Council will render its decision in writing within a reasonable time, which will not exceed thirty (30) days, and its decision will be final.

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A. Appeal Process for Negative Annual Resident Evaluation

Should a Resident wish to appeal an evaluation the following appeal process will be used.

1. The Resident informs the Program Director in writing that he/she wishes to appeal the evaluation.

2. The Program Director informs the Residency Training Committee that an appeal has been made. The Residency Training Committee is composed of the Program Director, the Chairman of the Department of Medicine, Vice-Chairman of the Department of Medicine, the Chief Residents and the three (3) Associate Program Directors.
3. The Residency Training Committee considers the appeal and renders a decision either to amend the evaluation or to refer the case forward to the Department of Medicine Grievance Committee.

4. If the case is forwarded to the Department of Medicine Grievance Committee, this Committee will be convened within two weeks of notification. The Committee will be appointed on an Ad hoc basis by the Chairman of the Department of Medicine. It will be composed of three (3) faculty members along with a resident physician. The Chairman of the Department of Medicine will appoint a Chairman of the Grievance Committee. The Department of Medicine Grievance Committee will convene with the Resident and an Advocate faculty member selected by the resident along with the Program Director. The Program Director may call witnesses and present documents as appropriate. The Resident and his/her Advocate will be allowed to present his/her case and call witnesses as necessary. The Grievance Committee will then dismiss the Resident and his/her Advocate along with the Program Director from the meeting. The Committee will deliberate and come to a decision and notify the Resident and the Program Director of their decision. Both the Resident and the Program Director can appeal the decision of this Committee to the Council of Graduate Medical Education (CGME) of Allegheny General Hospital.

IX. Resident Fatigue

Introduction:

Integral to its mission of excellence in patient care, Allegheny General Hospital is committed to providing an environment in which patients receive compassionate and safe medical care. The Hospital fully supports the provision of graduate medical education in a manner which balances the protection of the rights and welfare of patients, and also, the well-being of residents.

Policy:

The Council on Graduate Medical Education (CGME) is responsible for ensuring that all residents are able to perform their professional duties at the expected level of skill and competency, and that they are not impaired by fatigue which has resulted from over-commitment, and/or the lack of appropriate support when patient care responsibilities are complex and prolonged. All Allegheny General Hospital-sponsored residency programs will fully comply with all graduate medical education policies that specifically address resident duty hour limits. Programs’ compliance reflect an appreciation of the detrimental effects of sleep deprivation (acute or chronic) to residents’ clinical and educational performance, and also, the potential jeopardy to patient care.

Procedure:

1. Each Program Director must include in the formal written curriculum and discuss with the faculty and residents the signs, symptoms, and impact of sleepiness and fatigue. This is done during the intern orientation at the beginning of residency and by formal lectures given throughout the year.

   a. All faculty must observe residents for changes in neurobehavioral functions that may be indicators of fatigue. The signs and symptoms may include, but are not limited to:

      1. Alertness - unable to respond promptly, and/or consistently
      2. Vigilance - unable to prioritize tasks or appreciate urgency of circumstances
      3. Cognitive and physiological functions - decline in ability to analyze circumstances and make appropriate decisions, decline in hand-eye coordination, speech and speech patterns are incoherent, time-on-task decrements
      4. Working memory - unable to recall previous verbal orders or discussions regarding patient’s status
5. Situational awareness - decline or loss of orientation to day, time, place
6. Mood - irritable, anxious
b. Any resident who demonstrates the previously described sign(s)/symptom(s) of fatigue that may jeopardize patient care must be relieved of all clinical responsibilities
   1. The resident’s Program Director, or designee will be called and he or she will obtain appropriate coverage for the resident’s clinical responsibilities. In the event that the Program Director or designee is unavailable the Hospital Operations Manager will be called and he or she will obtain appropriate coverage for the resident’s clinical responsibilities.

   2. Each program will develop a plan for coverage of clinical responsibilities when a resident is relieved of duty due to fatigue.

   3. The Program Director will determine the length of time the resident is excused from duty. It is within the prerogative of the Program Director to require the resident to have a physical examination.

   4. The Program Director must provide approval before a resident may return to his or her responsibilities (clinical, academic or research).

c. The Program Director must provide written notification (within five (5) working days) to the Designated Institutional Official (Chairman, Council on Graduate Medical Education) of the circumstances necessitating the resident’s removal from duty, the action/treatment that was instituted, and the status of the residents’ fitness for duty.
   1. If it is determined that the resident is unable to return to duty the Program Director will notify the Designated Institutional Official (Chairman, Council on Graduate Medical Education) who will determine if further evaluation of the resident is indicated. If the Designated Institutional Official (Chairman, Council on Graduate Medical Education) believes it is necessary, the Physician Health - Impairment policy will be followed to determine the resident’s fitness for duty.

   2. To prevent acute and chronic sleep deprivation, all residency programs must fully comply with the Institutional policies and procedures outlined in Working Environment and Resident Duty Hours.

Sponsoring Institution’s Oversight
   1. Each residency/fellowship program will have written policies and procedures consistent with the Institutional and Program Requirements regarding resident fatigue. These policies will be distributed to the residents and the faculty.

   2. The Institutional oversight of the occurrence of resident fatigue will be through a biannual Resident Duty Hours Report, which will be submitted by each Program Director to the Council on Graduate Medical Education Oversight Sub-Committee for Duty Hour Compliance. (Reports are due April 1 and October 1.)

x. Moonlighting Policy
   a. Moonlighting will be allowed by third years who are on elective rotations that are not in danger of violating their work hours. Moonlighting can only be done within the institution.
   b. Residents must have permission from the Program Director.
   c. Moonlighting hours will be counted toward the 80 hour work limit.
   d. Residents must have an unrestricted license, DEA, hold medical staff privileges, and must not be on a restricted Visa.
   e. Residents must abide by the Rules and Regulations of the Graduate Medical Education policy.

xi. HIPPA Policy
a. All residents are required to complete the HIPAA (Health Insurance Portability & Accountability Act) compliance

XII. Assignment of On-call Rooms/Attending Rounds Conference Rooms/Library at AGH

B. On call rooms

8-A-3  Teaching R1 (8A)
8-C-3  Teaching R2 or R3 (8C)

6-C-7  Hospitalist Resident (6C)
Hemlock Pad OCR4  Hospitalist Intern

Hemlock Pad OCR13  MICU R2 or R3 (612)
Old Sleep Lab  R1 MICU (4th Floor Snyder Pavilion) 1st Room
Old Sleep Lab  R2 CCU (4th Floor Snyder Pavilion) 2nd Room

C. Attending Rounds Conference Room

A. Blue  8C57
B. Green  8A6-A
C. Yellow  8C59
D. Red  6A
E. Purple  8A4-A
F. Hospitalist  11 Family Meeting Room
G. CCU  Units
H. MICU  Units
I. Cardiology TS

D. Library

a. The library is available to the Resident on a 24 hour basis.

a. The library is open 0800-1900 hours, Monday through Friday. Any other time or day library can be accessed with your ID card and security clearance.

b. Various textbooks are permanently available in conference rooms on the teaching floors, specialty care areas and Medical Ambulatory Clinic.
AGH Human Resources Employee Assistance Program

6. **POLICY**

7. Allegheny recognizes the importance of employee physical and emotional health as it relates to job performance and overall quality of life. Allegheny shall make confidential assistance available to an eligible employee who may be experiencing personal problems and provide an opportunity for participation in the Employee Assistance Program.

8. The intent of this policy is to provide a program whereby an employee may present a problem, which may or may not be directly associated with job function; to afford an employee an opportunity to obtain professional help before the problem results in disability or unemployment; and to improve overall well-being and/or work performance by providing an approach to the prevention, diagnosis and treatment of these problems. This policy does not alter or replace existing policies concerning job performance or discipline; rather, it serves as an additional tool to assist in the administration of those policies.

9. **DEFINITION**

10. **Employee Assistance Program**

11. Employee Assistance Program (EAP) is defined as a service designed to assist an employee who is troubled by personal problems. The objectives of the EAP are: to provide a system of early problem identification so as to maximize the possibility for successful resolution; to provide a resource for an employee or family member when a personal or behavior/medical problem interferes with optimal functioning; to ensure that appropriate professional services are available to an employee or family members; and to provide information and encourage utilization of available resources to improve job performance and the overall quality of life.

12. **RESPONSIBILITIES**

13. Employee

14. An employee is responsible for maintaining an acceptable level of job performance. An employee may use the services available through the EAP and/or other appropriate community resources to help deal with personal problems affecting job performance and/or personal well-being.

15. Supervisors

16. Supervisors are responsible for informing employees of the existence of the EAP and for referring, not diagnosing, personal problems, including but not limited to chemical dependency and depression. Supervisors shall support the confidentiality guidelines established by the Advisory Committee and contained within this policy. In addition, supervisors shall attend educational programs which address such issues as the supervisors’ role in the EAP, methods of referral and follow-up.

17. EAP Staff

18. The EAP staff is responsible for interpretation and implementation of procedures established by the Advisory Committee, in support of the EAP.

19. **REGULATIONS**

20. **Scope and Function**

21. The EAP is responsible to a broad range of human problems that impact an employee's job performance and well-being. These problems may include but are not limited to excessive stress, physical/mental or emotional illness, chemical dependency, depression, marital or family strife, grief and loss issues, and financial or legal difficulties. Chemical dependence is recognized as a primary, progressive, chronic and potentially fatal disease which is treatable. It not only harms the individual dependent on drugs and/or alcohol, but affects family members, friends, and can also affect the individual's job performance.

22. Depression is recognized as a mood disorder that is often characterized by problems with sleep, appetite, energy, concentration, outlook, anxiety and interpersonal relationships. This condition is highly responsive to treatment with counseling, and where appropriate, antidepressant medications.

23. The EAP is a confidential service which includes the following: conducting assessments, making referrals to internal or community resources, and providing follow-up support after a referral has been made.

24. Program Eligibility
25. An employee is eligible to participate in the EAP regardless of length of service, job title or responsibility. In addition, family members and other individuals having close personal relationships with an employee may also use the services of the EAP.
26. The stipulations set forth in this policy do not pertain to a temporary employee.
27. Confidentiality
28. Information pertaining to a contact with the EAP or any subsequent information arising from that contact shall be treated in a confidential manner, and only released as set forth in the following guidelines:
29. Verbal or written information about program participants may be released with the participant's written authorization, or when such disclosure is required by law. In addition, information may be released when the participant presents a clear and present danger to himself or to another person or another person's property.
30. Information regarding employee contact with or participation in the program shall not be included in an employee's personnel file.
31. Participation in the program shall not jeopardize an employee's status with regard to transfer, promotion, reassignment, compensation, benefits or other terms and conditions of employment.
32. Any records that are kept shall be maintained privately and securely from other records with access limited to EAP staff.
33. The following information shall be disclosed to the supervisor as a result of a formal referral:
34. Verification of attendance, participation in assessment or counseling sessions;
35. Acceptance/rejection of counselor's recommendations;
36. Actual follow-through with counselor's recommendations; and
37. If applicable, information pertaining to a request for necessary time away from work.
38. EAP activity reports submitted to Allegheny's administration shall consist of only statistical summaries of the number of referrals, types of problems treated and general demographic data.
39. Referrals
40. An employee and/or family member(s) of an employee may be referred to the EAP by one of the following means:
   41. Self-referral - Eligible individuals can contact the EAP directly for assistance.
   42. Peer referral - A peer, co-worker or colleague may suggest that a fellow employee contact the EAP for assistance.
   43. Family referral - A family member(s) may contact the EAP directly regarding a concern which involves an employee.
   44. Supervisory referral -
       45. Informal - A supervisor may suggest that an employee use the EAP as a helpful gesture when a personal problem is identified by the supervisor or reported by the employee.
       46. Formal - A supervisor may direct an employee to the EAP for evaluation when personal problems appear to be attributing to unsatisfactory performance and/or in other instances, such as when there are questions concerning fitness for duty.
   47. Employee Health referral - A health professional may suggest or direct EAP intervention when, during the course of an examination and/or treatment for a health-related problem, a personal problem is identified.
   48. Medical referral - A physician or other health-care professional may suggest that an employee and/or family member use the EAP when a personal problem is identified.
   49. Pastoral Care or Social Service referral - A staff member may discuss and facilitate an employee's referral to the EAP when a personal problem is identified.
50. Other appropriate referrals - Representatives of Human Resources, the EAP Advisory Committee, and other individuals with whom the employee has discussed the personal problem may suggest EAP intervention.
51. EAP Appointments
52. An employee shall schedule appointments with the EAP Counselor during non-work time, such as on a day off or prior to or following the employee's scheduled shift. An employee may also request the use of personal holiday hours when it is necessary to schedule appointments during the work day.
53. An employee shall be paid for time spent with the EAP Counselor in situations where the appointment resulted from a formal referral by the employee's supervisor or when directed by an Employee Health professional. In most instances, these appointments will be made during the employee's work hours and total hours paid shall not exceed the employee's scheduled hours of work.
54. Costs
55. Assessment and referral services provided by the EAP Counselor are free.
56. Fees charges by agencies or care providers to whom the participant is referred shall be the responsibility of the employee/participant. However, an individual's ability to pay for the services, accessibility and available insurance benefits will be considered in the referral process.
57. Fees charged by care providers may be covered by the medical insurance programs provided by Allegheny if the individual subscribes to them. The EAP staff will collaborate with the Benefits Office to provide assistance to an employee in determining medical coverage, level of benefits and cost factors.

58. Time Off for Treatment

59. Sick leave for treatment or licensed rehabilitation, recommended by the EAP Counselor and/or mental health professional, will be granted on the same basis as other health problems and in accordance with the provisions of the Family Medical Leave Act.

60. Consideration may be given for the use of vacation and/or other means of time off in accordance with personnel policies and procedures.

61. Return to Work

62. An employee shall be reviewed before he/she returns to work following a period of treatment or rehabilitation. This review shall be made by the Employee Assistance Counselor and/or Employee Health Office in concert with the responsible supervisor.

63. When warranted by the particular circumstances, executing a back-to-work/last chance agreement will be required of the employee before returning to work. The agreement will stipulate the conditions required for continued employment. In these situations, a back-to-work conference which includes the employee, responsible supervisor, Human Resources and EAP Counselor will be encouraged to facilitate re-entry into the workforce.

64. VISAS

65. When residents on H-1B visas want to rotate outside of our area (Pittsburgh), they need to have the place where they plan to rotate added to their Labor Condition Application.

66. Under the new Consortium all requests for elective rotations MUST be approved by the GMEC.

67. There is a form that must be completed and returned to the program director at least 3 weeks prior to the following GMEC meeting.

68. any outside elective rotations must provide a really good educational experience that cannot be provided within our own health system or else they may be denied.

I. Key Features of the

II. West Penn Allegheny Health System

Starting January 1, 2010, you will have access to the West Penn Allegheny Health System WorkLife Balance Program which is an easy, confidential consultation, resource, and referral service that can help you deal with everyday personal or work-related challenges—24 hours a day, 7 days a week, 365 days a year. All employees, their family and household members and other dependents are eligible for unlimited telephonic consultations, web resources, educational information, and up to five in-person counseling sessions at no charge to the users. Assistance is provided for:

- Marital & Relationship problems
- Family & Parenting concerns
- Emotional issues
- Self-improvement planning
- Work-Life balance
- Adjusting to and coping with Change or Burnout
- Anger Management
Co-worker challenges  Legal & Financial services
Time Management  Supervisory support
Grief and Bereavement  Trauma support
Substance Abuse (alcohol & drugs)  Dependent Care services
Stress and Anxiety  And more!

1. LIFE MANAGEMENT SERVICES
- Resource and pre-screened, qualified referral services for all of life’s major events
- Assistance and information on: preparing for pregnancy, parenting, child care, adoption, special needs, educational choices, elder care and active aging/retirement planning
- Educational materials—books, videos/DVDs, tapes/CDs, brochures and workbooks
- Customized information packets tailored to meet your specific needs

2. LEGAL, FINANCIAL & IDENTITY THEFT SERVICES
- Free telephonic or in-person consultation with an attorney and telephone consultations with financial experts at no charge
- Assistance with issues such as: consumer debt, lease vs. purchase, tax issues, college funding, retirement and estate planning, family and divorce law, civil and criminal matters, identity theft prevention and resources and more
- Discounted fees for continuing services

INTERNET SERVICES at www.MagellanHealth.com/Member. Online resources are available on a broad range of health and wellness and life management issues:
- Interactive Tools
- Self-assessments & screenings
- Personalized development planning
- Hundreds of articles
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