

THE UNIVERSITY OF TENNESSEE HEALTH SCIENCE CENTER
INTERNAL MEDICINE RESIDENCY PROGRAM
HOUSE OFFICER'S MANUAL

INDEX

TOPIC	PAGE
Introduction	1
Goals and Objectives	1
Procedures	3
Conferences	3
Curriculum	4
Pagers	4
Reading	4
Research	5
Supervision	5
Teaching	6
Intern Job Description	6
Resident Job Description	7
MOD Job Description	9
Attending Physician Teaching and Supervision Responsibility	10
Professional Conduct	11
Evaluation of House Officers	12
Evaluation of Training Program	13
Backup Call	13
Change Over Days	13
Duty Hour Restrictions, Days Off, Vacation, and Other Absences	13
Moonlighting/Sunlighting Policy	16
Charting	16
Orders	17
Medical Records	17
Yearly Schedule	18
Daily Schedule	20
Sign-Out Rounds	20
MED Wards	20
MUH Wards	21
VAMC Wards	22
MICU Service	22
Medicine Consults	23
Subspecialty Services	24

Attachement 1 Residency Requirements for Academic Appeal Process

Attachement 2 University Employee Protection Against Liability

THE UNIVERSITY OF TENNESSEE HEALTH SCIENCE CENTER
INTERNAL MEDICINE RESIDENCY PROGRAM
HOUSE OFFICER'S MANUAL

INTRODUCTION

The University of Tennessee, Department of Medicine aspires to train both clinically competent and scholarly physicians. The curriculum which is competency-based is designed to give the resident the maximum exposure to a wide variety of patients, both in-patient and ambulatory. The following are the guidelines of the UT Internal Medicine training program. It is to be referred to for questions concerning daily routines and responsibilities. These are the minimum requirements expected of a house officer in order to complete the program. All house staff are responsible for all information contained in this manual.

PROGRAM GOALS AND OBJECTIVES

Goals:

- To train internal medicine residents to competently practice general internal medicine in preparation for ambulatory and hospital practice, further subspecialty training, or an academic career.
- To train preliminary medicine residents in the basics of internal medicine practice to become fully prepared for careers in a variety of medical disciplines.
- To assure board certification status for all categorical, primary care, and medicine/pediatric residents.
- To assure competency in six areas: medical knowledge, patient care, professionalism, systems-based practice, interpersonal and communication skills, and practice-based learning improvement.

Objectives:

- Provide patient care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health in adults.
- Demonstrate knowledge about established and evolving biomedical, clinical, and cognate (epidemiological and social-behavioral) sciences and the application of this knowledge to patient care.
- Investigate and evaluate their patient care practices, appraise and assimilate scientific evidence, and improve their patient care practices.
- Demonstrate interpersonal and communication skills that result in effective information exchange and teaming with patients, patient families, and professional associates.
- Demonstrate a commitment to carry out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population.
- Demonstrate an awareness of and responsiveness to the larger context and system of health care and the ability to effectively call on system resources to provide care that is of optimal value.

It is our intention that each house officer will have educationally sound experiences in each of the following disciplines:

- General Internal Medicine: Inpatient and ambulatory, episodic and continuous care
- Subspecialty Internal Medicine: Adolescent Medicine, Geriatric Medicine, Cardiology, Endocrinology, Gastroenterology, Hematology/Oncology, Infections Disease, Medicine Consult, Nephrology, Pulmonary, Rheumatology, Critical Care Medicine
- Non-Internal Medicine Specialties: Gynecology/Women's Health, Orthopedics, ENT, Psychiatry, Ophthalmology, Neurology, Rehabilitation Medicine, Emergency Medicine, and Dermatology
- Procedural Internal Medicine: ETT, flexible sigmoidoscopy, skin biopsy, arterial and venous cannulations, arthrocentesis, paracentesis, lumbar punctures, thoracentesis, ACLS, hemodynamic monitoring, and central line placement.
- Ethics, Occupational Health, Medical Genetics, Quality Assessment and Improvement, Preventive Medicine, Medical Informatics, Critical Reading Skills, Perioperative Clearance
- Research & Scholarly Activities

AMBULATORY MEDICINE

The major experience in ambulatory medicine is the general medicine continuity clinic. Each house officer is assigned to clinic one half day per week in which he/she will be exposed to a variety of patients typical of an internist's practice. Teaching is patient-centered with care directed at acute problems as well as primary prevention and maintenance of wellness. All patients seen in the clinic must be discussed with the attending physician prior to discharge. Additionally, an ambulatory medicine curriculum featuring clinic "small talks" will be used which will be lead by the attending physician at the start of clinic. Reading for this clinic experience should include the use of one of several primary care internal medicine textbooks including either the text edited by Barker or Goroll. Clinic talks are posted on the general internal medicine website – (www.utmem.edu/gim) for reading prior to the clinic session. The ambulatory syllabus is also available online.

In addition to the continuity of care clinic, residents will participate in a variety of other outpatient experiences. These include subspecialty clinics, emergency medicine rotations, ambulatory block rotations, secondary clinics for junior and senior residents, private clinics, and office-based preceptorships. In addition, elective rotations in office orthopedics, otolaryngology, gynecology, dermatology, adolescent medicine and ophthalmology are available.

All categorical residents must complete a required ambulatory rotation encompassing psychiatry, rehabilitation medicine, ENT, ophthalmology, orthopedics, dermatology, and office gynecology. Primary care residents are exposed to these disciplines over several months of required ambulatory experiences. Elective ambulatory block rotations may also include office based procedures such as flexible sigmoidoscopy, treadmill testing, Holter monitoring, EKG interpretation, and skin biopsy.

INPATIENT MEDICINE

General and subspecialty ward rotations are another important component of the educational process in the Department of Medicine. These rotations teach about the diseases of the hospitalized patient in a variety of hospital settings. During these rotations, the house staff assumes major responsibility for the evaluation, diagnosis and treatment of a variety of diseases. The resident has three roles during ward rotations: primary care provider (with close supervision by the attending staff), teacher of junior colleagues (including medical students) and active learner. Teaching occurs by both didactic and patient-based methods. Didactics should include brief lectures on a variety of topics given by all team members. Patient-based teaching largely occurs in the form of bedside teaching rounds which allow the attending physician to review pertinent historical and physical findings with the residents and students. Bedside rounds must occur as part of attending rounds at least 75% of the time. Active learning should occur by reading about assigned patients in a textbook of medicine or online database and reviewing pertinent journal articles found in the medical literature. The inpatient curriculum must be reviewed at the beginning of each ward month by the attending and residents together to help guide learning. The attending physician should provide one-on-one feedback regarding the house officer's role as caregiver, self-learner, and teacher at the middle and end of each rotation.

EMERGENCY MEDICINE

Each resident will participate in a minimum of 2-3 months of emergency medicine that fosters training in acute episodic care in multiple settings. The experiences will provide exposure to a wide variety of illnesses from minor to life-threatening conditions. These rotations reinforce skills in patient assessment, cost-effective management of the acutely ill patient, and ambulatory procedures. Teaching by the supervising staff physicians consists of both a hands-on, patient-based approach as well as lectures, on-line, and case based-learning given by attendings. Residents are required to attend all house staff conferences and clinics during their emergency medicine months provided RRC duty hour guidelines are not violated.

INTENSIVE CARE

Rotations in critical care medicine comprise 3 - 5 months of the residency. The educational premise of the rotations is to train our residents in the principles of management of the critically ill patient. These experiences occur in medicine and cardiology intensive care units in a variety of hospitals. Residents will gain experience in hemodynamic monitoring, mechanical ventilation, nutritional and pharmacological support of the intensive care patient, and management of acute cardiac diseases. The core of the educational experience is patient-based with written curriculum and didactics.

PROCEDURES

Throughout the course of the residency, house officers will have numerous occasions to become proficient with many medical procedures. These include ACLS, flexible sigmoidoscopy, thoracentesis, paracentesis, pelvic/breast/rectal examinations, venous and arterial cannulations, hemodynamic monitoring, and lumbar puncture. Additionally, residents will become proficient in the interpretation of EKGs, chest radiographs, basic spirometry, urinalysis, vaginal preps, sputum gram stains, and peripheral blood smears. These additional skills are assessed on Blackboard, a UT-based online testing service. Performing an invasive procedure on a patient should be viewed in light of indications, contraindications and the need for informed consent. All residents **must** maintain a procedure log to assist with obtaining hospital privileges in the future. All procedures should be logged immediately after performance using the New Innovations computerized system.

All elective procedures require:

- Discussion with the attending physician prior to the procedure to guarantee appropriateness and supervision when possible.
- Explaining to the patient and/or legal guardian the indications for the procedure, details of the procedure, possible complications, other options, and information to be gained from the procedure.
- Witnessed and signed consent of the patient or legal guardian.
- A procedure note written after the procedure documenting the indications and receipt of informed consent, a brief detail of the procedure, any complications of the procedure, and the presence of a supervising house officer or attending.
- Because of billing restrictions the attending physician should be present for all procedures where possible.

CONFERENCES

Attendance at all conferences is required and is monitored. A minimum of 60% attendance is expected for each house officer.

- Morning Report is held 8am to 9am Tuesday and Thursday at the VA (conference room on first floor) and **7:15am to 8 am** at the MED (Adams 6th floor conference room). Morning Report at Methodist is in the Education office at 8am every day except Wednesday. The format will generally be the presentation of a recently admitted patient to an attending physician or chief resident by the medical student, intern, or resident on the service who is caring for the patient. The presentation should be succinct, lasting no longer than five minutes and emphasize the pertinent points of the history and physical examination. The discussion, which follows, typically led by the chief resident or faculty member, will address important aspects of the history and physical examination, formulation of a complete differential diagnosis, and management of the disease process in the individual patient. In order to effectively discuss each case, the presenter should prepare to answer pertinent questions concerning the patient's work-up, including lab values and test results. Any available radiology studies, EKGs, or slides should be brought to the conference when possible. The presenter should also have a basic knowledge, obtainable from a textbook of medicine or UpToDate, about the patient's diagnosis. This is not intended to be a morbidity and mortality conference; however, the managing physicians should prepare to defend their decisions and reasoning. **Attendance at morning report is required for residents on ward services and encouraged for all others.**
- Noon conference begins at 12:15 PM on Monday, Tuesday, Thursday and Fridays in the Coleman **North** Auditorium for the MED/VA, in the Education Classroom at Methodist, and in a seminar room at Baptist. Lunch is often provided; this will be reflected on the conference schedule that is posted on the UT Internal Medicine website. The noon conferences consist of forty-five minute didactic sessions on both general medicine and subspecialty topics. Lecturers are faculty members who present topics from a planned 18-month curriculum designed to provide each resident with a broad knowledge base of Internal Medicine. In addition, the noon conferences cover topics in preventive medicine, pain management, adolescent medicine, end-of-life care, substance abuse, QA/QI, critical reading skills, law and public policy, physician impairment, medical genetics, and domestic violence. The conferences are directed at providing information pertinent to the American Board of Internal Medicine (ABIM) certification examination. Conferences are also available for review on-line at the Internal Medicine website. Sixty percent conference attendance is required for all medicine, med-peds, and med-neuro residents during their medicine rotations.

- Medicine Grand Rounds begins at 8:00 AM on Wednesdays. The presenter is either a member of our faculty or a visiting faculty lecturer. Attendance is taken at Grand Rounds separately from noon conference, and 60% attendance is required. The housestaff has the opportunity to evaluate lecturers anonymously through GME.
- Morbidity and Mortality, a QA/QI conference, is held monthly on a Friday at noon as part of our commitment to quality improvement. The chief residents present cases with unexpected or unusual outcomes with the intent to avoid future adverse outcomes and improve the quality of patient care.
- Journal club occurs monthly and has two components. On the third Tuesday evening of the month two residents with the assistance of faculty review articles from this past month's major medical journals. This event is usually held at a local restaurant and is a good way to keep up with the current literature as well as to socialize with fellow residents and faculty. The second component occurs during a Friday noon conference and consists of a resident critically reviewing two recent journal articles, emphasizing the importance of evidence based medicine. A faculty member with expertise in critical literature analysis assists with the selection and review of the journal articles. All residents are required to participate in the journal club series. Med-peds residents have a separate monthly journal club which fulfills the required scholarly activity. The chief residents make the resident journal club assignments and yearly schedule.
- House Staff meetings typically occur in the Coleman Building on the second Friday of each month. Their purpose is to discuss issues and problems that pertain to the residency.
- Clinical Pathology Conference occurs monthly on the third Friday of each month and is presented by the chief residents. This conference is a case presentation with a review of the pertinent histologic findings by a pathologist.
- Medstudy occurs weekly on Wednesdays at the Med/VA and Baptist and on Fridays at Methodist. All housestaff are encouraged to attend, but it is mandatory for housestaff scoring below the thirty fourth percentile on the annual in-service examination. The goal of the Medstudy program is to prepare residents for the ABIM certifying examination. The program provides all housestaff except preliminary interns with a complete set of Medstudy booklets near the start of their residency. Prior to the conference, housestaff read a brief section of Medstudy (5-10 pages). An attending physician gives a short quiz covering the reading material at the start of the conference followed by a review of MKSAP questions pertaining to the same topic. Attendance and scoring are both expected to be at least 75% for each houseofficer. Failure to complete the Medstudy requirements will result in the resident failing to qualify to take the ABIM certifying examination.

CURRICULUM/EDUCATION

The academic residency in Internal Medicine provides a competency-based curriculum of didactic sessions and interactive case-based conferences. This curriculum is intended to form a foundation of knowledge that the house officer can expand upon by case-based reading and self-education. The rotation-specific curriculum is available on the web at <http://www.utmcm.edu/internal> and must be reviewed with the attending physician at the beginning of the rotation.

PAGERS

- Each house officer is assigned an alpha numeric pager for use for the duration of the residency training.
- It is the responsibility of the house officer to pay for the replacement of the pager should it be damaged, lost or stolen.
- Pagers are given to house officers so that the Internal Medicine program and other personnel who might require their assistance may contact them. In addition, conference reminders/cancellations and any other pertinent information may be sent via text message from the chief resident's office. Pages received at home are infrequent but may be important. Housestaff officers are encouraged to leave their pagers on whenever reasonable. All residents on call or back-up call must return their pages promptly at any hour.
- As part of the routine admission orders, house officers should list their pager numbers. It is advisable to record the pager number each time orders are written. The Med Pharmacy will provide each resident with a rubber stamp that includes the pager number if requested.

READING

Reading and self-education are the most successful methods to achieve a strong knowledge base in Internal Medicine. To foster this goal, the program strongly encourages all house officers to read a textbook of medicine in its entirety during their residency. The recommended texts are *Cecil's Textbook of Medicine* or *Harrison's Textbook of Medicine*. Reading an entire text is a daunting task. It must be done on a daily basis starting during internship. Additionally, the house officer is expected to remain up to date with the current Internal Medicine literature,

especially that relevant to his current patients. *The New England Journal of Medicine* and the *Annals of Internal Medicine* are both highly recommended. UpToDate is the best computer-based resource available and is purchased by the program office for all house officers.

RESEARCH

Clinical and/or basic science research is strongly recommended and many research opportunities are available for housestaff. Housestaff may elect to perform up to two months of research during their residency. All proposals for research electives must be presented in writing to the Program Director or Chief Residents. Visit the website under "Research" to find a list of research mentors, housestaff publications, and Powerpoint presentations on research. There is also a research forum on the second Tuesday night of each month at a local restaurant.

SCHOLARLY ACTIVITY

As a requirement of the RRC for Internal Medicine, all residents must complete a scholarly activity before finishing the residency. This requirement may be fulfilled in a variety of ways, including research projects, written literature reviews, case reports, noon conference presentations, and quality assurance/quality improvement projects. All projects require a faculty mentor, and all projects must be approved by the program director.

SUPERVISION

Supervision is defined at three levels: General, Direct, and Personal

- General supervision means that the care or procedure is conducted under the staff member's overall direction and control but the physician's presence is not required at the time of care.
- Direct supervision requires that the physician must be immediately available to furnish assistance and direction.
- Personal supervision means that the staff physician must be in attendance in the room during the procedure.

GENERAL SUPERVISION POLICY

- The program director and chairman of the department are responsible for supervising the resident. Responsibility for the specific supervision may be assigned to a staff member on various academic rotations. Residents are members of the medical staff as defined in the hospital by-laws. They provide care to patients assigned to their attending physician.
- All patients receiving care at this institution are assigned to a member of the attending staff. The staff member responsible for the care of the patient will provide the appropriate level of supervision based on the nature of the patient's condition, the likelihood of major changes in the management plan, the complexity of care, and the experience and judgment demonstrated by the residents being supervised.
- As part of the training program, residents are given progressive responsibility for the care of patients and to act in a teaching capacity and provide supervision to less experienced residents and students. It is the decision of the staff member, with advice from the program director, as to which activities the resident will be allowed to perform within the context of the assigned levels of responsibility. The overriding consideration must be the safe and effective care of the patient.
- Documentation of supervision will be by progress note or signature by the attending physician or reflected within the resident's progress notes at a frequency appropriate to the patient's condition.
- Inpatient Supervision: In general, patients admitted by residents to the hospital who are in stable condition will receive General supervision. The resident should immediately notify the attending physician at the discretion of that attending (e.g. for every patient admitted or for selected patients). The attending physician will be expected to see the patient and review the management plan within 24 hours.
- Outpatient Clinic: Residents seeing patients in an outpatient clinic will receive Direct supervision. Management plans for new patients or revision of management plans will be reviewed before the patients have left the clinic.

- **Emergency Room:** Residents assigned to the emergency room service will receive Direct or Personal supervision depending on the severity of the problem and experience of the resident. Residents providing consultation or care to patients followed by their respective services receive General supervision by the staff of their service. Dispositions of these patients may be discussed by phone with the appropriate staff member and/or reviewed on return to an outpatient facility. If the patient is admitted, the treatment plan will be reviewed by the attending faculty the next day.
- **Operating Room or Special Procedure Facility:** Residents performing diagnostic procedures that require a high level of expertise in performance or interpretation will receive General, Direct, or Personal supervision by a faculty member depending on the experience and proficiency previously demonstrated by the resident.
- **Emergency Care:** In an emergency, defined as a situation where immediate care is necessary to preserve life or prevent serious impairment of health, residents are permitted to perform everything possible to save a patient from serious harm pending arrival of more qualified staff. The appropriate staff practitioner will be notified as soon as possible.
- At the beginning of the curriculum, the supervisory policy is again stated in a condensed fashion. When the residents and faculty discuss the curriculum at the start of each month, they should also discuss supervision. Faculty may vary individually as to when they wish to be notified. Nonetheless, housestaff must be able to contact their attending physician promptly at all times. If a resident encounters any situation in which he feels that attending supervision is inadequate, he should immediately notify the chief residents or program director.

TEACHING

An integral part of the learning experience is the ability to teach others. Residents in charge of a ward service are expected to present at least one oral presentation weekly to the interns and students on the service. Additional bedside teaching is expected as part of the daily ward activity.

JOB DESCRIPTIONS

Intern:

The internship's focus is two-fold: 1) to improve the house-staff officer's general knowledge base through didactic sessions and reading; and 2) to promote excellence in inpatient primary care with emphasis on acute diagnosis, intervention, and patient follow-up.

Responsibilities:

- The intern is expected to arrive at the hospital in time to evaluate all assigned patients prior to morning work/attending rounds. It is impossible to conduct effective work rounds if you have not seen your patients before rounds begin.
- The intern is expected to attend all noon conferences and morning report while on inpatient services.
- The intern must perform and document a complete history and physical examination (using old records), develop a differential diagnosis, and implement a diagnostic and therapeutic plan. A complete ROS (10+ systems) must be part of this evaluation. The completed H and P must be charted within 24 hours of admission and may not be completed by a third year medical student.
- The intern should use all available preprinted orders at each hospital.
- The intern must write the admission orders. He must read the resident admission note and discuss the assessment and plan with the resident or attending prior to any major interventions.
- The intern must provide daily care for each patient on the service including a daily assessment, progress note, and daily orders. When working with patients assigned to an M3, the intern must read/correct medical student notes daily and write a two to five line addendum to demonstrate understanding and command of the case. Brief comments such as "patient seen, agree with above" are not sufficient.
- The intern must supervise and instruct medical students on the proper way to perform and document a history and physical examination. The intern must supervise and teach invasive procedures to the student and supervise, instruct, and sign medical student orders. To summarize, the intern is responsible for the instruction of the M3 medical student.

- The intern must maintain close communication with family members and guardians, especially when a change in the condition or prognosis of a patient occurs. Thorough documentation of all discussions with the patient and family is essential.
- The intern must follow-up all laboratory, radiological, and other diagnostic test results with documentation in the chart in a timely manner. This includes test results that return after patient discharge.
- The intern must communicate with colleagues concerning each patient's test results, plans of investigation or treatment, and other relative aspects of their care.
- When on long-call the intern must perform all cross-cover on assigned patients and must attend all codes and assist as directed by the ward resident.
- The intern should complete all discharge summary dictations on the day of discharge. Delinquency will result in extra call and suspension from duty and/or a disciplinary letter in the houseofficer's GME file. See other sections of this manual for medical record information.
- Prior to changing services at the end of the rotation, the intern must write a comprehensive off-service note. For particularly lengthy hospital courses, this may be accomplished as a stat discharge summary to be placed on the chart.
- The intern on consult services must respond in a timely fashion to the request for a consult and communicate with fellows and attendings so they may also judge the level of urgency.
- The intern should participate in consult service clinics, conferences, and meetings that do not conflict with fixed educational and outpatient responsibilities (such as medicine noon conference and continuity clinic).
- Since interns change services at the first of the month (often with attendings and fellows) the continuing care of service patients must be communicated with the houseofficers who are rotating onto the service. Interns should write off-service notes summarizing the patient's hospital course and future plan of care.

Outpatient Clinics:

- All interns are assigned 1/2 day per week of continuity clinic. Clinic attending physicians teach outpatient diagnosis and management of chronic medical illnesses here as well as prevention and screening.
- Morning clinic starts promptly at 8AM at Medplex and 9 am at MTP. All afternoon clinics begin at 1PM. A 15 minute curriculum-based lecture will be given at the beginning of the clinic session. On-time attendance is required, and penalties will be assessed for persistent tardiness.
- Clinic is a required experience that is not pre-empted by any event other than emergency inpatient care. In case of an emergency, the resident or attending should be notified of the situation and your need to go to clinic.
- Interns assigned to MICU and nightfloat rotations are exempt from weekly continuity clinic but will attend one clinic during the month in order to provide continuity for those patients who require close follow up.
- It is the intern's responsibility twelve weeks in advance to notify the clinic scheduling clerk and chief resident of vacations or post-call clinics that need to be cancelled. In the event of insufficient notice, patients will not be rescheduled and the resident is required to find another intern or resident to see the scheduled patients.
- Clinic cancellations for urgent/emergent reasons (serious illness, family emergency, etc.) must have the approval of the clinic attending physician.

RESIDENT JOB DESCRIPTION (PGY 2-4)

Residents are given responsibility for direct patient care and direct supervision and teaching of interns and medical students on the teaching service. This is subject to review and intervention by the attending physician.

Responsibilities:

- Teach the intern how to work-up and care for patients and ensure that all patients on the service receive appropriate care.
- Oversee each medicine admission, supervising the interns and students.
- Write legible and educational resident admission notes (RAN) on new patients including a brief differential diagnosis and a plan outlining the work-up and treatment.
- Hold work rounds. These are morning work rounds with interns conducted daily prior to attending rounds. Interns should have seen their patients, reviewed labs, obtained reports of diagnostic studies and have their notes on the chart prior to morning work rounds.
- Provide direct patient care when the PGY-1 has exceeded the twelve patient maximum.

- Conduct didactic sessions with the interns and students at least three days a week.
- Supervise and teach fourth year medical students serving as junior interns.
- Supervise all procedures performed by the intern or M4 on the service.
- Coordinate attending rounds assuring timely initiation and completion of teaching rounds.
- Assure all team members attend morning report and are well prepared when presenting cases.
- Assure that team members are present and adequately prepared for rounds.
- Assure interns conduct daily sign-out rounds with a thorough checkout list.
- Assure that all team members have the correct number of days off each month. This must be done at the start of each rotation. Each team member may require either four or five days off (one day of seven).
- Review daily student and intern notes for quality assurance (i.e. check for legible notes which define an accurate problem list and plan of action, review lab data, and coordinate discharge planning). Follow-up notes on patients previously admitted are expected at least every other day.
- Ensure that all patients are evaluated when an intern or M4 is absent.
- Review the level of care daily when patients are in the units or on telemetry to see if a lower level of care is appropriate.
- Provide a complete list of all patients on service with their problems and pending work-up to the oncoming supervisory resident at the time of monthly switch-over.
- Respond to and lead resuscitation teams. The on-call resident (and ICU resident) will carry a dedicated pager for rapid response to codes. If the on call resident has clinic, he/she should hand the pager off to a colleague during clinic. All residents in the vicinity of a code, especially senior-level residents, should report to see if they can provide assistance. Assistance from the MOD may be requested at any time.
- The on-call resident must assist with cross-cover issues, procedures and ICU transfers as needed. If necessary, the MOD is also available to assist with such matters.

Consult and Subspecialty Rotations:

- The resident must complete a full review of the chart (and medical record if necessary) with an interview & examination of the patient.
- The resident must respond in a timely fashion to requests for consultation and communicate with fellows and attendings so they may also judge the level of urgency.
- The resident should participate in consult service clinics, conferences and meetings that do not conflict with other fixed educational and outpatient responsibilities (such as medicine noon conference and continuity clinic).
- When at the end of the rotation, the resident must communicate patient information to housestaff rotating onto the service.
- The resident is required to take a written test given by the subspecialty attending at the end of the consult rotation.

Outpatient Clinics

- All residents will continue their previously scheduled weekly continuity clinic and will be assigned to one additional clinic per week for the PGY2 year. This clinic will be a hospital follow-up clinic at the VA and/or a subspecialty clinic. During the PGY3 year the resident will continue to attend continuity clinic and will rotate through a variety of subspecialty clinics.
- Primary care residents will attend the student health clinic at Rhodes College during the PGY2 year. This will be replaced by subspecialty clinics during the PGY3 year (which may include Rhodes College clinic).
- Medicine-Pediatrics residents will continue alternating between the medicine and pediatric primary care clinics through the PGY 3 year. PGY4 residents will be reassigned to a private or community med-peds clinic once the RRC requirement of attendance in 72 medicine continuity clinics is reached. In addition, fourth year med-peds residents will be assigned an additional 1/2 day subspecialty clinic each week. Residents will rotate through 4 subspecialty clinics divided into 3 month blocks. Attendance at these clinics is expected even while rotating on pediatrics.
- Clinics are required experiences not to be pre-empted by any event other than urgent/emergent inpatient care.
- Starting times at clinic are 8 am and 1pm at Medplex and 9 am and 1pm at MTP. Please plan your day accordingly.
- Residents rotating through MICU rotation will be required to attend one continuity clinic during the rotation. During MICU, night float, and ED months, residents are excused from secondary and subspecialty clinics. Primary Care residents will continue to attend Rhodes Clinic, and med-peds residents

- are required to attend their pediatric clinics during MICU rotations.
- During ED rotations, residents will be required to attend continuity clinic but not secondary or subspecialty clinics. If the resident has an overnight shift prior to continuity clinic, the clinic will be cancelled in accordance with RRC requirements.
- During night float months, residents will attend one clinic on a Friday morning to provide continuity of care to those patients who require monthly follow-up.

MOD JOB DESCRIPTION - RESPONSIBILITIES

The MOD (Medical Officer of the Day) is a senior resident on call to provide medicine consults to off service patients and to admit overcap patients from the night float system. The MOD may also occasionally be asked to assist with resuscitations, ICU transfers, and supervision of procedures. Hospital specific duties are listed below. The MOD should make arrangements to pick up the Methodist consult pager from the consult resident at 4:30pm and return it to the consult resident at 7am. The MED consult pager needs to be picked up from the consult residents at 5pm and returned at 8am. The pager should be transferred person to person; it is inappropriate to leave the pager unattended.

The MOD is not required to stay in house overnight, as long as any new consults received at either hospital can be seen within 30 minutes. There is a call room available at both the Med and Methodist if needed.

The MOD has a maximum new patient cap of 7 during the week and on weekends. The backup MOD will assist the MOD in an overcap situation. Overcap admissions and new consults worked up by the MOD count toward the cap. Old patients on the medicine consult service that are seen by the MOD on the weekends are not included in the cap.

The Regional Medical Center

Weekdays:

- Overcap admissions from long call team until night float team arrives
- Overcap admissions from night float team until morning call team arrives
- The MOD may request the ED intern or resident to write the H and P and admission orders. For patients evaluated by the ED intern, the MOD must see the patient, review the H and P and orders, and write a brief RAN. This is applicable on weekdays and weekends.
- Medicine consults that are urgent/emergent from 5pm-7pm
- The night float resident is responsible for urgent/emergent medicine consults from 7pm-7am. The night float resident may ask the MOD to take the consults if he/she is overloaded with admissions.

Weekends:

- Overcap admissions from long call team until night float team arrives
- Overcap admissions from night float team until morning call team arrives
- Rounding on medicine consult service patients
- New medicine consults received anytime on the weekend, with the exception of consults received late on Sunday evening that are not urgent/emergent

Methodist University Hospital

Weekdays:

- Medicine consults that are urgent/emergent from 4:30pm-7am

Weekends:

- Rounding on all medicine consult service patients
- New medicine consults received anytime on the weekend, with the exception of consults received late on Sunday evening that are not urgent/emergent

VA Medical Center

Weekdays:

- Overcap admissions after the long call team has capped at ten patients.
- No medicine consult responsibilities except when the long call team is capped.

Weekends:

- Overcap admissions from long call team until morning team arrives..
- No medicine consult responsibilities. The long call medicine resident will be responsible for emergent/urgent consults on the weekends and those patients will be followed by the medicine team. However, if the long call team is capped the MOD will have to see consults and assign them to the long call team.

NIGHT FLOAT RESPONSIBILITIES

A night float system operates at the MED and MUH and is responsible for admissions, medicine consults, and cross-cover between 7pm and 7am (7:30 pm and 7:30 am at MUH). The NF team consists of one resident and two interns and operates every day of the week. Patients are distributed at intake rounds the next morning based upon the team census of the services. At the VA, there is one NF intern who comes in at 7PM (Sunday-Thursday) and assists the long call team with admissions and cross-cover.

ATTENDING PHYSICIAN TEACHING AND SUPERVISION RESPONSIBILITIES

Conduct teaching or management/teaching rounds with the house staff at least seven hours per week and assist with any problems that arise. These rounds should not interfere with morning report or noon conference and must include case presentations, interpretation of data, discussion of pathophysiology, differential diagnosis, management, use of technology, use of best evidence and patient values in decision making, disease prevention, and bedside teaching. The RRC mandates that 75% of rounds should include some direct resident and attending interaction with patients with <25% permitted as "card flip" exclusively. Attending physicians should also:

- Review the rotation curriculum with the housestaff at the beginning of the month. The curriculum is available on line and is emailed to each attending at the beginning of the month.
- Supervise and teach team members. Review and critique medical students' and housestaff's history and physicals, daily progress notes, and oral presentations.
- Accept medical responsibility for the care of patients assigned to the service. Write a brief admit note on all patients within 24 hours of admission documenting that the patient has been examined, the housestaff documentation has been reviewed, and recommending any changes in assessment or management. Both MUH and the Med strongly encourage daily progress notes. The VAMC requires at least one note per week.
- Be available by pager at all times to assist housestaff and be available in person if requested. Attempt to be present during procedures.
- Provide feedback to both students and house staff mid-month and at the end of the rotation. If a team member's performance is unsatisfactory, it is the duty of the attending physician to notify the student or housestaff officer as soon as a problem is noticed to provide the team member ample opportunity for improvement.
- Administer a quiz to team members based on curriculum topics covered during the month.

SUPERVISION

A more detailed statement about supervision is available on the UT Internal Medicine and GME websites.

1) Patients Admitted by the Night Float Service -All patients will have a Ward Service Attending Physician assigned at the time of admission. This Department of Medicine Attending Physician should be called to discuss any questions regarding patient care and must be notified promptly whenever any patient is clinically unstable or is moved to a higher level of care, has a major change in status or is made DNR. Physician must see and evaluate the patient within one calendar day of admission.

2) Patients Admitted to the Medicine Service -The Department of Medicine Attending Physician for the patient should be called to discuss any questions regarding patient care and must be notified promptly whenever any patient is clinically unstable or is moved to a higher level of care, has a major change in status or is made DNR. The attending physician must see and evaluate the patient within one calendar day of admission and must be involved in any discharge or transfer decision.

3) Consult Service (MOD) --The General Internal Medicine (GIM) Attending Physician on call should be called to discuss any questions regarding patient care and must be notified promptly for any consults that: are going to the operating room, are clinically unstable, are moved to a higher level of care, or have a major change in status,

or need for discharge prior to staffing by the attending.

4) Intensive Care Units – The critical care fellow (either pulmonary or cardiology) is expected to see these patients promptly after admission. The fellow is expected to notify the attending physician immediately if there are any questions about patient care. The attending physician is expected to round daily on these patients.

5) Documentation – Housestaff should document attending involvement in the care of patients with such statements as, “I have seen and/or discussed the patient with my attending physician, Dr. X, who agrees with my assessment and plan.”

PROFESSIONAL CONDUCT

House officers are expected to maintain a high level of professional conduct. Professionalism is one of the six clinical competencies in which residents must demonstrate proficiency in order to successfully complete residency. Professionalism includes maintaining a professional appearance as well as demonstrating a high standard of moral and ethical behavior. Some examples of expected behavior that should be maintained throughout a physician’s career are listed below. Other examples are given in the Academic Appeals Process section.

Communication:

- Discuss treatment plans or changes in status with patients and families daily
- Personally call all consultants at the time the consult order is written
- Call the patient's primary care provider upon admission and discharge and send a copy of the discharge summary to the physician’s office
- Discuss issues concerning patient management with fellow colleagues personally and in a professional manner. Do not write inflammatory or disparaging remarks about colleagues in the chart.
- Notify the appropriate personnel including hospital paging operators immediately about any call schedule changes

Confidentiality:

- All residents and staff must comply with federal HIPPA guidelines. GME requires all housestaff to complete an online course documenting knowledge of the policy.
- Respect patient privacy at all times. Avoid using patients’ names and personal information in public places. Shred all documents with personal information, including patient census lists.

Honesty:

- All information written in the chart must be accurate and true. Any medical errors or adverse patient outcomes must be documented honestly and disclosed to the patient and/or family.
- Honesty must be used when taking any program-related examination or course.
- Never document conference attendance for another houseofficer.
- Never lie about being sick.
- Falsification of a document and/or cheating on an examination are considered gross misconduct and are reasons for immediate dismissal.

Appearance:

- Project a professional, confident, and caring image.
- Be well-groomed, professionally attired, and practice good hygiene.

Dedication:

- Possess a sound work ethic
- Judiciously use the back-up call system
- Follow a diligent reading regimen
- Ensure proper follow-up of inpatient and outpatients
- Develop a good working relationships with colleagues and consultants
- Teach fellow residents and medical students
- Comply with the 80 hour work week and 30 hour continuous duty rule
- Always be on time.
- Promptly respond to all pages.

Respect :

- For all hospital and UT employees regardless of position
- For all patients and their families
- Respond sensitively to patients' and co-workers culture, age, gender, and disabilities

EVALUATION OF HOUSE OFFICERS

The resident's daily work will be observed by the attending, chief resident, supervising resident (for interns), and the program director. The daily evaluation will concern itself with knowledge and procedural skills, including choice of diagnostic studies, formulation of a differential diagnosis, and development of plans for short and long term management. House officers should be able to reference current articles and texts in support of their clinical decisions and demonstrate a broad knowledge base. Residents will be evaluated specifically on patient care, medical knowledge, practice-based learning improvement, interpersonal and communication skills, professionalism, system-based learning, overall clinical competence and a chart review audit. The house officer's teaching skills will also be evaluated. Specific methods of evaluation include:

- Mini-CEX: During the PGY-1 year, all categorical, primary care, medicine-pediatrics and medicine-neurology house officers will perform five abbreviated parts of the history and physical examination and subsequent patient encounter under the observation of an attending physician, senior resident, or fellow. These will be done in different venues, i.e., ward, ED, MICU, clinic, etc. These should be documented in the provided booklet and must be turned in to complete the intern year.
- In-training examination: There is a yearly in-training examination in October to aid the residents in assessing their knowledge. Preliminary interns are exempt from the exam. Residents scoring below the 34th percentile will be required to attend Med Study with 75% attendance and 75% scoring on the pretest quizzes. Although the results of this test are not used for decisions concerning promotion, this examination should be taken seriously. The in-training examination has been shown to be predictive of ultimate performance on the ABIM certifying examination.
- The curriculum always requires an end of month global evaluation by the attending physician. Many rotations provide end-of-rotation tests. Other evaluation methodology includes 360 degree evaluations (peers, nurses, patients, etc.), Blackboard testing (for sputum gram stains, vaginal preps, urinalyses, EKGs, CXRs, critical reading skills, blood smears), ACLS certification, and procedure logs.
- Residents have assigned advisors to aid them with their progress quarterly and inform them of any weaknesses. Residents may change their faculty advisor by asking another faculty member to be their advisor. If the faculty member agrees to take on the responsibility of being an advisor, the resident will then need to notify the program director. Faculty advisors also meet quarterly as the Faculty Advisor Committee to discuss the progress of all residents in the program and provide career counseling.
- The house officer will also have the opportunity to evaluate the attending physicians monthly and annually. These evaluations are valued, extensively reviewed, and aid in faculty counseling and promotion. They should be entered via the New Innovations computerized system and go only to the program office. Once a year these evaluations are aggregated and used for feedback with complete preservation of resident anonymity.
- There will be a semi-annual evaluation of each resident by the outpatient clinic attending physicians.
- There will be two semi-annual evaluations for housestaff by the Program Director or his designee. The end-of-year evaluation must be summative, written, and address the competencies.

DISCIPLINARY ACTION

- Residents who are perceived to be having serious academic or other program-related difficulties will be referred to the Clinical Competence Committee (CCC) by the program director. The CCC will review the resident's record and allow the resident to appear before the committee, if the resident desires, before giving recommendations to the program director. The final decisions relating to the resident's progress in the program are made by the program director.
- Resident's files are considered to be confidential and can only be reviewed by others on a "need to know basis." Approval for access to files must be obtained from the program director.
- Residents at The University of Tennessee are guaranteed disciplinary and academic due process. The UT GME Residency Requirements and Procedure for Academic Review can be found in this document as Attachment 1.

EVALUATION AND IMPROVEMENT OF THE TRAINING PROGRAM

The Internal Medicine Program is committed to constant improvement through resident input. Several committees currently exist to guide the evolution of the program and are listed below.

- **Resident Executive Committee:** This committee helps the program director to identify problems in the residency program and to help formulate solutions to them. It meets monthly and is comprised of 2 internal medicine representatives from each class (1 categorical and 1 primary care), 1 medicine/pediatric resident for each year of training, 1 preliminary intern, 1 medicine-neuro resident, the Chief Residents, the Medicine Service Chiefs, and the Program Director. These committee members are elected by the housestaff at the start of each academic year.
- **Curriculum and Subspecialty Program Directors' Committee:** This committee plays a key role in curriculum development and implementation and in monitoring the subspecialties. It meets quarterly and is comprised of the Chief Residents, resident and fellow representatives, Fellowship Program Directors, and the Program Director.
- **Program Directors Committee:** This committee conducts the annual review of the program as well as monitors RRC compliance. It meets at least quarterly and consists of the Program Director, Associate Program Directors, Chief Residents, and a resident representative.
- **Evaluation of Training Program:** Residents are expected to fill out monthly and year-end evaluations of the faculty and training program. This information is vital to efforts to improve the training experience for residents.

BACKUP CALL

Each month, residents on electives will be assigned 2-4 backup calls. The backup resident must be available to report for duty in the event another resident is unable to take a scheduled call due to illness, family emergency, etc. The backup resident must be reachable by pager or cell phone and be able to arrive at the hospital within one hour of receiving notification from the chief resident. The following are general guidelines:

- A resident will not be assigned to backup call if that resident is on call, pre-call or post-call. Occasionally the resident may be placed on backup call 2 days from a scheduled call.
- A resident may not schedule moonlighting or sunlighting responsibilities while scheduled for backup call.
- All utilization of the backup resident will be done via the Chief Resident. Housestaff are not permitted to ask the backup resident to take a scheduled call.
- All utilization of the backup call system will require "repayment" of the call to the backup resident if that person wishes to be repayed. The scheduled resident can take an existing call from the backup resident or ask the chief residents to incorporate the payback in an upcoming schedule.
- Residents and interns on Wards, ED, ICU, or away electives will not be considered for backup call. The exception to this is the CICU service at Methodist, which has elective call with backup for the intern. Residents rotating at the CICU at Methodist have ICU call without backup call.
- Residents are allowed to trade calls as long as the trade will not violate RRC duty hour rules or affect continuity clinics. The chief residents must be notified of and approve the change so it can be updated on the schedule. Residents are responsible for notifying hospital operators of any changes to the call schedule.

CHANGE OVER DAYS

- PGY-1s change services on the first of the month. The exception to this is on January 4th when all housestaff return from the holiday schedule and begin the new year.
- All PGY-2, 3 & 4 residents change services on the 4th of each month with the exception of July 1st when all housestaff and attendings start the new academic year.
- Attendings always change the first day of each month
- Housestaff are not allowed to take days off on change-over days.

DUTY HOUR RESTRICTIONS, VACATION, AND OTHER ABSENCES

The internal medicine residency program adheres strictly to the RRC guidelines. They are summarized below and the entire policy can be viewed online at www.acgme.org under resident duty hours.

- The program will assure each housestaff officer has at least one 24-hour period away from the hospital averaged over a four week period for a minimum of four days off per four weeks. If a resident has consecutive ward months or consecutive ICU and ward months then he or she should receive **five** days off in the second month.
- The resident's duty hours will be limited to 80 hours per week averaged over a four week period. Residents may not be on duty more than 30 continuous hours and must have at least 10 hours off between

shifts. Post-overnight call residents must leave the hospital premises promptly at 1 pm or earlier if they started the previous day before 7 a.m. Teamwork is essential in order to comply with the RRC guidelines.

- Following an overnight call, housestaff must not care for any new inpatients, but can participate in the continuity clinic.
- The ward team should work together in assigning days off for the month. This should be done on the first day of the rotation to assure that all team members get the required number of days off. Any problems with arranging adequate numbers of days off should be communicated to the Chief Medicine Resident. Days off should be avoided on switch days
- Interns should cover for each other on their days off. The resident may offer to be the primary provider if patient volume or complexity dictates since interns may not round on more than 12 patients. The resident is generally expected to cover the junior intern's patients but may assign their care to another intern at his discretion.
- Housestaff on consult services and other electives are off on weekends.
- Days off are built into the ED schedules.
- Hours spent moonlighting at any of our training facilities must be counted toward the 80-hour work week.

Vacation:

- Vacations are allowed only during elective/selective rotations.
- A holiday schedule is constructed so that all housestaff will receive 6 days off during the holiday period, either Dec 23-Dec 28 or Dec 29-Jan 3.
- Each PGY1 receives two weeks of vacation and the last week of June as unpaid leave.
- Each PGY 2, 3, and 4 receives three weeks of vacation.
- Medicine-Pediatrics PGY1s receive 1 week of vacation during the Medicine block and 1 week of vacation during the Pediatrics block in addition to the unpaid leave the last week of June. Med-Peds PGY2 & PGY4 residents have 1 week of vacation during the Medicine block and 2 weeks during the Pediatrics block. Med-Peds PGY3 residents have 2 weeks of vacation during the Medicine block and 1 week during the Pediatrics block.
- No vacations may be taken between December 4 and January 3 to allow construction of the holiday schedule. Vacations in the last week of June for PGY 2's, 3's, and 4's will be subject to approval (i.e. proven need to move during that time period).
- A vacation is considered 5 working days. If the 5 days are taken as Monday-Friday, then surrounding weekends will also generally be granted for a total of 9 days.
- Any unusual vacation requests will require program director approval. No vacation greater than 3 weeks in duration will be granted, including those that entail foreign travel. Vacations of 2 weeks or more duration must be taken during back to back elective months, with part of the vacation occurring at the end of one elective and the remainder at the start of the next elective. Any other arrangements must be approved by the program director. Remember that you must have 10 working days of a rotation to receive credit. If foreign travel is anticipated, it is the resident's responsibility to have complied with all visa restrictions and rules. Questions concerning foreign travel by international medical graduates must be resolved and answered prior to leaving this country. International graduates who are considering foreign travel must see Ms. Mary Ann Watson, the Assistant Dean for Graduate Medical Education prior to making travel plans.
- For those who take extended vacations it is expected that he or she returns exactly on the planned return date. For those who extend their vacation, an additional night call will be assigned for each day late with a minimum of two extra night calls plus a week of back-up call.
- For those residents who must renew their visa status, this should be accomplished during planned vacations. Additional time off or educational leave will not be granted to accomplish visa renewal.
- Vacation requests must be submitted when requested by the chief residents, generally 2 to 3 months prior to the month for which vacation is requested. Requests should be submitted online through the amion.com website. Late requests may be considered but are not guaranteed. Given the size of our program, changes to the call schedule are often difficult to arrange and may negatively impact your colleagues. Once the monthly call schedule is released, changes will only be made to correct errors made by the chief residents. Residents are responsible for rearranging their call schedule by trading with colleagues if needed, except in emergencies when the backup call system is utilized. If a resident changes a previously scheduled vacation, he/she is responsible for finding coverage of any assigned calls and any uncancelled clinics (since clinic requires a 90 day cancellation notice). The chief residents must be notified immediately of any changes to the call schedule, and all changes are subject to approval. The chief residents will make

every effort to grant scheduling requests but rarely the number of vacations during a particular week or month may have to be limited.

- House officers must notify their continuity clinics of any planned time off at least **12 weeks prior to the planned vacation**. Otherwise, the housestaff officer must attend his/her continuity of care clinic during the vacation week or find coverage.
- Note that scheduled vacations and requests not to be on call for specified days do have an impact on the generation of a call schedule. If your call schedule seems to be unusual or unfair, the most likely explanation is that the chief medicine residents have attempted to accommodate a large number of schedule requests. Therefore you should limit the number of requests that you have and prioritize those that are of significant importance to you. We will endeavor to have the monthly schedule completed early enough so that you can make any necessary plans.
- Residents should verify the approval of their vacation requests prior to making any non-refundable purchases such as airline tickets. Do not purchase airline tickets for the mid-year holidays until the holiday schedule is completed.
- Time away from the program that involves health care delivery to an underserved population will generally count as an elective academic credit, not vacation, but must be approved in advance by the program director.

Educational leave:

In order to encourage scholarship, up to five days of educational leave (per three years) is available to all interns and residents during the course of the residency. This leave must be approved by the program director and is generally limited to elective months. For unapproved requests or requests that extend beyond the allowable days, the resident may use vacation days. The program encourages resident presentations at state, regional, and national meetings. Days spent at such a conference do not count as leave, but travel days count as days off.

Sick leave / personal leave:

All residents are allowed 21 days throughout each year for legitimate illness (brief or under the care of a physician) or illness/death in close family members. Periods of time longer than this may be covered under the Family Leave Act and are handled on a case by case basis. While leave under these circumstances may cause no loss in standing, it may necessitate additional time to satisfy completion of the minimum months required by the resident's training program. Remember that despite illnesses or family emergencies, the care of our patients does not disappear. The back - up call system will be used to provide continuity of care to our patients. Please work closely with the chief residents upon your return to determine the impact of any obligations created by your absence. It may be necessary to repay the call to those who assisted the resident while he/she was taking leave.

Time off for interviews:

Although it is recognized that days off for interviewing for fellowship training or securing employment after your residency may be necessary, these should be kept to a minimum. All requests for days off for interviewing must be approved by the Program Director. Up to 7 days per calendar year may be used for interviewing; vacation days may be used if the limit is exceeded. Interview days should be scheduled during ward or intensive care months only as a last resort.

Maternity & Paternity Leave

- For female residents within the program, 4 weeks of maternity leave are allowed. If time is needed beyond this amount, available vacation may be used. Pay during maternity leave is based on sick (21 days) and annual leave (2-3 weeks depending on the PG year). Any days over this will be considered leave without pay. The resident may take additional time as unpaid leave as per the Family Leave Act. This will not result in a loss of position; however, periods of leave extending beyond maternity and vacation days may necessitate additional time to complete the minimum requirements of the individual training program.
- For male residents of the program, 7 days of paternity leave are allowed. If more time is needed, vacation time may be used. The resident may then take unpaid leave if additional time is needed. This will not result in a loss of position; however, periods of leave extending beyond paternity and vacation days may necessitate additional time to complete of the minimum requirements of the individual training program.

Maximum Leave Time:

The American Board of Internal Medicine mandates a maximum of 13 weeks for all types of Leave of Absences (LOA). This includes all types of vacation and leave during a 36-month internal medicine residency. Leave in excess of 13 weeks will need to be made up with additional training time for residents to be eligible to take the certifying examination in Internal Medicine. The ABIM discourages more than one month of leave per year. Any additional ("make-up") time must be completed by August 31 of your final year to take the certifying examination on schedule. The policy for combined residencies has not been decided by ABIM.

MOONLIGHTING / SUNLIGHTING POLICY

- Any resident who wishes to moonlight/sunlight must obtain written approval from the Program Director. A request for moonlighting form is located on the internal medicine website <http://www.utmem.edu/Internal>. Moonlighting in program training facilities must never cause a resident to work more than 80 hours per week.
- Moonlighting/sunlighting is not allowed during medicine wards or any ICU months.
- No moonlighting/sunlighting pre-call, post-call or when on back-up call.
- During ER months, any moonlighting/sunlighting must be separated by at least 10 hours from any ER shift.
- Moonlighting/sunlighting shall not occur more frequently than twice per week and for a maximum duration of 24 hours per week.
- Moonlighting/sunlighting cannot interfere with scheduled afternoon or weekend rounds.
- PGY-1 residents may not moonlight/sunlight.
- Residents required to attend MedStudy may not moonlight.
- No moonlighting/sunlighting during sick leave or maternity leave. No sunlighting during leaves of absence.
- Residents who plan to moonlight outside of the system must notify the program director of this intention in writing. They will then need to notify the program director of the location, type and schedule of moonlighting by the first of each month.
- All moonlighting/sunlighting by residents is ultimately subject to the program director's approval.
- Permission to moonlight/sunlight can be revoked if this activity interferes with a resident's ability to fulfill his responsibilities to the training program, or interferes with his ability to educate himself, or if the resident is found to be in violation of this moonlighting/sunlighting policy.
- Moonlighting hours combined with residency work hours must not exceed 80 hours per week when averaged over a 4 week period.

CHARTING

The medical record stands alone as the sole authority and proof that you examined, evaluated and treated a patient. In today's litigious climate complete and legible charting is vital. The phrase "if you did not chart it, it did not happen" is often used to demonstrate the importance of accurate charting; nothing speaks louder in court than the omission of important information from the chart.

Legibility:

All orders and notes must be written legibly and clearly with attention to grammar and spelling. Ballpoint pens with black ink are preferred. Printing is encouraged when script handwriting is illegible. When an error is made in the chart, a single line is drawn through the incorrect information and then initialed and dated. Correct information, if entered, should have date, time, and signature.

Dating and Timing:

Any entry into any chart must be dated and timed according to the actual time of writing, not observance. This will clearly demonstrate the time at which you addressed a problem. All orders must also be timed and dated. Both notes and orders should be signed with "MD" or "DO" after your name. Add your pager number after your name. Some hospitals also require a physician number after signed orders.

ORDERS

Orders must be written on the appropriate order sheet and must be timed and dated. Orders should be as clear and specific as possible. All orders must be signed and have a legible name and pager number written below the signature. Antibiotic orders should include the frequency of administration and when the first dose should be given. Any "STAT" order written should be conveyed to the nurse verbally. Do not use unapproved abbreviations including "U", "qod," "qd," or "MSO4." When writing numbers, use a "0" before a decimal but never use them after a decimal point.

First call order:

All admission orders should have a "first call" order. This is to be written as "First call Dr. John Doe (576-1234)". This order will tell the nurses who to call first for questions. Interns or junior interns will normally be the "first call" doctor except where residents are the primary doctor. It is also advisable to include both the supervising resident's and attending's names as alternative call persons on the admission orders. In addition, it is helpful to those viewing the chart if the physician records his/her pager number after all signatures/orders.

TRANSFERS

All transfers between floors, units, and teams require a full set of orders and a transfer note. Transfers from the floor to the ICU should have orders and transfer note written by the ward intern or resident. Transfers from ICU to the floor must have orders and a transfer note written by the ICU intern or resident. Additionally, **an ICU attending or fellow** must document in the chart that the patient's condition is stable for transfer to the floor. The following criteria should be followed when transferring patients out of the ICU. Since patients are transferred from the ICU to general medicine teams at times when there are no "floor" beds available, physicians should always re-apply the transfer criteria to patients prior to the actual physical transfer from the unit.

Respiratory

1. Mechanical ventilatory support is no longer needed (excluding CPAP).
2. The patient requires <50% oxygen (O2 sat >90% on 50% oxygen).
3. The patient requires physiotherapy to clear secretions no more often than every 3-4 hours.
4. It is unlikely that the patient could have a sudden deterioration of respiratory function requiring immediate endotracheal intubation and mechanical ventilation. pH and pCO2 tension are stable.

Circulatory

1. No need for vasoactive drugs to support cardiac output or arterial blood pressure.
2. The circulation is stable except for required modest volume replacement (pulse rate between 50-110).
3. There are no signs of failing tissue perfusion, such as tachycardia, new onset confusion, cool cyanosed extremities, poor capillary refill, metabolic acidosis, increased blood lactate, and poor urine output (<0.5 ml/kg/h).
4. There is no need for intensive or high-dependency care.

Neurologic

1. The airway and protective reflexes are neurologically functioning, and invasive neurologic monitoring is not required or the patient has a tracheostomy.
2. There is a stable Glasgow coma score, and seizures are controlled.

Renal

1. There is no need for acute hemodialysis, hemofiltration, or hemodiafiltration.

MEDICAL RECORDS

One of the major components of "quality assurance" is timely completion of the medical record; specifically, an appropriately detailed discharge summary dictated on the day of the patient's discharge. At the time of discharge the house officer should make a quick review of the chart and co-sign any verbal orders, consults, or student notes. The summary should be dictated on the day of the patient's discharge. If this is impossible, the dictation must be done within two weeks of discharge. If the summary has not been completed within two weeks, it is deemed delinquent and disciplinary action may be taken against the assigned resident. Extra guest call may be assigned during selective/elective months and documentation of poor professional behavior may be filed in the house officer's permanent GME record. Additionally, the resident may be suspended from clinical duties until all charts are completed, which may result in an extension of training time. Failure to complete medical records within the allotted time has an adverse impact not only on reimbursement for physician services but also on patient care.

MED:

1. The patient chart will remain on the floor until 8am the morning after discharge. It is sent to the Medical Record Department for processing. The chart is assigned to an attending physician who will ask housestaff to dictate using his dictation number. Is this still correct??
2. The medical records department of the MED is located on the first floor of the Chandler building. Each house officer has a file where incomplete charts will be temporarily kept.
3. Housestaff will receive email notification of chart deficiencies.
4. Medical record personnel are available twenty-four hours a day. If you should need assistance on weekdays call 545-8451 or 545-7549. After 4:30 PM and on weekends call 545-7585.

MED Discharge Summaries:

To facilitate the transfer of information, medical records should be as complete and concise as possible. A good discharge summary should read in a logical progression without dwelling on useless information. For example, if the review of systems is normal, "review of systems negative" should be documented rather than listing the entire review of systems. Speak clearly, keep your sentences short, and learn to follow an outline. The transcriptionist will find it helpful if you spell all names and difficult words and avoid abbreviations. Finally, be sure to document that the discharge summary has been completed and sign and date the gold face sheet. A general outline for discharge summaries is provided below:

1. Physician's name (please spell). Also include the name of the attending physician
2. Patient's name and medical record number
3. Admission date and discharge date
4. Service that the patient was admitted to (i.e. Medicine team ____)
5. Discharge diagnosis: list principle diagnosis followed by secondary diagnoses
6. Presenting history and physical (pertinent points only)
7. Significant laboratory and x-ray results
8. Hospital course
9. Procedures (i.e. echocardiograms, ETT, radiological procedures, etc.)
10. Discharge medications, diet, activity, and special instructions. Be sure the dictated medications perfectly match those listed on the medication reconciliation form. Include all medications to be taken by the patient.
11. Planned follow-up appointments (list place, date, and time if known) with recommended laboratory testing
12. Copy to primary care provider (list address if available)

VAMC:

The medical records are kept on the floor until the dictations are completed. Each house officer has a file where incomplete charts will be temporarily kept.

VAMC Discharge Summary:

Discharge summaries must be dictated prior to the patient's actual discharge. All ward clerks are instructed not to initiate the processing of discharge orders without confirmation that the dictation summary has occurred. Discharge summaries may be dictated up to 48 hours before the time of anticipated discharge or transfer. At the time of discharge, the house officer should make a quick review of the chart to co-sign verbal orders, consults, and student notes.

*Note: VA policy requires that a military history be included in admission information as well as discharge summaries.

NEED TO INCLUDE MU POLICY HERE

YEARLY SCHEDULE (TEMPLATE) DOES THIS NEED TO BE IN H-O MANUAL

CATEGORICAL	PGY-1	PGY-2	PGY-3
--------------------	--------------	--------------	--------------

Medicine Wards	7	4	3
Emergency Medicine	1	0-1	0-1
Medicine ICU	1	1	0
CICU/Cardiology*	0-1	1-2	1-2
S/Electives	2-3	4	7-8

*To include total of 2 months cardiology and 2 months CICU

PRIMARY CARE/ WOMEN'S HEALTH	PGY-1	PGY-2	PGY-3
Medicine Wards	6	4	3
Emergency Medicine*	1	1	0
Medicine ICU	1	1	0
CICU/Cardiology	0-1	1	1
S/Electives	1-2	3	5
Ambulatory	2	2	3

MED/PEDS	PGY-1	PGY-2	PGY-3	PGY-4
Medicine Wards	3	2	2	1
Emergency Medicine	1	0	1	0
Medicine ICU	1	1	0	0
CICU	0	0	1	0
S/Electives	1	2	2	4
Ambulatory	0	1	0	1

MED/NEURO	PGY-1	PGY-2	PGY-3	PGY-4	PGY-5
Medicine Wards	6	2	2	1	1
Emergency Medicine	1	1	0	1	0
Medicine ICU	1	0	1	0	0
CICU	0	1	0	0	0
S/Electives	4	2	3	1	2

PRELIMINARY	PGY-1
Medicine Ward	5-6
Emergency Medicine	1-2
Medicine ICU	1
CICU	0-1
Elective/Selective	3-4

* Primary Care/Women's Health Track residents may substitute a Baptist Minor Med rotation as one of their ER required months.

DAILY WARD SCHEDULE

- The routine workday hours (excluding call days) are 7:00 am to 4:30 pm on weekdays and 7:00 am to 10:00 am on weekends. All housestaff staying overnight for call must leave the hospital premises 30 hours after their shift began without exception. Any remaining work should be checked out to other housestaff who are not post-call.

- Usual workday for interns:
 - 7:15 AM-8AM Morning Report (MED Ward Resident will be at Intake Rounds from 7:00 am until 7:15 am)
 - 8:00 AM – 10:00 AM Morning Work Rounds
 - 10:00 AM - 12:00 PM Attending Rounds
 - 12:15 PM - 1:00 PM Noon conference
 - 1:15 PM – 4:00 PM Ward work
 - 4:30 PM Sign-out rounds

- All call schedules are available online at www.amion.com.

SIGN-OUT

Housestaff are required to give thorough sign-out to the cross-cover team. A copy of the team's list must be provided and should include pertinent information regarding the patient's diagnosis, active problems, anticipated problems, pending labwork and code status. While cross-cover may need to follow-up some lab results, it is inappropriate to ask them to perform procedures or follow-up on post-procedure x-rays, EKGs, or ABGs.

MED WARDS

There are 4 teaching teams (Medicine A, B, C, and D) at the MED with each team consisting of an attending physician, a resident, 2 interns and medical students. A fifth team ("E") may operate also as a partial ward service which takes patients from NF.

"Long call" will be every fourth day from 7am to **5pm**. From 5 p.m. until 7 p.m., the team may also take admissions assuming that the cap is not exceeded and the resident can leave the hospital by 9 p.m. However, from 5 p.m. until 7 p.m., the admitting resident may defer the admission to the ED intern/resident (H and P, admit orders) and MOD. From 7pm to 7am, admissions will be the responsibility of the night float team consisting of a night float resident and 2 night float interns.

Patient caps for both ward residents and night float residents during each respective admitting period will be 10 patients with an intern cap of 5 patients per 24 hour period. Patients exceeding this cap will be evaluated by the Med ED intern with the assistance of the MOD or the MOD alone if the ED intern is unavailable.

Turnover/redistribution of night float patients and overcap patients will occur at 7:00 am in the 6th floor Adams conference room on weekdays and in the resident lounge on the 5th floor of Adams building on weekends. All ward residents (or designated team intern if the resident is off), the night float team, and a chief resident are expected to attend.

Limitations on Admissions and Patient Census:

1. Admissions to interns are capped at 5 new admissions during an admitting day and 8 new admissions during a 48-hour period. Residents are capped at 10 new admissions per admitting day and 16 new admissions in a 48-hour period. Further admissions will be the responsibility of the MOD.
2. Residents are responsible for the ongoing care of no more than 24 patients at a time, including the intern's patients being supervised. If the service has only one intern, the resident is capped at 16 patients and the intern at 12. The chief resident should be contacted immediately when the census threatens to exceed 24 patients.
3. Interns are responsible for the ongoing care of no more than 12 patients at a time.

Readmissions:

1. Any patient readmitted to the medicine service within the same calendar month will be transferred back to the intern who cared for the patient previously. This transfer should occur the day following admission including weekends and if the intern originally following the patient has the day off.
2. It will be the responsibility of the transferring resident to make the original team aware of the transfer. Readmissions transferred between two medicine services will be counted as new admissions.
3. Patients transferred to the ICU from a medicine service, then transferred back to a medicine service will also count as new admissions.

ICU transfers:

Patients will be transferred from the ICU to General Medicine services from 8:00 AM until 1:00 PM. These transfers will count as new admissions. The ICU must hold any patient transfers after 1:00 p.m. until 8:00 a.m. the following day.

MUH WARDS - need to change for nightfloat.

1. The three ward teams at MUH are staffed by full-time clinical faculty hospitalists and are designated red, white, and blue.
2. Morning report occurs between 7:30 and 8:30 a.m. daily at MUH and is mandatory for all internal medicine housestaff rotating at Methodist.
3. The call day starts at 7 a.m. every day and concludes at 7 a.m. the following day. A single team will be on call for 24 hours, but a second team will have short call each day.
4. Each team (Red, White, Blue) consists of one to two residents and two to three interns. Though a team takes 24 hour call every three nights, all team members will not be taking call. Ward call for residents and interns will average five to six times a month.
5. The overnight call team consists of two residents and three interns.
6. MUH is divided into six areas. Interns will cross-cover these areas not only for the ward service patients but also for emergency situations occurring with private patients.
7. Intern and resident call assignments:
 - a. Admitting intern - covers East and Thomas wings for cross-cover and death pronouncements.
 - b. ICU intern - covers ICUs, Sherad wing, and Crews wing
 - c. Third intern - covers Tower wing, cross-cover and death pronouncements, and re-admissions to other teams
 - d. Service Resident - takes service resident admissions and assists with cross-cover.
 - e. ICU Resident - takes ICU admissions, readmissions, and assists with cross-cover.
8. At 7 a.m. daily the team on call from the previous evening will hand over code pagers and floor pagers.
9. Beginning at 7 a.m., the on-call team will be responsible for answering all in-hospital codes called Emery Houses.
10. Patient caps are strictly enforced for all housestaff.
11. Residents and interns who will be taking guest calls at MUH starting at 4:30 p.m. need to page their fellow interns and residents at 7 a.m. so someone will take care of codes in their absence.
12. Guest call housestaff must report to medical education at 4:30 p.m. to receive their code pagers and attend check-out rounds.
13. When called upon for emergent care of a patient belonging to a private attending, the house officer must notify that attending about his evaluation. Chart all communications with that physician.
14. Document names of dying patients on service medicine in the Death Log which is located in the chief resident's office.
15. Teams are required to write names of admitted patients in Medical Educations by 7am daily.

VAMC WARDS

1. There are 3 teaching teams (Medicine A, B, C). Each team consists of an attending physician, two residents, three interns, and medical students.
2. The call sequence will be LONG (max 10 admissions) → OFF (no admissions) → SHORT (max 6 admissions) LONG
3. Long call will be q3 for the team, q6 for residents and q9 for interns.
4. On long call one resident and one intern will stay overnight to do admissions. The intern staying overnight will also be responsible for cross cover for service medicine patients.
5. A second intern (intern #2) from the same team will stay till 7pm and take initial admissions and do cross cover till 7pm. This intern will leave the hospital at not later than 7pm so that he/she can be back at 7am.
6. There will be nightfloat intern Sunday – Thursday 7pm – 7am, who will come and relieve intern #2 at 7pm. Both of these interns will share a combined cap of 5 admissions.
7. The post long call resident and intern will leave at 1pm post call (or earlier if they have been in the hospital for 30 hours) after checking out their patient to their co-resident and co-interns to assure continuity of care.
8. It will be the ward resident's responsibility to plan out days off for the team members, and it should be done within the first two days of the residents starting their rotation. Residents should honor the intern's wishes; however, if they feel that it is not possible to accommodate specific requests they can ask the interns to choose alternate days off.
9. The two ward residents should not take off on the same day and they should try to avoid taking a day off when their co-resident is in clinic. Resident days off must be approved by attendings.
10. Unless approved by the residents, the 2 interns should not take a day off on the same day and preferably not on days when co-interns are in clinic.
11. One way of deciding days off would be that if the team is on call then the resident and intern who are not on overnight call (or the intern not staying till 9pm) can take that day off, since the rest of the team members will be in the hospital for the whole day. This can minimize patient load on individual residents.
12. Short call will be from 7am – 3pm weekdays, 7am – 12noon weekends.
13. It is up to the ward residents on how they want to split patient admissions on short call, but the recommendation would be that both the ward residents take admissions together so that both of them can get out early on short call days. The residents can decide (based on the number of patients per intern) on how to assign patients to interns.
14. Over caps will be done by the MOD. Initially the over caps will go to the post-call team.

**The chief residents and program director reserve the right to alter this system as needed based on housestaff officer patient volume and RRC requirements.

MICU SERVICES - POLICIES AND EXPECTATIONS

There are three separate Medicine Intensive Care services at the MED, VAMC, and Methodist.

Each MICU service will consist of an attending physician, pulmonary/critical care fellow, internal medicine resident and one to three interns. Between the hours of 8:00am and 4:30pm M-F, admissions to the MICU will be worked up and admitted by the MICU service. On the weekends, the MICU team is responsible for admissions until 12 noon or until the ICU team has completed all work and has checked out, whichever happens first. MICU residents and interns are on-call every fourth night at all hospitals. The MICU intern is primarily responsible for cross-cover but should have a low threshold for involving the resident.

The critical care fellow should be notified immediately of all admissions to provide assistance.

MICU LIMITATIONS ON ADMISSIONS AND PATIENT CENSUS

Admissions caps are the same as outlined for ward services. As per RRC guidelines, interns are capped at 5 new admissions during an admitting day and 8 new admissions during a 48-hour period. Residents are capped at 10 new admissions per admitting day and 16 new admissions in a 48-hour period, including the intern's patients being supervised. However, these caps are generally not approached in the ICU setting. No intern should follow more than seven patients at the MED and VA and six at Methodist. The resident's supervisory cap will vary depending on the number of interns and students on the service. The resident is not allowed to be the primary provider for more than 3-4 patients. The most important RRC guidelines observed are the maximum 80-hour work week, the 30-hour work period, and the no new patient rule after 24 hours.

MEDICINE CONSULTS - POLICIES AND RECOMMENDATIONS

1. Medicine Consult services exist at the MED and Methodist. The VA has an independent consult service but occasionally the general medicine ward team may be asked to evaluate and follow a consultation at night or on weekends.
2. The consult resident and/or attending should be directly notified by a physician from the requesting service. From a professionalism and patient care standpoint, it is less desirable to be notified by a ward secretary.
3. The physician requesting the consultation should define the urgency of the consult. When reasonable, a consult request received in the evening may be deferred to the Medicine Consult Team on the following day. However, if the consult is urgent or emergent, it must be carried out by the appropriate house officer and staffed over the phone immediately.
4. After hours consults at the MED are performed by the MOD from 4:30 pm-7pm and the Night Float resident from 7pm-7am. If the Night Float resident is busy with admissions and does not have time to see the consult, he/she may ask the MOD to do the consult.
5. After hours consults at Methodist are the responsibility of the MOD.
6. At VAMC, emergent after hours consults are seen by the NF resident. Such consults should be transferred to either the VA staff or to the medicine ward team the following day.
7. Attending coverage is expected by the following calendar day for all consults completed by a medicine resident. Emergency cases must be staffed promptly by telephone or in person by the attending. Attendings on call must be available at any hour and on weekends.
8. The primary reason for patient admission should dictate what service receives the admission. For example, a patient who suffers an acute MI, a syncopal episode, and a subsequent hip fracture should be admitted to the medicine/cardiology service with an orthopedic consultant. However, the same patient with a new hip fracture, HTN, and DM should be admitted to Ortho. The Medicine Consult Team can in general provide better patient care perioperatively than can the ward team.
9. Postoperatively if medical problems predominate and extend the admission, the surgical service may appropriately request a transfer to a medicine ward team. The consulting medicine resident may elect to either transfer the patient to a ward team or to the consult attending's service. Any controversy about patient transfers should be settled at the attending level.
10. Some surgical services prefer follow-up care even when there are no active medical problems requiring intervention. The consult service may elect to follow these patients on a M-W-F or M-Th basis, but this decision needs to be carefully outlined in the chart so the surgery service knows who to call if a problem appears on an off day. The expectation is that unless otherwise defined in the chart, the consult service will see every patient every day.
11. Some consultations are unnecessary and can be handled by telephone. While the surgery service has the right to insist upon a written consult, the Medicine Consult Team may suggest telephone consultation in the following situations: need for a Medplex or VA medicine appointment and need to resume usual medications.

SUBSPECIALTY SERVICES

The Department of Medicine offers selective and elective rotations as a part of the Internal Medicine curriculum. These rotations include all Internal Medicine subspecialties as well as the majority of other

medical specialties. Residents rotating on these services should confer with the attending physician on the service and with the curriculum on the website for specifics regarding rounds, conferences, subspecialty clinics, and recommended reading.

Attachment 1

**University of Tennessee Health Science Center
Graduate Medical Education Program**

Academic Appeal Process

Review Process for Disciplinary Actions

The University of Tennessee College of Medicine assures the resident the right to appeal any disciplinary action proposed by the residency program or institution. The Academic Appeal process is intended to provide a formal, structured review of the proposed disciplinary action and its cause(s). All appeals must be processed according to the following policies and procedures.

The resident has the right to obtain legal counsel at any level of the Academic Appeal process, but attorneys are not allowed at academic grievance hearings or at reviews. However, the University of Tennessee College of Medicine cannot compel participation in the Academic Appeal process by peers, medical staff, patients, or other witnesses, even if such is requested by a resident seeking review. Residents who have been dismissed will receive no remuneration during the review.

Residents may obtain review of a disciplinary action(s) by submitting a written request for review to the program director within (10) ten-business days. The following Academic Appeal procedures shall apply:

1. A written request for review must be submitted to the program director within ten (10) business days. If the program director is not the department chair, the resident may ask the chair to hear the grievance.
2. The review request must include: (a) all information, documents and materials the resident wants considered, and (b) the reason the resident believes dismissal is not warranted. The resident may submit the names of fact witnesses whom the chair has discretion to interview as a part of the review process.
3. The chair may appoint a designee or designate an advisory committee to review the decision. The committee's recommendation to the chair shall be non-binding.
4. On reaching a decision, the chair will notify the resident in writing. If the decision is adverse to the resident, the notice shall advise the resident of the right to review on the record. At the discretion of the Associate Dean for Graduate Medical Education, a hearing may be allowed if requested by the resident. The Associate Dean shall determine whether a hearing or review on the record is appropriate. Review on the record may include a face-to-face meeting with the resident and interviews with witnesses by the Associate Dean. The resident may waive department-level review and begin the review process at the Associate Dean's level.
5. A written request for review by the Associate Dean for GME must include: (a) any information the resident wants considered, and (b) any reason the resident feels dismissal is not warranted. The resident may submit the names of fact witnesses whom the Associate Dean has discretion to interview as a part of the review process. The request for review is made utilizing the procedures in items a or b outlined below:
 - a. Within ten (10) business days of notice of the department chair's decision, the resident shall submit a written request for review to the Associate Dean for GME; or
 - b. Within ten (10) business days of notice of dismissal, the resident shall submit a signed waiver of department-level review and a written request for review to the Associate Dean for GME.
6. Upon reaching a decision, the Associate Dean for GME will notify the resident in writing and advise the resident concerning the next level of institutional review.
7. The resident may obtain additional review on the record by the Dean of the College of Medicine by submitting a written request within five (5) business days after being advised of the outcome of the GME level of review.
8. Additional review may be obtained from the Vice President and Chief Operating Officer of the University of Tennessee Health Science Center by submitting a written request within five (5) business days after being advised of the outcome of the Dean's review.
9. The resident may obtain final review on the record by the President of the University of Tennessee System by submitting a written request within five (5) business days of receiving the Vice President and Chief Operating Officer's response.

Remediation Actions

Remediation actions are designed to identify and correct areas of marginal and/or unsatisfactory performance by a resident. These actions include Performance Alert and Review (PAR), Academic Deficiency & Remediation (ADR), repeat rotation, repeat academic year, and denial of certificate of completion. Each of these remediation actions are not forms of discipline and therefore not subject to the University of Tennessee Graduate Medical Education Academic Appeal process.

Performance Alert and Review (PAR)

The PAR is a tool for program directors to formally notify residents regarding areas of marginal/unsatisfactory performance noted by the faculty and or the program director. The PAR is designed to replace more traditional methods to document marginal performance such as letters of warning and/or counseling sessions. Performance alerts and reviews are not to be used as a substitute for the ongoing assessment and evaluation of residents during training. Instead, they should be used as the first notice to the resident that his or her current performance is marginal or unsatisfactory in any of the six ACGME competencies. To be most effective, a PAR should be initiated as soon as the faculty member identifies an area(s) of concern and the resident informed within 7-10 working days.

Any resident who receives an overall marginal or unsatisfactory evaluation for any rotation, semi-annual evaluation, or year of training should have one or more PARs on file documenting the performance concern(s).

Academic Deficiency & Remediation (ADR)

ADR is a remediation action used in situations where a resident fails to comply with the academic requirements established by the residency training program, University of Tennessee Graduate Medical Education, and/or participating institutions. Placement on ADR serves as an official notice to the resident of unsatisfactory performance. Typically the deficiencies are associated with one or more of the six ACGME competencies. However, this may also include disruptive physician behaviors not specifically addressed in the ACGME competencies.

Each residency program should establish written criteria and thresholds for placing residents on ADR. Examples include but are not limited to the following: poor academic performance as documented by unsatisfactory faculty evaluations, intramural examinations and /or written in-service examinations; failure to attend scheduled monthly departmental activities, clinical performance or surgical skills which are below those expected for the level of training as documented by written evaluations by the faculty, unprofessional or inappropriate actions, disruptive behavior, failure to complete medical records in a timely manner, and failure to maintain procedure or surgical logs in a timely manner. Residency program requiring their residents to achieve a minimum score on an annual written in-service examination must publish this requirement at the beginning of each academic year.

The program director is required to provide the resident with a letter notifying him or her of ADR status and the area(s) of unsatisfactory performance, measures to improve performance, and time frame for completion.

Repeat Academic Year

Repeating an academic year is a remediation action that may be used in limited situations such as: overall unsatisfactory performance during the entire academic year, overall unsatisfactory performance for at least 50% of rotations during the academic year, or failure to pass an annual written in-service examination. Each residency program is responsible for establishing specific written criteria for repeating an academic year. The resident will be notified of his/her requirement to repeat the academic year at least 6 weeks prior to the end of the academic year.

Denial of Certificate of Completion

A resident may be denied a certificate of completion of training as a result of overall unsatisfactory performance during the final academic year of residency training. This may include the entire year or overall unsatisfactory performance for at least 50% of rotations during final academic year. Additionally, some programs may deny a certificate of completion to a resident who fails to pass the annual written in-service examination during the final year of training. Each residency program is responsible for

establishing specific written criteria for denial of certificate of completion.

Residents denied a certificate of completion must be notified in writing of unsatisfactory performance by the program director at least 6 weeks prior to scheduled completion of program. In most situations, the resident should be notified of this pending action as soon as possible.

In certain situations, a resident denied a certificate of completion may be offered the option of repeating the academic year but only at the discretion of the program director.

Disciplinary Actions

Disciplinary actions are typically utilized for serious acts requiring immediate actions. These actions include suspension, probation, and dismissal. The residency program, University of Tennessee Graduate Medical Education, or the University of Tennessee Health Science Center are under no obligation to pursue remediation actions prior to recommending a disciplinary action. All disciplinary actions are subject to the University of Tennessee Graduate Medical Education Academic Appeal process. All disciplinary actions will become a permanent part of the resident training record.

Suspension

A resident may be suspended from all program activities and duties by his or her program director, department chair, the Associate Dean for Graduate Medical Education, or the Dean of the College of Medicine. Program suspension may be imposed for program-related conduct that is deemed to be grossly unprofessional, incompetent, erratic, potentially criminal, noncompliant with the University of Tennessee policies, procedures, and Code of Conduct, federal health care program requirements, UT Medical Group Corporate Compliance Agreement, or conduct threatening to the well-being of patients, other residents, faculty, staff, or the resident.

A decision involving program suspension of a resident must be reviewed within three (3) working days by the department chair (or designee) to determine if the resident may return to some or all program activities and duties and/or whether further action is warranted (including, but not limited to counseling, fitness for duty evaluation, referral to the AIRS program, probation, non-renewal of contract, or dismissal). Suspension may be with or without pay at the discretion of institutional officials.

Probation

Probation is a disciplinary action that constitutes notification to the resident that dismissal from the program can occur at any time during or at the conclusion of probationary period. In most cases, remedial actions including but not limited to ADR are utilized prior to placement on probation, however, a resident may be placed on probation without prior remediation actions based upon individual program policies. Probation is typically the final step before dismissal occurs. However, dismissal prior to the conclusion of a probationary period will occur if there is further deterioration in performance or additional deficiencies are identified. Additionally, dismissal prior to the end of the probationary period may occur if grounds for suspension or dismissal exist.

Each residency program is responsible for establishing written criteria and thresholds for placing residents on probation. Examples include but are not limited to the following: failure to complete the requirements of ADR, not performing at an adequate level of competence, unprofessional or unethical behavior, misconduct, disruptive behavior, or failure to fulfill the responsibilities of the program in which he/she is enrolled.

Dismissal

Residents may be dismissed for a variety of serious acts. The resident does not need to be on suspension or probation for this action to be taken. These acts include but are not limited to the following: serious acts of incompetence, impairment, unprofessional behavior, falsifying information or lying, or noncompliance.

Immediate dismissal will occur if the resident is listed as an excluded individual by any of the following:

- Department of Health and Human Services Office of the Inspector General's "List of Excluded Individuals/Entities", or
- General services Administration "List of Parties Excluded from Federal Procurement and Non-Procurement Programs"; or
- Convicted of a crime related to the provision of health care items or services for which one may be excluded under 42 USC 1320a-7(a)

Attachment 2

**STATEMENT ON -
UNIVERSITY EMPLOYEE PROTECTIONS AGAINST LIABILITY**

Issued by the Office of the Vice President and General Counsel -
The University of Tennessee

Definition of Employee –

For the purpose of this statement on University employee protections against liability, the term “employee” means any person who is employed in the service of The University of Tennessee and whose compensation is paid by the University through its payroll system.

State Law Claims –

State law provides that state employees, including employees of The University of Tennessee, have absolute immunity from liability for acts or omissions within the scope of their employment, unless the acts or omissions are willful, malicious, criminal, or done for personal gain. This immunity means that no state or federal court in Tennessee may enter a judgment against the personal assets of a University employee on state law claims arising out of acts or omissions by the employee unless (1) the acts or omissions were outside the scope of the employee’s employment or (2) the acts or omissions were willful, malicious, criminal, or done for personal gain. Types of state law claims to which this immunity applies include claims for personal injury (including professional malpractice), property loss or damage, and libel and slander (defamation). -

The immunity of state employees under Tennessee law has no mandatory effect in the courts of other states. Whether courts in other states will apply Tennessee’s immunity doctrine is entirely dependent on their willingness to do so as a matter of comity. Generally speaking, if a state has granted immunity to its own employees, the courts of that state will be inclined to recognize the immunity granted by another state.

Federal Law Claims –

The immunity of state employees under Tennessee law has no effect in state or federal court actions for violation of the federal constitution or federal statutes. The United States Supreme Court has ruled that states cannot immunize their employees against liability under federal law. Therefore, University employees are subject to personal liability for both compensatory and punitive damages in certain kinds of federal civil rights actions. The most common federal civil rights actions against state employees in their personal capacities are based on alleged violations of the free speech clause of the First Amendment and the equal protection clause (class-based discrimination) and due process clause of the Fourteenth Amendment.

Reimbursement of Judgments and Settlements –

In recognition of the fact that state employees may be subject to personal liability in some cases, state law provides that the State Board of Claims will reimburse state employees for actual damages, costs, and attorney fees, up to \$300,000 per plaintiff and \$1,000,000 per occurrence, awarded by judgment or settlement in any case in which the employee’s immunity is not sustained. This includes all federal law actions (in which the employee’s state law immunity has no effect) and any given state law action in which the employee’s immunity is not sustained. In its discretion, the Board of Claims may reimburse the employee for amounts beyond the limits stated in the statute. The Board, however, will make no reimbursement for punitive damages. -

Prior to any reimbursement, the Board must make an independent determination that the employee was acting within the scope of his or her employment. Even if the Board finds that the employee was acting within the scope of his or her employment, the Board may reduce the reimbursement for any circumstance it finds warranting a reduction (for example, failure of the employee to cooperate fully in defense of the litigation). In addition, the Board may deny reimbursement if the employee or counsel for the employee did not make reasonable efforts to defend the action or if the employee’s actions were grossly negligent, willful, malicious, criminal, or done for personal gain.

Representation in Civil Cases –

Office of the Vice President and General Counsel -

The Office of the Vice President and General Counsel represents the University and University employees sued in their official capacities for acts or omissions within the scope of their employment. In addition, the Attorney General for the State of Tennessee, pursuant to requirements of state law, designates the Office of the Vice President and General Counsel to represent a University employee in his or her personal capacity if the alleged acts or omissions were done within the scope of the employee's employment with the University and if there is no conflict between the positions of the University and the employee. Before undertaking representation of an employee in his or her personal capacity, the Office of the Vice President and General Counsel, in consultation with the Attorney General, will make an initial assessment of whether any allegations of willful, malicious, or criminal acts or omissions, or acts or omissions done for personal gain, are sufficiently well-founded to warrant declining representation of an employee in his or her personal capacity.

In addition, the Office of the Vice President and General Counsel may decline to represent an employee in his or her personal capacity if the employee has acted contrary to advice given by the office. –

Private Counsel –

If the Office of the Vice President and General Counsel, in consultation with the Attorney General, determines that it cannot represent a University employee in his or her personal capacity in a civil case for acts or omissions within the scope of the employee's employment, state law makes other provisions for representation, except for willful, malicious, or criminal acts or omissions and acts or omissions done for personal gain. The Attorney General has discretion to determine that representation will be provided by (1) attorneys appointed by the Attorney General or (2) by payment of reasonable compensation to private counsel approved by the Attorney General.

Representation in Criminal Cases –

State law prohibits the Vice President and General Counsel and the Attorney General from representing or providing representation for a University employee in a criminal action arising out of an act done in the scope of the employee's official duties.

If the criminal charge is dismissed with prejudice or if the employee is acquitted at trial or on appeal, the Attorney General will pay all reasonable compensation for the employee's private counsel in the criminal action, as well as court costs or necessary incidental expenses, as determined in the sole discretion of the Attorney General. If the criminal charge is not prosecuted for any other reason, the Attorney General, in his discretion, may pay the reasonable fees of private counsel and necessary incidental expenses and court costs if the Attorney General finds that the employee was acting in the scope of his or her assigned duties under apparent lawful orders or authority.

Instructions to Follow when Sued –

If you receive a summons and complaint naming you or the University as a defendant in a civil lawsuit arising out of your employment with the University, please follow these instructions: -

1. Call the Office of the Vice President and General Counsel immediately. -
2. Do not discuss the suit with anyone other than University attorneys, including other defendants who may be named in the suit. -
3. Do not talk to the plaintiff about the suit. -
4. Do not talk to the plaintiff's attorney. -
5. Refer all requests for documents to the University attorney handling the case. -
6. Respond to media questions by saying you cannot discuss the suit while it is pending.