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THMEP HOUSESTAFF MANUAL – 2011-2012

June 1, 2011

Dear Physicians:

Welcome to the Tucson Hospitals Medical Education Program and to Tucson! Each of us at THMEP and the full-time, part-time and voluntary teaching staffs at Tucson Medical Center, University Medical Center and the Southern Arizona VA Medical Center are delighted you have joined us. We look forward to an exciting and productive year together.

This manual is intended to help orient you to the policies, schedules and expectations at TMC and elsewhere for housestaff members of the Transitional Year Program and for the University of Arizona-Tucson Hospitals Internal Medicine Residency Program (THIMRP) residents while at TMC and on community rotations. While it is unlikely that you will "digest" all of this in one sitting, we hope you will read through this important manual and refer to it from time to time to clarify areas of confusion.

Because the landscape of medical education changes rapidly, and because THMEP is committed to meeting the evolving needs of our housestaff, changes in the information contained here are likely. Our core belief in the value of community-based medical education, our philosophy of education through patient care and didactics and our understanding of you as both our student and our colleague will not change.

All of us at THMEP are dedicated to helping you succeed, now and in the future. Essential to this is our ability to recognize both our successes and our troubles, and to respond to each appropriately. We look to you to share your observations with us, and we welcome your input.

We look forward to working with you during the coming year. Please do not hesitate to speak with any of us at THMEP if we can help make this year's transition easier, or if we can help in any other way.

Sincerely,
Robert Aaronson, MD, FACP, FCCP
Executive Director, THMEP and Associate Program Director, THIMRP

Tyler Kent, MD, FACS
Transitional Program Director

TUCSON HOSPITALS MEDICAL EDUCATION PROGRAM

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DESCRIPTION OF PROGRAMS

The Transitional R1 year includes:

4 months General Medicine TMC/SAVAMC/UMC
1 month TMC Critical Care
1 month TMC Surgery
1 month TMC Emergency Medicine
3 months Electives
1 month SAVAMC Ambulatory General Surgery
1 month SAVAMC Cardiology

For details on the Internal Medicine and General Surgery Residency Programs, please visit the following websites:

University of Arizona - Tucson Hospitals Internal Medicine Residency Program:
www.meded.arizona.edu

University of Arizona - Tucson Hospitals General Surgery Residency Program:
www.surgery.arizona.edu

GENERAL WORK GUIDELINES FOR ALL SERVICES

Please also refer to the individual descriptions of each service for any specific requirements.

1) Lines of Responsibility

The lines of responsibility, on both inpatient and outpatient rotations, are based on the following principals:

- An attending physician is ultimately responsible for every patient.

- Optimal resident education requires meaningful clinical responsibilities, including the opportunity to make major management and treatment decisions, with appropriate attending input and supervision.

- The resident's clinical independence will progressively increase, commensurate with the resident's evolving abilities. However, an attending physician will remain ultimately responsible.

- To accomplish all of the above, timely, thorough and open communication between residents and attendings is essential.

- On inpatient rotations, the R1's clinical responsibilities are centered on the care of his or her patients. The R1 is the front-line, primary physician for the patient during hospitalization. The R1 is under the immediate direction of the team's R2 or R3. The R2 or R3 is responsible for the effective functioning of the team in its dual roles of educational forum and patient care entity. The R2 or R3 supervises the intern in all aspects of patient diagnosis and treatment, contributes to R1 education and ensures appropriate attending communication and oversight. The resident is expected to alert the attending or members of the THMEP Administration of any real or perceived difficulties faced in patient management or the proper functioning of the medical team.

- On subspecialty or ambulatory rotations, housestaff responsibilities vary depending upon the service. Lines of responsibility remain, with the attending ultimately responsible for patient care. The houseofficer's role may vary from primary physician, to consultant, to manager of a single aspect of a patient's multisystem disease. Many elective rotations include experiences with all of these. Specific expectations of the resident should be discussed with the attending at the beginning of the rotation.

2) Patient Limits

The following limits apply to **all** inpatient medicine services at all sites:

- No R1 shall admit more than 5 new patients in 16 hours.

- No R1 shall be responsible for the ongoing care of more than 12 patients.

- Each R2 or R3 should admit (or oversee the admission of) no more than 10 patients per 24 hours, and no more than 16 patients per 48 hours.

- A R2 or R3 shall be responsible for the ongoing care of no more than 24 patients at any one time, including those patients cared for by R1(s) under his/her supervision. On teams with only one R1, the total team cap with be 14 patients.

These limits may require that R2's and R3's admit some patients by themselves while on call, up to the mandated limits. These patients may later be assigned to a less heavily burdened R1, or kept" by the R2 or R3 throughout the patient's hospitalization. A certain amount of "patient shifting" between R1's or teams may be required, as determined by the R2 or R3, with oversight by the Chief Resident.

Once the limits described above have been met, you are required to refuse new admissions. Please explain to the attending physician why you are unable to accept the patient and refer any misunderstandings to the THMEP office.

However, you should respond immediately to any real or perceived life-threatening emergency, even if a patient limit has been reached. Unless patients can be shifted or discharged immediately to allow for this admission, the attending physician should assume total care for the patient as soon as possible (within minutes to a few hours). Any difficulties with this should be referred **immediately** to the Program Director or other members of program administration.

Any requests by an attending physician to supersede any of these limits must be politely refused but **immediately** referred to the Program Director or other appropriate members of the program administration.

3) Work Hours

- When averaged over any month long rotation, no resident should work more than 80 hours per week.

- PGY-1 residents must not exceed 16 hours in a duty period.

- PGY-2 resident may not work more than 24 hours continuously, with 24 hours spent admitting new patients and/or caring for ongoing patients, with an additional 4 hours for ongoing patient care and effective transiton.

- In general, night call is every 4th night on all inpatient services. Call may also be required for Community Medicine and during some electives. **In the**

event of resident illness, scheduling adjustments will be made, and call may increase to no more than every 3rd night, on average.

- On average, each resident will have at least one full day off per week.
- During Emergency Medicine, shifts must not exceed 12 hours, and must be separated by at least 8 hours off work.
- Schedule changes: Any changes to the published schedule must **first** be approved by the Residency office.

4) Writing Orders

All orders for patients on the inpatient teaching services should be written by the medical housestaff. If a medical emergency requires that an attending write an order for a teaching service patient, the intern or resident caring for the patient should be notified immediately and involved in the ongoing patient management. Exempted from this rule are patients not on the teaching service but seen by a medical resident in consultation, usually during an elective subspecialty rotation.

5) Daily Notes (inpatient services)

Progress notes must be written for each patient every day, including when on-call. The team's R2 or R3 is expected to write the notes on the R1's day off.

6) Cross Coverage Notes

Cross coverage notes must be written every time a covering houseofficer is called to see a patient. Telephone orders must be given for only the most minor of problems. **Sedatives and narcotics should not be ordered over the telephone without first seeing the patient.** All telephone orders must be signed within 24 hours.

7) Non-teaching Service Patients

Housestaff are **not** responsible for the routine care of non-teaching service patients, including admission, orders, phone calls or discharge. However, housestaff are

expected to respond immediately to any call for emergency assistance on any patient, including non-teaching service patients. All care for the patient should revert to the attending physician immediately after the emergent situation, unless the patient is then transferred to the teaching service.

8) Sign-out

On every inpatient rotation, housestaff are expected to communicate essential patient information to the covering house officer before leaving for the day. Each houseofficer departing for home or continuity clinic should also inform the hospital operator whom he or she has signed-out to before leaving the hospital.

9) On/Off Service Notes

On every inpatient rotation, housestaff are expect to communicate essential patient information to the covering houseofficer before leaving for the day. Each houseofficer departing for home or continuity clinic should also inform the hospital operator to who he or she has signed-out before leaving the hospital.

10) Consultations

During both general internal medicine and subspecialty rotations, residents may be asked to perform consultations. As always, the attending physician is responsible for the content of these consultations and, as such, must be fully involved in all ultimate recommendations and treatments. For this reason, the resident must discuss the patient with the attending before any suggestions are made and before the consultation note is placed in the medical record. If the attending chooses not to see the patient immediately (at the attendings discretion), the resident and the attending will arrive at a plan over the telephone. The resident will write: "This has been discussed with and agreed to by Dr. (Attending)" and will then sign the consultation note as "Dr. (Resident) for Dr. (Attending)."

At TMC, internal medicine consultations are usually performed under the direction of one of the TMC Hospitalist's. The TMC Hospitalist on duty must be contacted and must agree to serve as the supervising attending consultant. Up to 2 consults each may be performed by the day call and the night call team, with these encounters counting towards the admission cap.

11) Completeness of Physical Examinations

The initial complete physical examination of a patient admitted to hospital or when first seen in your clinic should include otoscopy, rhinoscopy, ophthalmoscopy, breast examination, rectal examination, and pelvic examination, unless medically inappropriate. Male residents should always perform a woman's breast examination or pelvic examination with a female chaperone (physician or nurse).

TRANSITIONAL YEAR RESIDENCY PROGRAM OVERALL EDUCATIONAL GOALS AND OBJECTIVES

Goal: To provide a well-balanced one-year program in multiple clinical disciplines:

A. In preparation for a specific specialty or
B. To facilitate the choice of a specific specialty or
C. For students who are planning to serve in organizations such as the public health service or the military as a general medical officer prior to completing a program in graduate medical education or
D. For students who must have at least one year of fundamental clinical education prior to entering a career path which does not require broad clinical skills such as administrative medicine or non-clinical research.

I. The program will require and measure resident's competence in patient care, medical knowledge, interpersonal & communication skills, professionalism, system based practice and practice based learning improvement. Curriculum and assessment will occur throughout the Transitional Year during orientation, monthly rotations, housestaff meetings, tutorials and relevant assignments.

Objectives for the following competencies are:

Patient Care: The resident will be able to orient easily to clinical duties as manifested by timely clinical workup of patients
Complete accurate & timely history & physicals as determined by satisfactory global evaluations and chart reviews
Perform basic procedures as manifested by satisfactory Mini-CEX evaluations
Have good diagnostic and treatment decisions as determined by global evaluations, and Mini-CEX evaluations

Medical Knowledge: The resident should be able to acquire & continually review basic clinical knowledge as determined by his scholarly activity,

written examinations and daily clinical interaction
Have an interest in learning

Professionalism: The resident should be dependable, follow through on tasks
Have an acceptable personal appearance & demeanor
Meets deadlines
Be punctual
Timely medical records completion
Be respectful - patients, nurses, colleagues & staff
This objective will be measured by nurse evaluations and global monthly evaluations

Communication Skills: The resident should be able to listen well
Be a team member
Relate well with patients/families/staff
Measuring tools will include global evaluations and formal scholarly presentations

Practice Based Learning: The resident should be able to correct shortcomings
Be familiar with statistics, literature
Use information technology effectively
Measurements will include scholarly activity, global evaluations and select reading presentations on rotation

System Based Practice: The resident should be aware of safety issues
Healthcare system costs
Service, access the system
Quality measures and practice
Satisfactory completion of this objective will be determined by completion of project assignments and global evaluations

Educational Objectives - General

The Transitional Year Program is designed to meet the educational need and residents. Service obligations are secondary.

A. The objective of mature, clinical judgment under proper supervision will be accomplished
by:
i. Direct patient care responsibility
ii. Planning care, writing order notes and relevant records

B. At the end of the Transitional Year, a resident should be able to

i. Perform complete medical history and physical exam
ii. Define Patient problems
iii. Develop plan for diagnosis
iv. Implement appropriate therapy and management for most patients with common clinical entities
v. This objective will be measured by assessment tools, exercises and global evaluations

III. Educational Goals - Rotation Specific

A. Internal Medicine (4 months)

1. To expand on the ability to obtain accurate medical histories and perform comprehensive physical examinations on all patients.
2. To utilize this database to formulate plans for accurate diagnosis and appropriate therapy to be applied in various clinical situations.
3. To participate in the regular educational activities in conjunction with the categorical medicine residents on the general medical wards and in the CCU.
4. To acquire some clinical skills in the management of critically ill patients both in the CCU and ICU.

B. General Surgery (1 month)

1. To develop clinical competence in the perioperative management of many of the problems encountered in general surgery, inpatient and outpatient services.
2. To actively participate in patient care in conjunction with senior surgical residents, including management of critically ill patients on the surgical service.
3. To evaluate surgical patients preoperatively in the clinics and Emergency Room and to follow their postoperative courses in the hospital and outpatient clinics.
4. Understand the decision-making process required of the surgeon and the principles on which the decisions are based.
5. Understand the basics of the surgical procedure performed, including tubes placed, drains placed, lines placed, etc.
6. Develop, with the aid of senior resident and attending surgeon, a postoperative plan of care and surveillance. Anticipate problems particular to this patient or disease entity.
7. To participate in the regular educational activities of the surgical service, as applicable to categorical first year residents.

C. Emergency Medicine (1 month)

1. To provide an intensive experience in the acute management of all patients who present to the Emergency Department; this includes both medical and surgical specialties. Residents will be exposed to a variety of medical, surgical, gynecologic and psychiatric problems.

2. To obtain those manual skills necessary to evaluate and repair lacerations, splint orthopedic injuries, place venous access lines and other skills necessary in the Emergency Department.

3. To work as a team member in the resuscitation of patients suffering both medical or surgical catastrophes.

4. To learn to triage patients based on the acuity of their condition when first seen in the department.

5. To obtain experience in the management of urgent care patients, in addition to the emergency room patients.

6. To consult with senior residents and attendings in various specialties as required for both high quality patient care and educational input.

D. Ambulatory Care (140 hours)

1. To provide ambulatory care as part of the rotations on the general surgery through outpatient clinics.

2. To incorporate equivalent ambulatory care experience through the Urgent Care section of the Emergency Medicine Department throughout the month's rotation.

3. To provide the majority of ambulatory care experience during rotations in medical, surgical, or other fundamental clinical skill rotations.

E. Elective Services (3 months)

1. To provide optional elective rotations in many specialties for the purpose of
   a. Enhancing their background for their future chosen career specialty and/or
   b. Remedy a lack of exposure to a particular specialty of importance during their medical school education.

2. Each resident provides goals and objectives for the selection for each elective prior to each rotation. In addition, all residents are provided with the programs educational goals and objectives for a specific elective prior to this rotation.

F. Critical Care (1 month)

a. To understand monitoring, coordination of specialists, ethical issues in the ICU and Critical Care setting.
b. Become familiar with common, acute and intensive problems and procedures.
c. To enhance your background for requirements in their chosen career specialty.

Residents will be provided goals and objectives for their Critical Care Rotation prior to this rotation which will also include assignments and expectations for their performance.

G. Cardiology (1 month)
   1. Provide an intensive experience in the management of cardiac patients in the emergency department, as a consultant, on an inpatient and critical care setting. Residents will be exposed to a variety of cardiac pathophysiology, including common and rare disease states.
   2. They will obtain some manual skills necessary to evaluate and treat and manage cardiac disease.
   3. They will work as a team member on inpatient, clinic and consultation services on patients suffering cardiac illness.
   4. They will consult with senior residents, fellows and attendings in this specialty to learn quality patient care and gain a broad general educational experience in cardiology.
   5. They will participate in the regular educational activities of the cardiac service during this rotation.

THMEP POLICY FOR TRANSITIONAL YEAR RESIDENT PROMOTION

The following is the criteria for satisfactory completion of the transitional year program:

1. Transitional Year Resident must meet all requirements as noted in the ACGME Transitional Year Program requirement document.

2. A transitional resident must have a satisfactory or higher rating in the cumulative scores of their evaluations on all rotations at the completion of their transitional year.

3. They must achieve a satisfactory or superior overall clinical competence score on all rotations.

4. For any performance that needs attention, remediation or appropriate mentoring must be completed.

5. Mandatory assignments and assessment methods must be completed satisfactorily.

6. All scholarly activity projects must be completed.

7. They must complete end of the year administrative clearance procedures.

8. Residents must attend obligatory housestaff meetings and conferences. They should have a satisfactory medical records completion profile.

9. Residents need to satisfactorily achieve the THMEP transitional year program goals and objectives and core competency skills and instructions.
10. Take USMLE Step III examination.
11. Complete required EMR training at all participating institutions.

TRANSITIONAL YEAR CURRICULUM – CORE COMPETENCIES

I. PATIENT CARE

Description: Residents should develop treatment skills involving patient's health care that are compassionate and effective. Residents will have direct experience and progressive responsibility of patient management.

Teaching Methods:

a. Supervised direct patient care on medicine, surgery and ED monthly rotations. Faculty from the sponsoring and affiliated institutions will supervise with senior resident assistance.

b. Didactic lectures, conferences, morning reports, teaching rounds, assigned readings, clinical vignettes, learning modules, ACLS, procedures and emergency medicine tutorial.

Evaluation Methods:

a. Monthly electronic resident evaluation forms (global)
b. Mini-CEX examination
c. Computer-based training modules:
   1. Infection Control
   2. TB Education
   3. Medication Safety
   4. Line Sepsis
d. ACLS course
e. Sleep deprivation readings
f. Emergency medicine tutorial
g. Conscious sedation module
h. Clinical knowledge examination
i. Chart reviews
j. Simulator – UMC
k. USMLE Step III Exam

II. MEDICAL KNOWLEDGE

Description: Residents should continually acquire knowledge of clinical, bio-medical and epidemiological sciences. They should have an interest in learning and applying this to patient care.

Teaching Methods:

a. Supervised direct patient care.
b. Didactic lectures, assigned independent readings, conferences, ACLS, tutorials, teaching rounds, Surgical and Medical M & M conferences and presentations, system-based practice projects and clinical vignettes.
c. Elective rotation – one on one faculty/resident instruction and mentoring.
d. Computer based training

Evaluation Methods:

a. Monthly electronic resident evaluations
b. Mini-CEX examinations
c. M & M conference presentation
d. Clinical vignettes
e. Emergency medicine tutorial
f. Conscious sedation modules
g. Clinical knowledge examination
h. ACLS examination
i. Computer based training examination:
   1. Pain Management
   2. Medication Safety
j. Critical Care Manual and pre-test

III. PRACTICE-BASED LEARNING AND IMPROVEMENT

Description: Residents should be self-motivated and able to investigate and evaluate their patient care practice. They will learn from scientific studies, statistical methodology and be able to use information technology.

Teaching Methods:

a. Supervised direct patient care with emphasis on literature search and application to their patient care. This includes presentations during M & M, morning report and teaching rounds
b. Medical library information technology workshops.
c. Evidence-based medicine conference, Grand Rounds and Surgical M & M.
d. Clinical vignette – research, preparation and presentation (a didactic presentation to peer and faculty).
e. Resident evaluation of service and faculty performance.
f. Quality improvement readings and testings.

Evaluation Methods:

a. Global electronic resident evaluations
b. Clinical vignette presentations, evaluations and scoring
c. System project written report
d. Surgical M & M presentation
e. Medical library information technology evaluation (PubMed)
f. Medical student evaluation of resident performance

g. Medical and surgical conference attendance records

IV. INTERPERSONAL COMMUNICATION SKILLS

Description: Residents should be effective listeners and team members. They should be able to relate and provide information to patients, family members, staff and their peer healthcare professionals.

Teaching Methods:

a. During patient care activities, residents observe attendings, fellow residents and personnel demonstrating effective communication and interpersonal skills. This occurs during rounds, family meetings, procedures and core conferences.
b. During teaching rounds, M & M conferences and clinical vignettes, residents discuss patient management and care. They should be able to communicate in a precise, concise and logical fashion through brief oral presentations.
c. Residents present a scholarly project at the end of the year in a clinical vignette format.
d. Residents attend ethics conferences, medical affairs conference and complete computer based tutorials in work place violence, security, and HIPAA, patients rights.
e. Residents complete virtual mentor exercise in cross cultural communication, informed consent and end of life care.
f. Web based tutorial on interpersonal and communication skills.

Evaluation Methods:

a. Virtual mentor exercises
b. Computer based training:
   1. Cultural Competence
   2. Patient Communication
   3. Informed Consent
   4. HIPAA Privacy
   5. Age Competencies Testing
c. Global monthly resident evaluations
d. Mini-CEX exercises
e. Nurse evaluations
f. M & M presentations and clinical vignettes
g. Clinical efficiency time measures

V. PROFESSIONALISM

Description: Residents should be responsible and compassionate in performing their professional duties. They should demonstrate ethical, respectful and sensitive practice patterns.

Teaching Methods:

a. Supervised teaching and preceptoring during patient care settings on each

rotation, and in outpatient clinics at St. Elizabeth's Indigent Care Clinic.

b. Selective readings in professionalism during orientation and review sessions.
c. Orientation workshop with emphasis on medical record responsibilities, confidentiality issues, and HIPAA regulations.
d. Ethics and medical affairs conferencing.
e. Web based tutorial on interpersonal and communication skills.

Evaluation Methods:

a. Global monthly resident evaluation
b. Mini-CEX evaluations
c. Select readings in professionalism & evaluation
d. Medical record completion data
e. M & M presentations
f. Clinical vignettes
g. Conference attendance records
h. Orientation computer based training:
   1. Medical Ethics
   2. Age Competencies
i. Ethics conference & Medical Affairs conference
j. Web based tutorial on interpersonal and communication skills

VI. SYSTEM-BASED PRACTICE

Description: Residents should understand medical practice in larger systems and a knowledge of delivery of healthcare. They will develop an awareness of patient safety and advocacy, as well as the practice of cost effective care.

Teaching Methods:

a. Discharge planning, case management & financial cost basis during monthly patient care activities and clinic rotations including St. Elizabeth's Clinic.
b. Medical record completion data and financial cost data of hospital admissions will occur on an ongoing basis. They will access the system for laboratory, radiologic and specialty services. A monthly Business of Medicine conference covering cost/benefit analysis, risk contracting and HMO.
c. Computer based training module:
   1. Adverse Events
   2. Medication Safety
   3. Line Sepsis
d. Closed claim review presentation during Fall Housestaff meeting.
e. Patient safety readings and orientation presentation.
f. Tucson Medical Center quality improvement plan and tutorial.
g. Individual research and written summary of a system-based project in a field of interest selected by the resident.
h. Research and presentation for Surgical M & M related to patient safety or cost benefit or delivery of healthcare.

Evaluation Methods:

a. Monthly global resident evaluations

b. System project research and summary
c. Clinical vignette presentation
d. Surgical M & M presentation
e. TMC quality measures exam
f. Patient safety exam
g. Computer based training:
   1. Adverse Events
   2. Medication Safety

(AT TMC)INPATIENT ADMITTING PROTOCOL

The following protocol is sent periodically to all admitting Teaching Attendings:

1) *Have the operator page the resident on-call , who will call you back promptly*

2) *Inform the resident about essential patient data. For admissions through the ED, the ED physician may (if willing and appropriate) call the resident for you. Alternatively, a ward clerk may notify the resident of the admission but you must be available to discuss the patient with the residents after they have assessed the patient.*

3) *Please do not provide the resident with an assessment and plan (except, of course, when urgent intervention is needed).*

4) *After the resident and the intern have seen the patient, one of them will call you to discuss their assessment and plan.*
   - *Please use this opportunity to teach (physical findings, data, differential diagnosis, diagnostic options and therapy) and to lay any appropriate ground rules (e.g., "You need not call me if…").*

5) *The intern or resident* ***must*** *write all non-STAT orders. As such, it is essential that you and the housestaff communicate daily.* ***Communication via the chart is not encouraged, as it minimizes meaningful interaction.***

   ** If you must write a STAT order, please involve the housestaff immediately, so they may contribute to the ongoing management of the patient.**

6) *The housestaff will assist in the discharge planning for the patient, and the intern will dictate a discharge summary. A copy of this will be sent to your office.*

   ** The Program Requirements published in July 2001 by the Accreditation Council for Graduate Medical Education (ACGME) mandates that the housestaff "must write all orders for patients under their care. In those unusual circumstances when an attending physician or subspecialty resident writes an order on a resident's*

patient, the attending or subspecialty resident must communicate his or her action to the resident in a timely manner" (V.E.3.).

** If we do not comply with this, we will lose our national accreditation and, ultimately, our residency program!"*

BEDSIDE TEACHING

Bedside teaching should occur at least twice a week (i.e. during at least two of the three teaching attending rounds weekly).

The following is a list of the basics to help assure a successful and enjoyable trip to the patient's bedside when you are accompanied by residents and/or students. When done well, patients enjoy bedside teaching… students and residents do as well.

I. Setting the ground rules

a. Make sure that your team knows what you expect of them - teach professionalism
b. Cover bedside etiquette
c. Limit beeper interruptions
d. Begin on time (everyone present at the start)
e. Schedule with the patient whenever possible (Have the resident arrange.)
f. Invite the patient's nurse when feasible (unfortunately, this is not often an option)
g. When at the bedside, limit your use of medical jargon

II. Introduction

a. Have the patient's doctor (student, intern, resident, you) introduce all members of all the team.
b. Explain the purpose of the visit
c. Allow the patient a polite refusal (rarely necessary)
d. Introduce yourself to family members if present; invite to stay, but only if okay with the patient.
e. Explain that much of what you and the team discuss may not apply directly to this particular patient
f. Invite participation and questions by the patient
g. POSITION THE PATIENT APPROPRIATELY; position your team around the bedside

III. The Presentation (History)

a. Avoid beginning the presentation with a statement about the patient's gender and

race; these should be obvious.

b. Do not refer to the patient by his-her first name unless you know for sure that it is appropriate
c. Avoid sitting on the patient's bed unless there is a reason to do so
d. Do NOT avoid sensitive material… just treat it in a sensitive manner
e. Allow interruptions by the patient, the students and residents, and by yourself to highlight important points or to probe in more detail
f. Never, EVER embarrass the patient's doctor - the student/resident won't like it and neither will the patient

IV. The Presentation (Examination)

a. Examine the pertinent or illustrative parts yourself
b. Invite the resident/students to examine the patient
c. Allow the patient to participate (many will greatly appreciate hearing the murmur or feeling the spleen that the rest of you seem so excited about)
d. Ask the team members to demonstrate proper techniques
e. Allow time for the team members to appreciate the findings; remember that it may take a while (and some ingenuity on your part) for a student or intern to truly hear an S4 for the first time

V. The presentation (Labs, etc.)

a. Stay at the bedside if possible
b. Have pertinent radiographs, EKG's, etc., available
c. Allow the patient to review

VI. Discussion

a. Remind the patient that not everything said will apply to them; be explicit when what you are discussing is directly applicable
b. Question junior team members first
c. Avoid asking theoretical questions to the patient's primary doctor; missing them in front of the patient is quite hard on the resident/student and may belittle them in the eyes of the patient
d. Don't allow "one-upmanship" to occur
e. Avoid asking the "What am I thinking?" question - you know, the ones that make a point but are primarily designed to make you look good
f. "I don't know" is an appropriate answer - both for you and for your team; it should be followed up, though, with a search for the correct answer if important

As you are about to leave the patient's bedside, allow his/her time for questions (although most will have been answered). Ask for feedback from the patient about the process. Oh and be sure to say thanks.

CURRICULUM:

The THMEP written curriculum is available to each transitional intern at the beginning of residency training, and is updated and distributed periodically. It delineates THMEP's educational goals and methods and serves as a guide for planning and implementing our clinical and didactic programs.

Residents are encouraged to discuss the curriculum with their attendings, especially during subspecialty months, when it can help focus didactics on essential clinical topics. The curriculum can also assist each resident in planning self-study, both during clinical rotations and when reviewing for board examinations.

EVALUATIONS:

The process of ongoing evaluation between the housestaff and the many components of the THMEP program (attendings, nurses, co-residents, and rotations) is essential to resident education and patient care. Evaluations of each resident are obtained frequently: monthly for every clinical rotation; biannually for continuity clinic; and once at completion of residency. Houseofficers are also asked to evaluate the program monthly, at the end of the year, on completion of the program and periodically after graduation. It is essential that evaluators be honest.

They should write down their criticisms and concerns in a constructive manner, and discuss them in a timely manner with the subject of the appraisal. Likewise, the person being evaluated should realize that an honest critique is part of the learning process, and is essential to maintenance of professionalism.

MEDICAL LIBRARIES AT TMC, UMC AND SAVAMC

The medical libraries at TMC, UMC and the SAVAMC provide housestaff 24-hour/day access to up-to-date periodicals and texts. Materials not available at these sites can be obtained quickly through interlibrary loans, usually at no cost. Audiovisual educational materials and equipment are also available.

THMEP has provided a PC and/or Laptop in the THMEP Conference Room and in both the TMC Medical Library and the call room solely for housestaff use, including literature searches, medical education software use, and general computer needs. The Medical Library staff is available to instruct you in computer searches or other medical research.

TMC is a local Internet Service Provider (ISP), allowing for ready access to the Internet from most PC terminals around the hospital, including free access to Medline, STAT-Ref and other useful databases of the Arizona Health Information Network (AZHIN) [url for AZHIN website is http://tmc.azhin.org]. TMC also offers free computer classes for a variety of computer applications. Computers in the Medical Library must be accessed using a username and password. These will be provided by the THMEP office. For additional information about the library, call 324-5140.

<u>PROTOCOL FOR THE TMC GENERAL MEDICINE SERVICE</u>

The general medicine service at TMC consists of four teams. Each team includes R1's and either an R2 or R3. The Chief Resident (R4) oversees the day-to-day functioning of the entire teaching service, which includes the general medicine, ICU and cardiology units. Internal medicine patients are, as much as possible, clustered on Acute Medical-Surgical Unit (AMSU), the 420/480 Unit (PCCU/CCU) and the 450 Unit (MICU).

The patients admitted to the general medicine service may be referred by either community-based physicians on our teaching staff or by TMC's Hospitalists, a group of full-time, TMC-based inpatient physicians. The admitting physician serves as the management attending during the patient's hospitalization, developing day-to-day management plans with the housestaff, and bearing ultimate responsibility for the patient's care. One Hospitalist is assigned to each of the four medical teams and is the attending of record for every Hospitalist patient on the team.

On weekdays between 7 a.m.- 4 p.m., all medicine admissions are distributed to the four medicine teams according to a night-call/post-call/day-call/off-call rotation.

Call is every <u>fourth</u> night. All R2 and R3's meet briefly at Morning Checkout Rounds at 7 a.m., where the Chief Resident briefly reviews the previous days admissions and overnight events, and sign-out occurs.

The Chief Resident may change the times of call as needed, while assuring compliance with all RRC/ACGME regulations. For instance, during "slow" months, it may be reasonable to end Day-call earlier, with an appropriate adjustment to Night-call. The goal is to remove time restrictions on Day-call teams, while ensuring adequate patient numbers for quality medical educational experiences.

<u>Morning Work Rounds</u> are carried out by each team. Rounds should be started as early as necessary so that unstable patients are seen and essential orders are written before morning conferences begin. Resident teaching should be done at this time. After conferences, patient status and the progress of AM plans should be reviewed prior to sign-out. Team work rounds may need to resume after teaching attending rounds/morning conferences.

Attending Teaching Rounds are usually held from 7:30 a.m. to 8:40 a.m. on Monday, Tuesday and Friday. These rounds are distinct from management rounds with admitting physicians, and are intended to be didactic.

Hospitalist Management Rounds are held briefly from about 10:00 a.m. to about 10:45 a.m. (extending this time as necessary) with the TMC Hospitalist assigned to each team. All Hospitalist patients on any given team are under the supervisory care of a TMC Hospitalist assigned to that team. During Hospitalist Management Rounds, patient follow up and status are quickly reviewed, and plans are made. This is also an excellent opportunity for teaching. In addition, Ad hoc **Management Rounds** with other admitting physicians should occur every day

Attending Rounds are held on Monday, Tuesday, Wednesday and Friday from 7:30 a.m. – 8:40 a.m.

Noon Conference occurs daily. See Daily Conference Schedule.

ATTENDANCE AT CONFERENCES IS REQUIRED. The post-call team is not required to attend 11:30 a.m. or noon conferences. Other residents may be absent from required conferences only in the event of medical exigencies. The day's activities should be planned accordingly, and conferences should start on time. Any work left undone after noon conference by the post-call housestaff should be signed out to the night-call team.

Afternoon Check-Out: On every inpatient rotation, housestaff are expected to communicate essential patient information to the covering house officer before leaving for the day. Each house officer departing for home or continuity clinic should also inform the hospital operator to whom he or she has signed-out before leaving the hospital.

Except for afternoons when a house officer is in continuity clinic, no team's R2 or R3 should checkout for the night before the team's R1's are ready to leave. Each house officer leaving the hospital should check-out to a corresponding member of the night-call team, and should notify the hospital operator of this prior to leaving the hospital.

TMC General Medicine Intern Responsibilities

The R1 is the front-line, primary physician for the patient during hospitalization. He or she is under the immediate direction of the team's R2 or R3, and ultimately answerable to the admitting physician for each patient. The R1 is responsible for admitting all patients to his or her service. The R1 will do the history and physical under the supervision of the R2 or R3, who will then direct the R1 in the formulation of an assessment and plan and will discuss this plan with the admitting physician. **The R1 will then write an admission note.**

The R1 will, whenever possible, **pre-round on his or her patients prior to Morning Work Rounds.** The R1 will formulate a patient plan for the day with the R2 or R3, communicate this to the admitting physician and come to a consensus with the admitting physician, and write all orders. The R1 (or the R2 or R3, if needed) will write daily progress notes on each patient and additional notes as the clinical situation dictates. These progress notes should include a problem-oriented assessment and plan. The progress notes should serve to document the patient's clinical status and the R1's assessment and plan. The chart should **not** be a forum for sharing one's attitudes or feelings about the patient or the patient's care.

The R1 should be the first physician called by the medical floor or Critical Care Units for questions or problems. However, the R1 should, without hesitation, involve the team's R2 or R3 or the admitting physician whenever appropriate. The R1 will perform all

invasive procedures under the guidance of a credentialed resident or attending physician. (See THMEP's "Certification & Documentation of Adequate Proficiency and Experience in Performing Invasive Procedures.")

Discharge summaries are to be dictated by the R1 as quickly as possible, and certainly within 48 hours. Copies should be sent to the admitting physician, the patient's primary care physician and to any consulting physicians to facilitate transfer of important clinical information to the outpatient setting.

As above, unless delayed by a real or potential patient **emergency,** the R1 is expected to attend all general medicine service functions (Grand Rounds, morning work rounds, teaching rounds, intern report, noon conference, afternoon seminars, etc.).

TMC General Medicine Resident (R2 and R3) Responsibilities

The R2 or R3 is responsible for the effective functioning of the team in its dual roles of educational forum and patient care entity. The R2 or R3 supervises the R1 in all aspects of patient diagnosis and treatment, and ensures appropriate attending communication and oversight. The R2 or R3 is also responsible for the educational progress, both practical and theoretical, of the team's R1's and medical students, if any.

The R2 or R3 will see each new admission to the team's service, with the R1 whenever possible, and will **write** a brief admission note on each patient. The R2 or R3 will review the R1's progress notes and will initial each to indicate agreement after writing any necessary comments.

The R2 or R3 will assist and supervise invasive procedures performed by the R1 when appropriate. See THMEP's "Certification & Documentation of Adequate Proficiency and Experience in Performing Invasive Procedures."

Unless delayed by a real or potential patient **emergency**, the R2 or R3 will attend all general medicine service functions (Grand Rounds, morning check-out rounds, morning work rounds, teaching rounds, resident report, noon conference, afternoon seminars, etc.). In addition, the R2 or R3 should cover for the R1's during Resident Report (R1), holding their beepers and helping with their work during this period.

Each Medicine Resident is expected to contribute to **Morbidity and Mortality conferences**. Each death on the medicine teaching service should be recorded on an M & M sheet (obtainable at THMEP), submitted to the THMEP office and briefly reported at M & M conference. Two or three patients who suffered either mortality or significant morbidity are fully presented and discussed.

GENERAL SURGERY

Transitional residents on the Surgical Service at TMC spend 1 month on the general surgery service. Their responsibilities for direct patient care and decision making are as part of the surgical teams on both services. These teams include surgical residents and appropriate attending staff. Direct supervision is provided by the senior residents and/or the attending staff.

The Transitional resident, functioning as a member of the team, is responsible for admitting history and physical examination, daily progress notes, the writing of orders, the general planning of in-house care and the continuing management of patients throughout their course. They attend one or two clinics a week for follow-up of post-hospitalization patients. They participate in surgical procedures as assistants to appropriate supervising faculty.

The educational goals on these services are to:

- To develop clinical competence in the perioperative management of many of the problems encountered in general surgery and trauma.
- To actively participate in patient care in conjunction with senior surgical residents, including management of critically ill patients on the surgical service.
- To evaluate surgical patients preoperatively in the clinics and Emergency Room and to follow their post operative courses in the hospital and outpatient clinics.
- To participate in the regular educational activities of the surgical service as applicable to categorical first year surgery residents.

PROTOCOL FOR AMBULATORY GEN SURGERY CLINIC (SAVAMC):

Surgery clinic consists of a 1 month rotation at the SAVAMC. Vacation time is not permitted. Clinics and resident attendance are required Monday - Friday between 8:00 a.m. - 4:00 p.m. Work hours are monitored by the SAVAMC administration.

Residents function as a clinical team worker with senior surgery residents, attendings and non-physician faculty. The majority of the clinics are general surgery with one procedure clinic per week.

PROTOCOL FOR SAVAMC GENERAL MEDICINE SERVICE:

Information will be provided during the experience

COMMUNITY MEDICINE (PRIVATE OFFICES)

This rotation takes place during the PGY-3 year, but additional months are available on an elective basis. The goal of this rotation is to immerse you in a community-based outpatient medicine experience, with the intention of your becoming a functioning member of the practice, as appropriate to your level of training. As a fully integrated member of the practice, you are expected to keep regular office hours, to follow your outpatients when hospitalized and to take call. All of these experiences should be performed under appropriate supervision by the one or more attendings in your practice. The local Directing Physician is responsible for the overall organization and oversight of your community-based medicine experience. The specifics of the resident's role may vary slightly from practice to practice. You should discuss this with the Directing Physician in your practice at the start of the month. In most instances, you will examine the patient and then discuss any findings and recommendations with the attending. Whenever possible, you will complete all aspects of the encounter, including needed procedures, instructions and charting. It is your responsibility to ensure that the attending physician is aware of all medical decisions, including any to perform an invasive procedure. You are not responsible for seeing each and every patient presenting to the practice on any given day, but you should work with the attending to identify patients appropriate for the outpatient teaching service.

Appropriate resident activities on the community medicine rotation include, but are not limited to: office hours, office-based procedures (treadmills, sigmoidoscopies, arthrocenteses, etc.), front-office and back-office education, hospital rounding, night call, house calls and nursing home visits.

TMC EMERGENCY MEDICINE

The R3 Internal Medicine resident and the R1 Transitional resident in the TMC Emergency Room are expected to evaluate and treat a variety of patients, spanning the spectrum of problems seen at this busy site. Residents are also expected to coordinate patient disposition, which includes contributing to admission decisions. Every patient seen by a resident must also be seen by and discussed with an Emergency Medicine attending, all of whom are board certified in Emergency Medicine. The R3 resident is expected to assist/oversee and teach the R1 resident.

Scheduling is done by the Emergency Medicine department and is coordinated with the THMEP office. Pediatrics and Emergency Medicine residents from the University of Arizona also participate in the rotation. Both THMEP and University of Arizona policies regarding work hours apply, in accordance with ACGME/RRC regulations.. See "General Work Guidelines for all Services."

MINOR EMERGENCY CLINIC (MEC)

The MEC is a fast paced section within the TMC Emergency Department, caring for a diverse group of patients with illnesses significant to warrant emergency care, but probably not requiring hospital admission. Examples would include minor fractures and dislocations, lacerations, cellulitis, Todd's paralysis, and aseptic meningitis. The resident in the MEC works closely with the MEC attending. Each patient under a resident's care must be seen by, and discussed with, an attending physician prior to disposition. Invasive procedures , parenteral medications and major diagnostic studies (MRI, CT, VQ-scan, etc.) should also first be discussed with the attending. Other specific policies and resident expectations are discussed on site.

The MEC is open from 8:00 a.m. to 10:30 p.m. daily, although patient care usually lasts longer. Scheduling is done by the Emergency Department and is coordinated with the THMEP office. Although shift lengths and times vary, THMEP and the University of Arizona policies regarding work hours remain in effect. See "General Work Guidelines for All Services."

ELECTIVES

Electives are offered in a wide variety of disciplines including Cardiology, Gastroenterology, Hematology/Oncology, Infectious Disease, Nephrology, Pathology, Pediatrics, Physical Medicine/Rehabilitation, Psychiatry, Pulmonary/Critical Care Medicine, Radiology and Rheumatology.

All elective rotations are conducted under the supervision of a single directing attending, although clinical activities may be coordinated with several members of a practice or clinical department. Usual working hours are from 7:00 a.m. – 5:00 p.m., Monday – Friday. However, housestaff should discuss this and other expectations with the directing attending at the beginning of the month. Some elective services do require weekend and night-call work. An 80-hour work week limit applies

CONFERENCES

Attendance at all conferences is mandatory. Absences are allowable for the urgent medical evaluation and/or care of patients, however. Routine medical activities (e.g. note writing, dictations, etc.) are not valid reasons to miss educational activities.

Mandatory for housestaff on TMC inpatient rotations; otherwise strongly encouraged:

Grand Rounds	1st and 3 Wednesday of every month at 12:00 p.m.
Teaching Attending Rounds	Monday, Tuesday, Wednesday & Friday, 7:30a.m. – 8:40 a.m.
Hospitalist Management Rounds	Monday-Friday, 10:00 a.m. - 10:45 a.m.
Medical Student Teaching	Thursday, 7:30 a.m. – 8:30 a.m.

Hem/Onc	1st & 3rd Friday 12:00 p.m. - 1:00 p.m.
Noon Conference*	Monday-Wednesday & Friday, 12:00 p.m. – 1:00 p.m.
Academic Half-Day (At VA)	Every Thursday 1:00 p.m. – 4:00 p.m.

* Includes Morbidity and Mortality Conference, ICU Core Lectures and General Medicine Core Lectures/Board Review, GI, Cardiology, Medical Ethics, EBM, ID, Business of Medicine, Neurology, Pulmonary, Endocrinology.

Medical Student Responsibilities while on Inpatient Medicine at TMC:

12. MS-III students are not expected to participate in night call, but are welcome to do so. MS-III students should be assigned three or four patients at any given time. However, these patients should be under the direct care of an intern and his/her resident. The medical student should, on occasion, be asked to write complete history and physical notes on these patients, but this H & P should not be used in lieu of the H & P that is required by the intern. Likewise the MS-III student should write daily progress notes on his/her patient, but these do not serve as a substitute for a daily progress note by the intern or resident. All MS-III notes must be co-signed by a supervising resident, who should review both the note and the patient with the medical student daily. MS-III students should not be asked to perform dictations. MS-III students should not write orders.

13. MS-IV (Sub-Intern) medical students should perform in a manner more similar to that of an intern. The MS-IV student should participate in night call, admitting and caring for patients akin to the team's interns. However, all orders written by the sub-intern should be reviewed immediately by the resident and co-signed. All notes should be reviewed with the resident (not the intern), discussed and co-signed. In general, a sub-intern should carry a patient load similar to that of an average intern, with both careful oversight and necessary adjustments made based on the capabilities and confidence of the sub-intern.

Any concerns or questions about this or any other issues regarding medical students at TMC should be discussed as soon as possible with THMEP administration.

MEDICAL MORBIDITY & MORTALITY CONFERENCE

Medical Morbidity & Mortality Conference is a vital forum for discussing untoward outcomes and opportunities to improve medical care. This conference is open only to active medical staff at TMC.

1. Patients should be referred to by their initials, not their name.
2. A certain amount of structure and formality will hopefully facilitate discussion. To this end, the presenter will be provided with a podium and a pointer.
3. The program should begin with the R2 or R3 (or his or her substitute) presenting the total number of deaths on the service, dividing these into "expected" and "unexpected" deaths. All deaths on the medical ward service should be recorded by the houseofficer involved on a Morbidity and Mortality sheet which will be saved at the THMEP office. However, only a few cases, picked by the chief resident or program director should be presented fully.
4. Whenever possible, the R1 involved in the patient's care should present the case. When this is not possible, the responsible R2 or R3 should do so.
5. Whichever house officer presents the case should consider it his or her responsibility to contact the key physicians involved, and arrange for their attendance. If this is not possible, a substitute physician in the appropriate discipline should be asked to attend.
6. Whenever possible, pathology and/or autopsy slides should be presented. The pathologist should be invited well ahead of time, to avoid scheduling conflicts.
7. The case should be presented in such a way as to highlight the clinical dilemmas or medical mishaps.
8. Next, questions should be entertained from the audience.
9. At this point, the house officer presenting the case should be prepared to give a short synopsis of his/her opinion about what is to be learned from this case. The invited physicians should be given an opportunity to describe their opinions and offer more information about the clinical entities described. The house officers involved in the case are expected to have read sufficiently about the subject in question to discuss it from a knowledgeable perspective.

PRIVACY/CONFIDENTIALITY

Patient confidentiality and privacy must be strictly enforced. Both THMEP and TMC strictly comply with rules as mandated by the Health Insurance Portability and Accessibility Act (HIPAA). Handwritten or typed patient note cards, notes or other documentation must not be left unattended or open to public view. Confidential patient information must not be placed on publicly accessible computers. Patient information must not be discussed in any area where disclosure of confidential information is reasonably likely, including hallways, cafeterias, elevators and bathrooms. Because inpatients are frequently are often not in private rooms, care should be taken to minimize unintended exchanges of information to the patients roommate in all reasonable ways.

ACLS CERTIFICATION

Every resident must maintain current ACLS certification, on file with the THMEP office. To facilitate this, an ACLS course is included in THMEP Orientation Week, given just prior to the start of Internship clinical duties.

LEARNING TOOLS

THMEP provides a number of other learning tools that residents are encouraged to use. These include the Medical Knowledge Self-Assessment Program (MKSAP), Mayo Internal Medicine Board Review audiotapes, JournalWatch, MD Consult, the ABIM In-Training Examination, the American College of Physicians' Journal Club, Annals of Internal Medicine, and heart and lung auscultation audiotapes. The medical libraries at TMC, UMC and SAVAMC also provide a number of multimedia resources available to you.

CLINICAL LABORATORY

TMC, UMC and the SAVAMC offer comprehensive Clinical Laboratory services, although some tests may be sent to outside laboratories. Clinical laboratory facilities and their staff are accessible to medical residents 24-hours/day and are available to help you perform and interpret Gram stains, wet-mounts and other essential tests.

MEDICAL RECORDS

Timely completion of medical records is a requirement for ongoing hospital staff privileges and for continued employment with THMEP. Failure to complete medical records may result in suspension from the residency program without pay or dismissal. During a resident's suspension from clinical activities while on inpatient services or emergency medicine, other residents may be required to cover. Any time missed while on suspension must be made up at the end of the residency program.

INVASIVE PROCEDURES:

Certification & Documentation of Adequate Proficiency and Experience in Performing Invasive Procedures

UA-THIMRP houseofficers must comply with their programs invasive procedures policy. In general, privileging criteria in each of this programs participating hospitals (UMC, TMC and SAVAMC) should be essentially identical, with privileges obtained at one hospital usually pertaining to the others as well. However, privileging is done separately at each hospital, and residents should verify that privileges have been granted prior to performing any invasive procedure. Privileging status can be verified by contacting the THMEP office, or by checking on the Vision 2000 site available on any TMC intranet computer. Any discrepancies between expected privileges and actual privilege status should be discussed with THMEP Administration immediately.

The American Board of Internal Medicine requires observation during residency training of satisfactory skill in the performance and interpretation of invasive diagnostic and therapeutic procedures. Furthermore, many hospitals and clinics now require documentation of formal training, experience and competency in performing invasive procedures for credentialing. For these reasons, the following guidelines have been adopted.

All Transitional residents and THIMRP residents should follow the following guidelines:

1. All housestaff must become familiar with the accepted indications for and potential complications of each invasive procedure they perform, and must be able to knowledgeably counsel the patient on these.

2. The houseofficer performing the procedure is responsible for obtaining prior consent for the procedure and is responsible for adequate documentation in a procedure note. The houseofficer is also responsible for follow-up of both the results of the procedure and any complications or potential complications.

Any Transitional resident either performing or supervising an invasive procedure must fill out the "Documentation Log for Internal Medicine procedures: including patient identification, medical record number, hospital, procedure type, evaluation of procedure, indications, complications and follow-up intended. These log books can be obtained in the THMEP office, and the forms are kept in the resident's permanent file. The procedure form must be completed and signed by the attending or supervising resident (Level 3 privileged). One copy should be returned to the THMEP office as soon as possible for documentation purposes. The other copy should be retained by the houseofficer. THIMRP residents should complete the invasive procedure documentation form for their program in a similar manner.

Credentialing of Transitional residents for the performance of invasive procedures is based on three levels of clinical privileges:

Level 1 - The individual can perform the procedure only **under the direct supervision of either the attending physician or a resident with Level 3 privileges.**

Level 2 - The individual can perform the procedure under indirect supervision **of the attending physician.** That is, the attending physician must explicitly agree that the procedure is appropriate, and must be aware that the resident is performing this procedure.

Level 3 - The individual can both perform the procedure under indirect supervision of the attending physician **and** can supervise and certify others performing this procedure.

Entering PGY-1's are Level 1 in all procedures.

Level 2 privileges should be obtained during the PGY-1 year for most procedures.

Whenever possible, Level 3 privileges should be obtained upon promotion to the PGY-2 year. However, Level 3 privileges are only granted by the Program Director or Associate Program Director at TMC when the observation criteria for the procedure are met **AND** the trainee's performance and understanding of the risks and benefits of the procedure make the granting of the privilege appropriate.

Privileging status for any procedure can be viewed by the resident and appropriate Hospital Staff on the TMC Intranet *home page*, select *Physician & Allied Health*, then select *Practitioner Privilege Site*. Instructions on that screen tell you how to access your name and your privilege status of required invasive procedures. Procedures in black print indicate you are qualified to do the procedure, red indicates the procedure needs to be done under direct supervision of either the attending physician or a resident with Level 3 privileges, and green indicates that the resident is qualified to proctor (supervise) the procedure. Required procedures are also listed on the next three pages of this handbook.

CLINICAL PROCEDURES REQUIRING CREDENTIALING:

1. BASIC PROCEDURES:

PROCEDURE	**CRITERIA for Level 2 Privileges and required by UA-THIMRP**
1. Abdominal Paracentesis	5 certified, supervised procedures
2. Arterial Line Placement	5 certified, supervised procedures
3. Arthrocentesis (Joint Injection)	5 certified, supervised procedures
4. Central Venous Access: Internal Jugular or Femoral or Subclavian	(Must have 5 certified total) 5 certified, supervised procedures 5 certified, supervised procedures 5 certified, supervised procedures
5. *Drawing venous blood	5 certified, supervised procedures
6. *Drawing arterial blood	5 certified, supervised procedures
7. Incision and drainage of an abscess	5 certified, supervised procedures
8. Lumbar puncture	5 certified, supervised procedures
9. Nasogastric intubation	3 certified, supervised procedures
10. *Pap smear & endocervical culture	5 certified, supervised procedures
11. *Placing a peripheral venous line	5 certified, supervised procedures
12. Pulmonary artery catheter placement	5 certified, supervised procedures
13. Thoracentesis	5 certified, supervised procedures
14. Endotracheal intubation	3 certified, supervised procedures

15. Swan Ganz insertion	5 certified, supervised procedures
16. *ACLS Certification	

*ABIM mandated procedures - Criteria subject to change according to ABIM/RRC Guidelines. These procedures should be certified by the completion of the PGY-1 year.

If emergency endotracheal intubation is required, nursing staff should be instructed to call for appropriate backup immediately and emergency endotracheal intubation should proceed after preoxygenation with 100% oxygen by bag-valve-mask. If unsuccessful, bag-mask-valve ventilation should continue until the arrival of an anesthesiologist (or another individual with expertise in endotracheal intubation). Elective endotracheal intubation should never be performed by a resident without the express permission of the attending. In addition, an anesthesiologist (or another physician with adequate expertise in endotracheal intubation) must be present for backup before the beginning of the procedure.

2. ADVANCED PROCEDURES: Each resident is credentialed Level 1 throughout training and is required to perform these procedures under the **direct** supervision of an attending physician.

PROCEDURE	CRITERIA
1. Flexible sigmoidoscopy	Always Level 1 Privileges during Residency
2. Pericardiocentesis	Always Level 1 Privileges during Residency
3. Transvenous pacemaker	Always Level 1 Privileges during Residency

3. OTHER PROCEDURES: These are not required by the Transitional RRC, ABIM or UA-THIMRP, but may be done under program attending supervision and should be documented. They may include but are not limited to:
Endometrial Biopsy, Skin Biopsy, Temporary Pacemaker, Treadmill and Interpretation, Breast Exam, Chest Tube, Intradermal injection, Incision & drainage superficial abscess, Subcutaneous Injection, Suture Removal, Skin Punch Biopsy, Peripheral IV Lines, Perform EKG.

HOLIDAYS

THMEP holidays are:
Christmas
New Year's Day
Memorial Day
Fourth of July
Labor Day
Thanksgiving

VACATION

THMEP housestaff are given a total of four weeks of paid vacation per year, to be taken in one-week blocks. No more than one week of vacation may be taken from any month long rotation. Two weeks of vacation may be taken consecutively, provided they are the last week of one rotation and the first week of the following rotation.

R1's may **not** take vacation from:

1. Rotations at SAVAMC
2. At the same time on the same team on General Medicine at TMC
3. Pediatrics (elective)

All housestaff may **not** take vacation during:

1. The first week in July
2. The last week of June, with the following exception: R1's who begin residency elsewhere on July 1 may take vacation during the last week of June providing vacation time is due and adequate coverage of the service is maintained.

COVERAGE DURING ILLNESS

Unfortunately, houseofficers and their families get sick during the year and it is necessary to provide coverage for housestaff who are not able to work. The following guidelines are an attempt to cause the least disruption to patient care and the educational process.

The Transitional Residency Program is obligated to provide R1's to the following services: Inpatient at TMC and SAVAMC; TMC Emergency Medicine, TMC Surgery and UMC Trauma. If an R1 on one of these services is unable to work, the R1 on elective will be asked to drop the elective to cover the service vacated by the sick R1.

Housestaff will not be asked to give up scheduled vacation time to cover for sick residents.

POLICY FOR RESIDENT ABSENCE FROM WORK:

If the resident is unable to come to work, he/she must obtain permission from the Program Director and the attending physician to whom the resident is assigned. Approval may not be granted by the Chief Resident or another resident. In cases where this policy is not honored, disciplinary action will follow. Appropriate actions might include probation, suspension or permanent dismissal from the program.

UNIVERSAL PRECAUTIONS FOR HANDLING BLOOD AND BODY FLUIDS

During your internship and residency, you will occasionally be required to care for patients with known HIV infection, chronic hepatitis or other blood-borne and communicable diseases. If you have to draw blood or obtain other body fluids from these patients, it should be obvious to you that gloves must be worn during the procedure and great care should be exercised in handling the fluid.

Because patients may be infected with such diseases and not know it, the Tucson Hospitals Medical Education Program has instituted Universal Precautions for the handling of body fluids and secretions. What this means is that all patients are to be regarded as potentially infected with HIV and other communicable diseases and gloves must be worn when handling body fluids from any patient.

After using needles for drawing blood or other purposes, the needles should not be recapped -- they should be placed directly in the nearest disposal unit designated for such purposes. Most needle sticks occur when people try to recap the needle.

If a needle stick should occur, you should follow the procedures outlined on the following pages/paragraphs.

If you have any questions about proper handling of body fluids, please ask your senior resident or attending before attempting the procedure.

SHARPS INJURY/BODILY FLUID EXPOSURE

For your safety, following is the policy concerning medical care and follow-up for sharps injuries, (needle sticks, scalpel injuries, etc.) and bodily fluid exposures that occur on the job. If you suffer a sharps injury or if you are splashed with bodily fluids to your mucous membranes:

- Call TMC Employee Health immediately at extension 47106.
- Your Hepatitis B antigen status will be determined and you will vaccinated if necessary.
- You will receive Hepatitis B immunoglobulin prophylaxis and treatment if indicated.
- You will be counseled and offered serial HIV AB testing.
- You will be referred to an infectious disease physician for AZT prophylaxis if indicated.

- The source patient, if known, will be counseled and asked to consent to HIV AB and Hep B_5A_g testing if indicated. Blood will be drawn on the source patient with consent.

WORK EXPOSURE TO BODILY FLUIDS

NOTICE TO EMPLOYEES (TMC/THMEP)

Re: Human Immunodeficiency Virus (HIV)
and Acquired Immune Deficiency Syndrome (AIDS)

Employees are notified that a claim may be made for a condition, infection, disease of disability involving or related to the Human Immunodeficiency Virus (HIV) or Acquired Immune Deficiency Syndrome (AIDS) of the Industrial Commission of Arizona. Such a claim shall include the occurrence of a significant exposure at work, which generally means contact of an employees' ruptured or broken skin or mucous membrane with a person's blood, semen, vaginal fluid, surgical fluid(s) or any other fluid(s) containing blood. AN EMPLOYEE MUST CONSULT A PHYSICIAN TO SUPPORT A CLAIM. Claims can not arise from sexual activity or illegal drug use.

Certain classes of employees may more easily establish a claim related to HIV or AIDS, if they meet the following requirement:

1. The employee's regular course of employment involves handling or exposure to blood, semen, vaginal fluids, surgical fluid(s) or any other fluid(s) containing blood. Included in this category are health care providers, forensic laboratory workers, fire fighters, law enforcement officers, emergency medical technicians, paramedics and correctional officers.

2. NO LATER THAN TEN (10) CALENDAR DAYS after the possible significant exposure which arises out and in the course of employment, the employee reports in writing to the employer the details of the exposure as provided by Commission rules. Reporting forms are available at the hospitals or from the Industrial Commission of Arizona 800 W. Washington, Phoenix, AZ 85077 (602) 542-4661 or 2675 E. Broadway, Tucson, AZ 85716 628-5188. If an employee chooses not to complete the reporting form, that employee may be at risk of losing a prima facie claim.

3. NO LATER THAN TEN (10) CALENDAR DAYS after the possible significant exposure the employee has blood drawn, and NO LATER THAN THIRTY (30) CALENDAR DAYS the blood is tested for HIV by antibody testing and the test results are negative.

4. NO LATER THAN EIGHTEEN (18) MONTHS after the date of possible significant exposure at work, the employee is retested and the results of the test are HIV positive or the employee has been diagnosed as positive for the presence of HIV.

MOONLIGHTING POLICY

Participation in graduate medical education is considered a full-time commitment. As such, "moonlighting" is generally discouraged. Should you decide to moonlight outside the THMEP educational program, the following policies apply:

- Permission must be obtained for the specific activity from the residency Program Director. He has the prerogative to deny the request.

- The number of hours spent on moonlighting activities must be reported monthly to the Program Director and will be documented in the resident's records.

- Moonlighting must not interfere with the performance of your assigned patient care responsibilities and educational exercises.

- The total number of hours permitted for both the residency and moonlighting combined may not exceed 80 hours per week averaged over a four week period.

- THMEP will not provide medical liability insurance for any moonlighting activities.

- You must have a regular Arizona medical license to participate in such moonlighting.

PARENTAL LEAVE POLICY (THMEP EMPLOYEES)

Vacation time may be used for maternity or paternity leave. Thereafter, further time off is permissible but without pay. A complication of pregnancy or the post-partum period resulting in a longer absence from the program will be regarded as a "sickness" under our disability program.

POLICY ON NARCOTICS AND OTHER PRESCRIPTION MEDICATIONS

As residents, you will now have the ability to prescribe narcotics and other prescriptions for patients. This privilege also carries a tremendous responsibility. The misuse of narcotic medications, or even the appearance of misuse, can be one of the most serious and damaging threats to a young physician's career.

Therefore, it is essential that you never prescribe narcotics for yourself, or ask for them from a nurse or from a pharmacist. As a general rule, you should never prescribe any medication for yourself, and if you are in need of a prescription medication, you should establish care with one of the physicians here or under your health plan no matter how trivial the problem may seem.

Likewise, it is against Arizona State law to prescribe narcotics for a member of your family.

As a general rule, you should never prescribe narcotics for someone who is not under your direct medical care. The problem for which the drug is being prescribed must be in the chart and the number and dose of the medications must also be entered in the chart. Never write a prescription for a fellow physician, nurse, secretary or anyone else who asks you for narcotics. Just inform them that it is against the policy of THMEP and that you could lose your license.

Residents must personally see any patient before ordering Benzodiazepines or Narcotics. These medications should never be ordered on a patient without first assessing the patient. A short note should be written as to why a Benzodiazepine or Narcotic medication is being given.

It is also the policy of THMEP that residents and interns should not give medical advice or write prescriptions for ancillary staff such as secretaries, nurses, clerks, etc. A number of legal and professional conflicts arise when this happens and it is not in your best interest to try to help someone out in this manner. Again, if someone does ask you for medical advice or any kind of prescription, you must refer them back to their primary care physician or suggest that they see one of the members of the medical staff.

There will NO exceptions to the above rules.

THMEP RESIDENT SUPPORT/IMPAIRED RESIDENT PROGRAM

Overview:

The objective of the Resident Support and Impaired Resident (RS/IR) program is to retain valued residents who have problems that affect their job performance. These programs have been developed to assist residents in coping with stressful clinical or personal situations.

Philosophy:

THMEP recognizes that most problems can be successfully corrected when they are identified in the early stages and referral is made to an appropriate level of care. This applies if the problem is one of physical or mental illness, emotional stress, financial, marital or family distress, alcohol or drug, events triggered by adverse clinical outcomes, mal-practice events, or professional relationships. Unless the situation endangers a patient, visitor, or family member, residents may voluntarily access these programs. Otherwise, participation will result from a non-voluntary referral. All communications are confidential.

General Information

A. **Confidentiality/Records**

   All records are the property of the THMEP RS/IR Program. All records will be kept strictly confidential to the extent provided for by statute or regulation, and will not be noted in any official THMEP record. Information may only be released with the written permission of the resident in accordance with state or federal regulation, or in response to a court order. Records will be kept for a period of five years.

B. **Eligibility**

   The RS/IR program is available to all THMEP Residents. Residents may contact Optum Care24 at 1-888-887-4114 for an appointment or a referral.

C. **Residency Program Leadership**

   The residency Program Director is responsible for documenting resident performance and conduct, and when needed, to take appropriate action for correction, as provided by this program. The Program Director will not attempt to diagnose the medical or behavioral problem that is causing the inappropriate behavior, but will facilitate the formal or informal referral to assist the resident at the residency program's expense.

   The Residency Program Director will facilitate the referral of a resident to the RS/IR program before, during, or after a disciplinary step.

Services:

1) **Management Consultation**

The Residency Program Director may initiate the Employee Assistance Program (EAP) and request a confidential consultation concerning a resident. The Employee Assistance Program may also provide support/counseling to the Program Director regarding critical incident stress management, communication skills, conflict resolution, grief and change transition, and other issues.

2) **Resident Support System**

A. **Personal Referral Service**

Residents may contact the THMEP office to obtain a referral or schedule an appointment to meet with a counselor for an initial assessment or evaluation of need through the EAP @Optum Care24. Counseling services are available at no charge to residents.

The EAP referral services include individual, couple or family counseling, alcohol and drug abuse evaluation and rehabilitation referral, and referral for other addictions, such as gambling, sex, work, etc. Other services include: financial counseling, legal service, divorce counseling and support groups, parenting information, healthcare-burnout information, caregiver concerns and resources for the elderly, grief and loss counseling, and care for the caregiver.

B. **Critical Incident Stress Management Debriefing:**

In the event of a critical incident involving a THMEP resident and a participating institution any staff member or physician may request a debriefing, counseling and support through the EAP. All personnel directly involved are invited to participate. Debriefings are conducted by the critical incident stress management team. Individual debriefings are also available.

C. **Behavioral Issues Counseling:**

In a situation where the behavior or action of a resident jeopardizes the care of a patient or creates conflict with staff, the resident may be referred to the Employee Assistance Program for services such as conflict resolution, mediation, assessment, and short term counseling. Residents may elect to utilize counseling through THMEP or arrange for their own private follow-up.

Disciplinary processes will be in accordance with THMEP "Disciplinary Action and Appeals" policy and/or the Bylaws of a hospital's Professional Staff.

3) **Impaired Resident System**

This has been developed for the purpose of protecting patients from a resident who may be guilty of unprofessional conduct, or otherwise unable to safely engage in the practice of medicine. The program is conducted in collaboration with the Arizona State Board of Medical Examiners (BOMEX), and is in accordance with Arizona State Statute ARS Article 3, 32-1451.

A. **Self-referral:**

   Self-referral is encouraged and is consistent with the policies of BOMEX. All referrals are confidential except reporting as required by ARS 32-1451. A self-referral occurs when a resident contacts the Residency Program Director or THMEP Administration staff directly. A self-referral is recorded in the resident's file but information may not be released except as provided by the Bylaws of the Professional Staff of the involved institution.

B. **Non-voluntary Referral:**

   Non-voluntary referrals are made when the resident is found to be in violation of THMEP or institutional conduct guidelines such as: prohibiting practice while under the influence of alcohol or illegal drugs, or the use, possession, sale, purchase, transfer, or negotiation for sale of drugs on institution property or the institution's Bylaws of the Professional Staff. Referrals may result from alcohol or drug testing programs or law enforcement programs. BOMEX reporting will occur in such cases, and in accordance with ARS statute 32-1451. Referrals may also result from the resident acting in violation of any hospital policy, rule, regulation, or standard of performance that, in the opinion of the hospital medical staff leadership, or Professional Staff Office Leadership, might endanger the safety or well-being of a patient or those involved in the care of the patient. Referred residents will be entered into the Impaired Resident System for tracking purposes, in accordance with BOMEX regulations. The resident will be required to agree to the terms requested including reporting of treatment progress and random alcohol and drug testing. Should a resident refuse to agree to the terms, fail to successfully complete the program, or violate the terms of the agreement, then termination of employment and privileges or other disciplinary action may be implemented and BOMEX and/or other appropriate licensing agencies will be notified. All referrals are recorded in the resident's file.

POLICY ON ACCOMODATION OF RESIDENTS WITH DISABILITIES: AN INSTITUTIONAL POLICY

At the regular meeting of the Board of Directors of the Tucson Hospitals Medical Education Program, Inc. held on April 19, 2007 the following resolution was passed unanimously:

RESOLVED: It is the policy of the Tucson Hospitals Medical Education Program (THMEP) to comply with the Americans with Disabilities Act, Section 504 of the Rehabilitation Act of 1973, and state and local requirements regarding resident applicants and employees with disabilities. Under these laws, no otherwise qualified and competitive individual with a disability shall be denied access to or participation in THMEP programs solely on the basis of the disability.

Resident must be able to perform, with reasonable accommodation, all of the functions necessary for successful medical education and patient care.

Signed: __________________________ Date: _________________
Robert M. Aaronson, M.D.
President THMEP Board of Directors

TUCSON HOSPITALS MEDICAL EDUCATION PROGRAM (THMEP)

Educational Accommodation for Disabilities

Residents requesting accommodations must provide the following:

1. Written documentation of the disability

2. A qualified, certified/licensed/registered professional who is qualified to diagnose disabilities should prepare documentation, including but not limited to doctors of medicine, doctors of osteopathy, educational diagnosticians, learning specialists, psychologists, physical therapists, and occupational therapists.

3. Documentation should describe the resident's condition and should include:
   A. Specific diagnosis

   B. Information that provides the basis for the diagnosis

   C. A description of how the diagnosed condition has an impact on a major life activity, such as learning, and functional limitations the resident may have due to the disability

D. Recommendations for reasonable accommodations, if needed, and why such accommodations are needed

E. Name(s), address(es), telephone number(s), and qualifications of each professional who provides the documentation

TUCSON HOSPITALS MEDICAL EDUCATION PROGRAM (THMEP)

Resident's Formal Request for Accommodation due to a Disability

DATE: ________________

TO: THMEP Administration

I request accommodation due to a specific disability. The documentation of my disability is attached as specified in the THMEP institutional policy regarding residents with disabilities. I understand and hereby authorize that the documentation will be reviewed by the appropriate THMEP officials.

FROM: ____
Resident's Name (printed)

____
Resident's Signature

Attachment: Documentation of a Specific Disability

TUCSON HOSPITALS MEDICAL EDUCATION PROGRAM (THMEP)

Resident Job Description/Requirements

POSITION SUMMARY:

The resident shall function under the supervision of the attending medical staff. In this role, the resident assists with admissions, consultations, evaluations, diagnosis and treatment of patients. He/she may provide verbal, written and telephone orders.

PROCEDURES:

The resident must be able to successfully perform those procedures as required by the Residency Review Committee (RRC) necessary for successful completion of the program, and, if pertinent, eventual board certification.

QUALIFICATIONS:

Must be able and willing to establish and maintain effective working relationships with patients, families, hospital staff, attending physicians and the public; and perform high-level decision-making.

EDUCATION:

Doctor of Medicine (MD), or Doctor of Osteopathy (DO)

LICENSURE AND CERTIFICATION:

Current limited Arizona Training license

EXPERIENCE:

Medical Degree

OTHER KNOWLEDGE AND SKILLS:

Commensurate with degree, advancement and responsibilities

DEMANDS:

High level decision-making
Performs highly complex and varied tasks

PHYSICAL DEMANDS:

Ability to perform physical examination of patients
Dexterity needed to perform physical examination and procedures

ENVIRONMENT:

Exposure of Risk Level I exposure to infectious disease

EQUIPMENT:

Demonstrates competency and dexterity with all equipment utilized in the hospital environment

RELATIONSHIPS:

Reports to the applicable Program Director and/or Associate Program Director. Adheres to policies and procedures, stated and published of the THMEP Residency Program

SUPERVISES:

Medical students

INTERNAL RELATIONSHIPS:

Fellow residents, residency program faculty and staff, hospital staff, and medical staff

EXTERNAL RELATIONSHIPS:

Patients and families, and referring physicians

ESSENTIAL JOB FUNCTIONS:

- Develops and maintains a personal program of self-study and professional growth with guidance of the faculty
- Admission, consultation, evaluation, diagnosis and non-surgical treatment of patients with general medical problems. Provides safe, effective and compassionate patient care under supervision
- Demonstrates dexterity and competency to perform all essential and required procedures and provides complete, written documentation of all procedures
- Identifies need for patient education and orders or provides education
- Comprehensively documents in patients' charts in a timely and accurate manner
- Demonstrates awareness and sensitivity to patient and family issues, including age, gender and

cultural diversity

- Functions with an awareness and application of standard operating procedures including OSHA, Workers Right to Know. Clinical Compliance, General Safety, HIPAA
- Efficiently performs in emergency situations, including adherence to established clinic and hospital –specific protocols
- Demonstrates applied knowledge base including integration of skills as required through block rotation experiences
- Participates actively in all educational and residency program activities and assumes responsibility for teaching other residents and medical students
- Demonstrates awareness and applies knowledge of legal issues in all aspects of patient care, incorporating risk management skills, and quality control measures
- Actively participates on any assigned hospital committee as a member
- Demonstrates effective communication skills
- Participates in the resolution of residents' staffing conflicts and maintains flexibility regarding staffing patterns, including on-call schedule and daily schedules
- Provides coverage for temporary staffing conflicts of the Residency program
- Demonstrates ability for effective problem identification and resolution as well as the exercise of independent judgment
- Participates in research and scholarly activities
- Provides teaching, supervision and serves as a role model to other residents
- Performs such duties as assigned by the Program Director, in accordance with the description of the residency, to the best of his/her ability and under the highest personal bond of professional morals and ethics

SAFER PROGRAM

Please visit this website for more details
http://www.gme.medicine.arizona.edu/gme_business/safer.cfm