

SCRANTON-TEMPLE RESIDENCY PROGRAM

PRIMARY CARE INTERNAL MEDICINE

2008 - 2009

HOUSESTAFF POLICY MANUAL



TABLE OF CONTENTS

Letter from the President and CEO.....	3
Letter from the Program Director	4
Introduction.....	5
STRP Faculty.....	6
Professional Guidelines	10
General Information.....	11
Housestaff Duty Hours and Work Environment.....	12
In-Patient Medical Services	17
Intensive Care Unit Moses Taylor Hospital.....	19
Emergency Room Rotation, Consultative Services, Response to Cardiac Arrest	21
Medical Education and Licensure, M.D. and D.O.	22
Competencies.....	26
Progressive Learning Objectives	35
Ambulatory Care.....	42
Subspecialty Rotations.....	47
Individual Responsibility	48
Miscellaneous Benefits/Policies	50
Scheduling	51
On Call Responsibilities	57
Policy on Care of Non-Teaching Service Patients/STRP Resident Coverage.....	58
Weekend Coverage	59
Order Writing.....	60
Rounds.....	61
Conferences.....	62
Morning Report and Noon Conference Attendance.....	64
Medical Records	66
Evaluation Mechanism.....	72
Dismissal of Residents.....	74
Due Process.....	76
Osteopathic Internship: Additional Guidelines.....	80
Library Facilities/Laboratories.....	81
Informatics/Electronic Access and Usage Policy	82
Holiday Policy.....	85
Morbidity and Mortality Conferences/Autopsies.....	86
Moonlighting Policy	88
Off-site Elective Policy.....	92
Answering Service Functions	93
Hospital Safety Plan/Hospital Disaster Plan/Reporting Incidents	94
Schedule A: Medical Record Keeping.....	95
Schedule B: Attending Physician Peer Review	96
Schedule C: Osteopathic Internship Goals & Objectives	97
Schedule D: American Osteopathic Association Intern Logs.....	112

LETTER FROM THE PRESIDENT AND CEO

Welcome new residents!

On behalf of your colleagues, and the faculty, I welcome you to STRP and wish you every success here.

We believe that each resident contributes directly to STRP's growth and success, and we hope you will take pride in being a member of our team.

This manual was developed to describe some of what we expect of our residents and to outline the policies, programs, and benefits available to eligible residents. Residents should familiarize themselves with the contents of this manual as soon as possible. It will answer many questions about employment with STRP.

We hope that your experience here will be challenging, enjoyable, and rewarding. Again, welcome!

Robert E. Wright, M.D., F.A.C.P.
President and CEO
Scranton-Temple Residency Program

LETTER FROM THE PROGRAM DIRECTOR

We are so excited to welcome you to the Scranton-Temple Residency Program's educational family!

We are heavily invested in each of you and your success. Your continued professional development in becoming the best doctor you can be is our highest priority. We want your training in Internal Medicine with us to be as formative, valuable and memorable as possible. We welcome our trainees' perspectives and talents, and look forward to your contributions to STRP's programmatic development and future accomplishments.

We take pride in being learner focused and are proud to present to you this Housestaff Manual for your review and reference. This manual was developed and is routinely updated to describe comprehensively our expectations of our residents in training and to outline the policies, programs, and benefits available to you. Residents should familiarize themselves with the contents of this manual during their orientation and reference it throughout their training. We welcome and value residents' contributions to updating this manual on an annual basis.

We hope your time at STRP is personally and professionally gratifying. We will do everything possible to support your education. We're really excited you're here!

Sincerely,

Linda Thomas, M.D.
Program Director
Scranton-Temple Residency Program

INTRODUCTION

Congratulations and welcome to the Scranton-Temple Residency Program.

Scranton-Temple Residency Program Inc., is a non-profit corporation whose purpose is to develop and operate a residency program. The teaching hospitals of STRP have traditionally been Mercy Hospital and Moses Taylor Hospital but from July 2008, our residents will also be rotating at Community Medical Center. Ambulatory care training is provided at the Scranton Temple Health Center and the Mid Valley Practice. Temple University School of Medicine is our primary affiliate. Lake Erie College of Osteopathic Medicine and Philadelphia College of Osteopathic Medicine are linked to STRP through the Osteopathic physician training initiative.

At STRP we are proud of our tradition of providing the best educational environment for our residents helping them mature into well-rounded, competent and compassionate internists.

During your stay here this Housestaff Policy Manual will guide you with respect to your “rights and duties” while also giving a brief summary of the way rotations are set up in the program (the service blocks, the sub-specialty electives, ER, ICU and so on), on-call responsibilities, conference schedule etc. In short, this manual outlines the procedures followed by the professional staff of the residency program. Its purpose is to define the standards of medical practice and teaching for our residents and faculty and the means utilized to maintain them. Kindly take time out to familiarize yourself with this document as it will guide you throughout your stay here. If you still are not clear about an issue, feel free to contact the Program Administrator.

Wish you all the best!

Arjinder Sethi, M.D.
Associate Program Director
Scranton-Temple Residency Program

STRP FACULTY

Robert E. Wright, M.D., F.A.C.P.	President and CEO
Linda Thomas, M.D.	Program Director, Director Ambulatory Care, Director Mid-Valley Practice
Arjinder Sethi, M.D.	Associate Program Director, Clinical Coordinator at Community Medical Center
Vincent J. Vanston, M.D.	Key Clinical Faculty, Palliative Care Education Coordinator
Shubhra Shetty, M.D.	Key Clinical Faculty, Infectious Diseases Education Coordinator
John Guzek, M.D.	Key Clinical Faculty, Director Scranton Temple Health Center
Haitham Abughnia, M.D.	Key Clinical Faculty, Clinical Coordinator at Mercy Hospital
Shireen Lobo, M.D.	Key Clinical Faculty, Clinical Coordinator at Moses Taylor Hospital
John E. Prior, D.O.	DME Osteopathic Internship
Richard L. Weinberger, D.O.	Osteopathic Medical Education Coordinator
Edward Dzielak, D.O.	Geriatrics and Critical Care Education Coordinator
Stephen Pancoast, M.D.	Scranton-Temple Health Center Preceptor
Charles S. Deck, M.D.	Inpatient and Scranton-Temple Health Center Preceptor
Martin Hyzinski, M.D.	Inpatient and Scranton-Temple Health Center Preceptor

INTERNAL MEDICINE

Dr. Robert E. Wright	Dr. Linda Thomas	Dr. Arjinder Sethi
Dr. Vincent J. Vanston	Dr. Shubra Shetty	Dr. John Guzek
Dr. Haitham Abughnia	Dr. Shireen Lobo	Dr. Shawn McCall
Dr. John McGeehan	Dr. Richard Weinberger	Dr. James Sheerer
Dr. Randall Brundage	Dr. Charles S. Deck	Dr. Edward Dzielak
Dr. Rajan Mulloth		

ALLERGY & IMMUNOLOGY

Dr. Joel Laury	Dr. Rosanne Cech
----------------	------------------

ANESTHESIOLOGY

Dr. Joseph Ruzbarsky	Dr. Sanford Holland	Dr. Michael Kline
Dr. Senen Alday	Dr. James Arscott	Dr. Eric Barren
Dr. Subhash Arora	Dr. Patrick Grady	Dr. Barbara Penetar
Dr. Albert Belardi	Dr. Wael Hassanein	Dr. Cubyson Oxley
Dr. Rahmat Shah		

CARDIOLOGY

Dr. Christopher Dressel
Dr. Samir Pancholy
Dr. Sampath Kumar
Dr. Thomas Dzwonczyk
Dr. John Lundin (Electro-Physiologist)
Dr. Vitale Geyfman

Dr. Linda Barrasse
Dr. Leonard Denis
Dr. David Lohin
Dr. Thomas Roe
Dr. Stylianos Galanakis
Dr. Raymond S. Resnick

Dr. Stephen Voyce
Dr. Chau-Fe Huang
Dr. Sun-Tak Han
Dr. Madhava Rao
Dr. Dave Fitzpatrick
Dr. Barry Weinberger

DERMATOLOGY

Dr. Michael O'Donnell
Dr. Mark Marsili

Dr. Douglas Sheldon

Dr. Jo Ann Zenker
Dr. Greg Severs

EMERGENCY MEDICINE

Dr. Mary Sewatski
Dr. Tanja Adonizio
Dr. Richard Rudloff
Dr. Gerard Nealon
Dr. Adrian Dormans

Dr. Paul Dubiel
Dr. James Jones
Dr. Joseph Russo
Dr. John Viteritti

Dr. Anthony Sauter
Dr. Gerard Maritato
Dr. Ammie Maravelli
Dr. Dennis Kapp
Dr. Richard OBrien

ENDOCRINOLOGY

Dr. Gregory Borowski

Dr. Matthew Levy

FAMILY PRACTICE

Dr. Thomas Majernick
Dr. Lisa Robertson

Dr. Michael L. Kondash

Dr. Armando Sallavanti
Dr. Jehad Charabati

GASTROENTEROLOGY

Dr. Christopher Barbarevech
Dr. Bharatkumar Patel

Dr. Alexander Lalos
Dr. Ronald Cianni

Dr. David Rutta
Dr. Edward Sherwin

GERIATRICS

Dr. Edward Dzielak

HEMATOLOGY & ONCOLOGY

Dr. Christian Adonizio
Dr. Richard G. Emanuelson
Dr. William Heim
Dr. Gloria Morris

Dr. Martin Hyzinski
Dr. Salvatore Scialla
Dr. Edward Jordan

Dr. Abdalla Sholi
Dr. Lisa Thomas
Dr. Carl Barsigian

INFECTIOUS DISEASES

Dr. Rodger Fagerburg

Dr. Stephen Pancoast

Dr. Shubra Shetty

NEPHROLOGY

Dr. Jeremiah W. Eagen
Dr. Roger Getts

Dr. Henry Yeager

Dr. John E. Prior

NEUROLOGY

Dr. Michael Baccoli
Dr. Juan Barrera-Martinez

Dr. Seth Jones

Dr. Kevin Madden
Dr. Michael D. Kim

OBSTETRICS & GYNECOLOGY

Dr. Lee Davis and associates
Dr. Gehred Wetzel

Dr. J. M. Tedesco

Dr. Erroll Goldstein

OPHTHALMOLOGY

Dr. William J. Jordan
Dr. William Jordan, Jr

Dr. Arthur J. Jordan, Jr
Dr. Christopher S. Jordan

Dr. Jerome Jordan
Dr. Thomas Boland

ORTHOPEDICS

Dr. John Doherty, Jr

Dr. Theodore J. Tomaszewski

Dr. Kevin R. Colleran

OTORHINOLARYNGOLOGY

Dr. Mark A. Frattali
Dr. Keith M. Pritchik

Dr. Anthony Brutico

Dr. Louis DeGennaro

PALLIATIVE CARE

Dr. Vincent J. Vanston

PEDIATRICS

Dr. Linda Thomas
Dr. Kathleen Walsh
Dr. Michelle Sudo

Dr. Stanley Blondek
Dr. Martha Sauter

Dr. F. D. Dawgert and associates
Dr. Jeffrey Zero
Dr. Jill McCoy

PSYCHIATRY

Dr. Ashok Kumar Patel
Dr. Nelson K. Asante

Dr. Matthew Burger
Dr. Peter Moskel

Dr. Danilo DeSoto
Dr. Mohamad Rahman

PULMONARY MEDICINE

Dr. Ajay Shetty
Dr. Gregory Cali

Dr. S. Ramakrishna
Dr. Sander Levinson

Dr. Kenneth Jacobs
Dr. Terrence Lenahan

RADIOLOGY

Dr. Suman Patel
Dr. Charles Barax

Dr. Joe Lahoda

Dr. Timothy Farley

RHEUMATOLOGY

Dr. Eugene Grady
Dr. Julio Ramos

Dr. Marianne Santioni

Dr. Mark Cruciani

SURGERY

Dr. Joseph P. Bannon
Dr. David Onofrey
Dr. David Onofrey

Dr. Kristine Kelley
Dr. James Roche
Dr. Joseph DelSerra

Dr. John A. Kutz
Dr. Michael Sunday
Dr. Timothy J. Farrell

UROLOGY

Dr. Jerald Gilbert
Dr. James Stefanelli

Dr. Ronald Barrett
Dr. Ira Kohn

Dr. Donald Preate, Jr
Dr. Jeffrey Weiss

CLINICAL RESEARCH & INFORMATICS

Gustav J. Stangline, PhD

PROFESSIONAL GUIDELINES

Residents professional responsibilities fall into two major categories: PATIENT CARE AND EDUCATION. In the clinical setting, these two areas are inseparable and excellence in clinical care will result in a superior educational experience. Personal pride in the performance of responsibilities is the keystone of professional excellence. Although some specific responsibilities of various individuals (student, resident, attending physician) are clearly designated, patient care and education should be viewed as a team effort.

Attendance at conferences is expected of all students, house officers and attending physicians. These sessions are designed to improve the clinical and scientific knowledge upon which we base our judgment and decision making in the care of our patients. Conferences are designed to help us reflect on our clinical responsibilities and to expand our knowledge to solve clinical problems.

We strive to provide the finest patient care and educational experience. We require a dedication to excellence of students, residents and attending physicians.

Resident Physicians will be guided by the Medical Staff Bylaws and Rules and Regulations of the Medical Staff of Mercy Hospital, Moses Taylor Hospital and Community Medical Center. These are kept on file in the respective Medical Staff Offices. Appropriate portions of these Bylaws and Rules and Regulations have been incorporated into this manual and familiarity with the bylaws is required for each resident.

GENERAL INFORMATION

DRESS: All housestaff are expected to have a neat, professional appearance. Scrub suits should be worn only in the emergency room, intensive care unit and during night call. Respectable business attire under a clean white coat will be worn at all other times.

WORK DAY: The nominal work day is 8:00 am to 5:00 pm weekdays for senior residents. The interns on service will pre-round on their patients prior to coming to the morning report. They will however report for duty **no earlier than 6:30 am**. When on call, the resident must be available in the hospital at all times. Sleeping quarters are available. Weekend duty may require 24 hours on call.

Residents will work a maximum of 80 hours per week, averaged over a four week period.

ILLNESS: The STRP office must be notified latest by 9:00 am of a sick day to be taken and the illness involved. The STRP can require a written physician evaluation. If unable to work because of valid and acceptable reasons other than an illness, residents must arrange for coverage of their responsibilities and notify the chief resident or STRP faculty covering for the chief resident. **Recorded phone messages are not acceptable.**

RELATIONSHIPS WITH HEALTH

PROFESSIONALS: Respect for all members of the patient care team is essential. Undue familiarity, inappropriate levity in patient care areas, particularly in the intensive care unit, is discouraged.

MALPRACTICE: Malpractice insurance for the residents assigned by STRP is provided by the carriers of Mercy and Moses Taylor Hospital. Residents are not covered by STRP if they administer patient care while moonlighting in facilities other than the above.

HOUSESTAFF DUTY HOURS AND WORK ENVIRONMENT

PURPOSE

To provide an institutional statement regarding House Officers' duty hours and work environment as mandated by the ACGME.

DEFINITIONS

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

In-house call: Those duty hours beyond the normal work day when House Officers are required to be immediately available in the assigned institution.

Internal moonlighting: Clinical and administrative activities performed within the Residency Program and/or the sponsoring Institution or the non-hospital sponsor's primary clinical site(s) which are voluntary and NOT required, and for which additional compensation is given. This time must be counted toward the 80-hour weekly limit on duty hours.

New patient: Any patient for whom the House Officer has not previously provided care.

POLICY

Providing House Officers with sound academic and clinical education must be carefully planned with concerns for patient safety and House Officers well being. Each Program director must ensure that the learning objectives of the Program are not compromised by excessive reliance on residents to fulfill service obligations. Didactic and clinical education must have priority in the allotment of House Officers time and energies. Duty hour assignments must recognize that faculty and House Officers collectively have responsibility for the safety and welfare of patients. The Program Director must establish an environment that is optimal for Housestaff education and for patient care, while ensuring undue stress and fatigue among House Officers are avoided.

The educational goals of the Program and learning objective of House Officers must not be compromised by excessive reliance on House Officers to fulfill institutional service obligation. Duty hours, however, must reflect the fact that responsibilities for continuing patient care are not automatically discharged at specific times. Programs must ensure that House Officers are provided appropriate backup support when patient care responsibilities are especially difficult or prolonged.

House Officer duty hours and on-call time periods must not be excessive. The structuring of duty hours and on-call schedules must focus on the needs of the patient, continuity of care, and the educational needs of the House Officer. Duty hours must be consistent with the Institutional and Program

requirements that apply to each Program as outlined by the Accreditation Council for Graduate Medical Education (ACGME).

The Scranton-Temple Residency Program fully supports and adheres to the Residents Work Hours policy established by the Accreditation Council for Graduate Medical Education (ACGME), which sets forth the following requirements:

DUTY HOURS

1. A maximum of 80 hours per week averaged over four weeks, inclusive of all in-house call activities.
2. A minimum of 10 hour time period for rest and personal activities must be provided between all daily duty periods and after in-house call.
3. House Officers must be provided with 1 day in 7 free from all educational and clinical responsibilities, averaged over a four week period, inclusive of call. One day is defined as a continuous 24 hour period free from all clinical, educational and administrative activities.
4. 24 hours maximum continuous on-site duty with up to 6 additional hours permitted for patient transfer and other activities.
5. No new patients to be admitted by a resident after 24 hours of continuous duty.
6. House Officers time spent in the hospital during at-home call to be counted toward the 80 hour maximum.
7. In-house moonlighting to be counted toward the 80 maximum hours.
8. In-house call must occur not more than every 3rd night, averaged over four weeks.

Note: Re #3 above note that in the rare instance where the intern and senior resident of the same team are on call together on weekends, one must leave at 8:00 am and the resident who leaves will be responsible for rounds at 8:00 am the following day. Every team member must have an average of 1 in 7 days off in any four week period.

Also, in the initial months of the year when the ICU is staffed by two senior residents, each senior resident must average 1 in 7 days off. ICU rounds will be shared by senior residents on call or post call on weekend days.

Re #5 above note that there is adequate coverage with other non post-call service residents who can take those morning admissions.

SUPERVISION OF HOUSE OFFICERS

1. All patient care must be supervised by qualified faculty. The Program Director must ensure, direct and document adequate supervision of House Officers at all times. House Officers must be provided with rapid, reliable systems for communicating with supervising faculty.
2. Faculty schedules must be structured to provide House Officers with continuous supervision and consultation.
3. Faculty and House Officers must be educated to recognize the signs of fatigue and adopt and apply policies to prevent and counteract the potential negative effects.

WORK ENVIRONMENT

1. **Food services:** House Officers on duty must have access to adequate and appropriate food services. Food is provided to House Officers who take in-house call.
2. **Call rooms:** Call rooms are provided for House Officers who take in-house call.
3. **Support services:** Adequate ancillary support for patient care shall be provided for residents at all times.
4. **Laboratory/pathology/radiology services:** These services and the associated information systems must be available and adequate to support timely and quality patient care.
5. **Medical Records:** Medical records system that document the course of each patient's illness and care must be available at all times and must be adequate to support quality patient care, the education of the House Officer, quality assurance and provide a resource for scholarly activity.
6. **Security/safety:** Appropriate security and personal safety measures must be provided to House Officers at all training locations.

OVERSIGHT

1. Each ACGME accredited Residency and Fellowship Training Program must establish formal written policies governing resident duty hours that are consistent with the institutional and program requirements. This policy will be communicated to the House Officers and faculty annually.
2. The GME office must be provided with a copy of the policy on a yearly basis. These formal policies will apply to all participating institutions where House Officers are trained.
3. Program Directors and faculty must adopt policies to prevent and counteract effects of fatigue. Backup systems must be provided when patient care responsibilities are unusually difficult or prolonged, or if unexpected circumstances create resident fatigue sufficient to jeopardize patient care.
4. Duty hours must be monitored by each program and a copy forwarded to the GME office who will monitor duty hours at monthly, quarterly and/or random intervals. Each Program Director should review each House Officers rotation schedule to assure compliance with this institutional policy and the common program requirements.
5. Each Program Director should regularly monitor House Officers duty hours for compliance with this institutional policy and the common program requirements. Monitoring of duty hours is required with frequency sufficient to ensure an appropriate balance between education and service.
6. The GMEC shall monitor compliance with this policy through the:
 - a. Internal residency review process for each program
 - b. Annual GME reports of each program
 - c. Periodic monitoring of individual programs.
7. Falsification of duty hour's data or pressure to cause the falsification of such data is considered egregious behavior for House Officers and can result in disciplinary action to include dismissal.
8. House Officers must notify their Program Director of requests or pressure to work in excess of duty hours authorized by this policy.

DUTY HOURS EXCEPTIONS

A RRC may grant exceptions for up to 10 % of the 80 hour limit, to individual programs based on a sound educational rationale. The GMEC must review and formally endorse the exemption prior to submission to the RRC according to the following procedures:

1. The Program Director must submit a written request for an exemption to the GMEC Chair. The request must clearly document the following:
 - a. Patient Safety: Information must be submitted that describes how the program and institution will monitor, evaluate, and ensure patient safety with extended House Officer work hours. This process will include formal reviews with Program Directors, Program Coordinators, and House Officers through e-mail surveys and verbal queries.
 - b. Educational Rationale: The request must be based on a sound educational rationale which should be described in relation to the program's stated goals and objectives for the particular assignments, rotations, and level(s) of training for which the increase is requested. Blanket exceptions for the entire educational program should be considered the exception, not the rule.
 - c. Moonlighting Policy: Specific information regarding the program's moonlighting policies for the periods in question must be included.
 - d. Call Schedules: Specific information regarding the House Officers call schedule during the times specified for the exception must be provided.
 - e. Faculty Monitoring: Evidence of faculty development activities regarding the effects of Resident fatigue and sleep deprivation must be appended.
2. The Program Director will present the request in person to the GMEC for discussion.
3. If approved by the GMEC, the Designated Institutional Official (DIO) or the GMEC Chair will provide a documented written statement of Institutional endorsement of the proposal.
4. The Program Director must submit the request to the RRC according to the ACGME's RRC procedures for granting duty hours exceptions. The paperwork submitted to the RRC must include a copy of this policy and the current accreditation status of the program and the status of the sponsoring institution.

The term House Officer is used as a generic term to include interns, senior residents and fellows in an approved ACGME Residency Training Program at the Scranton-Temple Residency Program.

- ***Daily Schedule:***

- Pre-rounding:
 - PGY-1s pre-round (before the morning report) while on service. **They will not report for duty before 6:30 am under any circumstances, except when "post-call"**.
 - Senior residents and interns not on service do not pre-round.

- Calls:
 - *Interns & Senior Residents:*
 - a. When there is no night float:
 - Weekdays: 5:00 pm to 8:00 am the next morning
 - Sat. & Sun.: 8:00 am to 8:00 am the next morning
 - b. When there is a night float:
 - Weekdays: 5:00 pm to 9:00 pm the same day
 - Friday: 5:00 pm to 8:00 am the next day
 - Saturday: 8:00 am to 8:00 am the next day
 - Sunday: 8:00 am to 9:00 pm the same day
- Night float will cover calls starting 8:30 pm till 9:00 am the next day every night Sunday through Thursday. The overlap from 8:30 pm to 9:00 pm is provided for patient sign-outs.
- Post call
 - *Interns:*
 - **Weekdays:** They will admit no new patients after 8:00 am. The interns on the other teams (in Mercy Hospital) or the senior resident on the same or other team will handle all admissions after 8:00 am. The post-call intern has to do work rounds taking care of patients admitted over night and patients who were already on service, attend teaching rounds and **leave before the noon conference**. Sign out should have been given before that time.
 - **Weekends:** Resident should leave post-call at 8:00 am and have a full 24 hrs off. Teammate (and/or non-service resident on call that day) will be responsible for rounding that day and resident has to round on patients the weekend day that he is not post-call.
 - *Senior residents:*
 - Attend all morning activities including morning report, work rounds, teaching rounds and noon conference. Senior resident should **leave immediately after the noon conference**.

IN-PATIENT MEDICAL SERVICES

During this period of training, the residents are expected to develop skills in history taking, physical examination and patient management as part of developing the six core competencies of Patient Care, Medical Knowledge, Practice-Based Learning and Improvement, Interpersonal and Communication Skills, Professionalism and Systems-Based Practice (detailed elsewhere in this manual and on STRP's website www.strpweb.org). Other important areas that include how to use the laboratory services effectively and economically; and the appropriate use of x-ray and other diagnostic services. The residents learn how to work with consultants and how to resolve diagnostic and therapeutic dilemmas. Training also enables the residents to use the medical literature effectively.

One of the more important parts of the medical rotation is the opportunity to teach. Most frequently this will be on an informal basis with other residents or allied health professionals. In addition, when medical students are assigned to the service, there will be ample opportunity to provide example, guidance and training. The results of experiences with interesting problems and the summaries of literature searches may be presented at morning report or other conferences. The preparation of case reports for publication is strongly encouraged.

ORGANIZATION OF THE MEDICAL SERVICES

Teaching service patients are admitted into "Services" run at both the hospitals under the direct supervision of STRP faculty members. Service teams usually include an intern and a senior resident though occasionally can be run by a senior resident alone under the guidance of a STRP faculty member. Patient numbers in each service and admissions to each service per day are strictly within the ACGME parameters.

ADMISSION TO SERVICE

During the day, admissions are assigned either by the Chief Resident or a specified designator of admissions as assigned. A maximum number of 5 new patients per 24 hours may be admitted by an intern. Senior residents may admit up to 10 patients per 24 hours period. Our policy is to limit the number of admissions per 48 hour period to 8 per intern and 16 per senior resident. The maximum number of patients under the care of an intern should not exceed 12 and the maximum number of patients under the care of a supervising senior resident should not exceed 16 (when supervising one intern) or 24 (when supervising two interns). These numbers are as per the ACGME guidelines and will change whenever ACGME guidelines are changed.

Residents continue to follow their patients when they are transferred to the Mercy and/or Moses Taylor Hospital based Skilled Nursing Facility (SNF), Special Care Unit, Senior Medical and Mental Health (SMMH), Allied Rehab Unit and the Hospice Unit.

All residents/interns are strongly encouraged to visit their clinic patients when they are admitted to teaching service, even if the particular resident/intern is not on medical service.

ADMISSION POLICY TO TEACHING SERVICE **MERCY HOSPITAL**

Mercy Hospital medical services are organized as teams (“Services”). Each team has senior resident(s) and intern(s). Frequently medical students will also be posted with the teams.

1. The teaching services should have a maximum of twelve active patients being taken care of by each intern. The rest patients will be followed by the senior residents alone or with the medical students. A senior resident can take care of twenty four (when supervising two interns) or sixteen (when supervising one intern) patients at one time.
2. During the evening and night hours, the residents who admit a patient will follow up that patient till they hand over the care of that patient to the service residents in the morning.
3. Residents take care of the teaching service patients who are admitted to the ICU and follow them throughout their hospital stay.

ADMISSION POLICY TO TEACHING SERVICE **MOSES TAYLOR HOSPITAL**

There are two services at Moses Taylor Hospital. These services are comprised of teaching service patients and private admissions of Dr. Dzielak and Dr. Deck. All uncovered or “no doc” patients will be admitted to these services. One service will have a team of an intern and a senior resident and will follow the same rules as mentioned above for Mercy Hospital services. The other service will have only a senior resident and will take care of maximum six patients on any given day.

INTENSIVE CARE UNIT
MOSES TAYLOR HOSPITAL

Director: Edward Dzielak, D.O.

ASSIGNMENT

As a general rule, for the first several months, two (rarely three) senior residents are assigned to the intensive care unit during the day. Later during the year, two interns are assigned with one (rarely two) senior resident(s). Night coverage in the ICU is based on the Moses Taylor Hospital call schedule.

OBJECTIVES

To develop skills required to manage critically ill patients with both medical and surgical problems. These include insertion of central venous pressure catheters, Swan-Ganz catheters, arterial lines, Udalls and endotracheal intubations.

In addition, the residents learn the principals of operation and the application of respirators and management of respiratory failure.

They also develop skills in the diagnosis and treatment of arrhythmias, sepsis and other acute illnesses.

RESPONSIBILITIES OF RESIDENT, PATIENT CARE ATTENDING, TEACHING ATTENDING

Residents take care of the medical patients (or the medical issues of the surgical patients) in the ICU under the direct supervision of the patient care attending, which should be an internist but could be a medical sub-specialist involved in the care of the patient. All patient care issues need to be addressed by him/her and they are eventually responsible for providing medical care to their patients. The exception is when the attending physician specifically states that he/she does not want the residents to participate in the care of his/her patient. Residents are also not responsible for taking care of those patients who do not have an internist on the case.

The ICU Teaching Attending, on the other hand, is responsible for doing teaching rounds with the ICU residents 3-5 days per week. He/She could discuss general ICU topics or something specific about an ICU case but that is only for educational purposes. No treatment changes are to be based on that without it being discussed with the patient care attending first. Providing patient care of the ICU patients is NOT the responsibility of the ICU Teaching Attending.

SUPERVISION

The senior residents and interns assigned to the Intensive Care Unit are supervised for their patient care activities on each patient by the internist/sub-specialist involved in/responsible for the care of that patient.

DUTY HOURS AND COVERAGE

Successful fulfillment of the responsibilities outlined above requires that the residents be present in the Intensive Care Unit almost continuously. Specific hours are as outlined in the call schedule. **When the resident leaves the immediate area, the head nurse must be advised.**

The regular work day starts at 8:00 am. However, the ICU residents are expected to report at 7:30 am to take sign-out from the night float resident. You will receive an orientation on the first day of your ICU rotation.

CLINIC COVERAGE IN THE ICU

While on this rotation, interns will be assigned only one half day per week of clinic (continuity clinic). Senior residents will not go to clinic during their ICU rotation.

CONFERENCES

When in ICU, residents are expected to be at the ICU morning report on Thursdays and the Wednesday noon conference, whenever possible.

OFF TIME

All senior residents and interns on ICU rotation should have one 24 hour weekend day off per week.

EMERGENCY ROOM ROTATION

MERCY HOSPITAL

Director: Anthony Sauter, M.D.

The time spent by residents in the Emergency Room is considered meaningful patient responsibility. During this rotation, residents are supervised by the ER physicians. The goal is to become well versed with the emergencies seen in internal medicine.

A separate schedule will be issued to each resident working in the Emergency Room, including morning, afternoon and evening shifts. The residents should contact Dr. Sauter in advance to work out the schedule.

An intern or resident may not write prescriptions for drugs, controlled or otherwise, in the Emergency Room unless he or she maintains a limited license or an unrestricted license to practice medicine or surgery in the Commonwealth of Pennsylvania and also holds a valid DEA registration.

There will no clinic assigned during the emergency room rotation.

CONSULTATIVE SERVICES

Consultations are always performed by the senior residents on service, both at Mercy and Moses Taylor Hospitals.

Consults are usually placed by Ob-Gyn, Orthopedic, Surgery and Urology departments. The chief resident or a coordinator/attending is called with the consult, who then assigns the consult to the appropriate team.

Consults are written in the same format as the history and physical. The senior resident then discusses the case with the attending on service and calls the consulting attending with his or her opinion. He also dictates the consult saying which attending he is covering for.

If, after contributing to the care of the patient, the resident who is consulted does not feel the need to follow the patients further he can sign off the case only after discussing the matter with the attending on service/call and notifying the consulting attending of the decision.

RESPONSE TO CARDIAC ARRESTS

Senior residents and interns are expected to respond to cardiac arrests/codes within the hospital. They will be notified about cardiac arrests via their beepers or on the overhead paging system of the hospital.

MEDICAL EDUCATION AND LICENSURE

STATEMENT ON THE PRESCRIBING AUTHORITY OF PHYSICIANS APPROVED FOR TRAINING IN RESIDENCY PROGRAMS IN THE COMMONWEALTH OF PENNSYLVANIA:

1. An intern or resident, properly registered by the Board to participate in a training program in the Commonwealth of Pennsylvania, may write orders for "inpatients" in the hospital for drugs, controlled or otherwise. Such orders are legally valid so long as they are countersigned within a reasonable period of time by an attending staff physician licensed in the Commonwealth of Pennsylvania and holding a valid DEA registration.
2. An intern or resident, properly registered by the board to participate in a training program in the Commonwealth of Pennsylvania, **cannot** write prescriptions for drugs, controlled or otherwise, for "outpatients" in the ambulatory care settings or for "inpatients" on discharge unless he or she maintains an unrestricted license to practice medicine or surgery in the Commonwealth of Pennsylvania and also holds a valid DEA registration. Thus any prescriptions written for drugs, controlled or otherwise, in the two settings mentioned above have to be written by the preceptor in the clinic in the first case, and by attendings of the patient in the second case.
3. All new physicians licensed in the Commonwealth of Pennsylvania must apply to the Drug Enforcement Administration for their DEA number.
4. Under the current laws of the State of Pennsylvania and the federal government, until a resident in training receives his or her medical license, prescriptions for drugs, controlled or otherwise, written by residents using a hospital BNDD number with the prefix attached, which is the four digits of one's social security number, are not acceptable for pharmacies both in and out of the hospital.
5. A holder of a limited license in the Professional category (II-P) may write prescriptions only for non-narcotic drugs for "outpatients".

OSTEOPATHIC INTERNS

Osteopathic interns will take Part III of the osteopathic medical exams. Advancement to further training and completion of internship requirements will be governed by the rules set forth by the ADA Division of Postdoctoral Training.

INFORMATION FOR ALL RESIDENTS WHO ARE PARTICIPATING IN GRADUATE MEDICAL EDUCATION AT LEVEL I, II, AND III:

ALLOPATHIC LICENSURE REQUIREMENTS

Graduate license

(a) A graduate license authorizes the licensee to participate in a year of graduate medical training within the complex of the hospital to which the licensee is assigned, and a satellite facility or other training location utilized in the graduate training program.

(b) To secure a graduate license, an applicant shall satisfy one of the following:

(1) Have graduated from an accredited medical college or an unaccredited medical college and received a medical degree.

(2) Have completed the formal requirements for graduation from an unaccredited medical college, except an internship or social service requirement, and have successfully completed a fifth pathway program and an ECFMG certification examination.

(3) Hold a license to practice medicine without restriction in this Commonwealth or an equivalent license granted by another state, territory or possession of the United States, or the Dominion of Canada.

(c) Additional requirements for securing a graduate license are that the applicant shall satisfy the following:

(1) Have been certified by the ECFMG, if the applicant is a graduate of an unaccredited medical college.

(2) An applicant who is a graduate of an unaccredited medical college or who satisfies the requirements of subsection (b)(2), and files a complete application for a graduate license shall submit a diploma and transcript verified by a medical college listed in the International Medical Education Directory and chartered and recognized by the country in which it is situated for the provision of medical doctor education. The transcript must identify the successful completion of the equivalent of 4 academic years of medical education including 2 academic years in the study of the arts and sciences of medicine generally recognized by the medical education community in the United States and 2 academic years of clinical study of the practice of medicine as generally recognized by the medical education community in the United States.

(3) Satisfy the requirements in § 16.12 (relating to general qualifications for licenses and certificates).

(d) To participate in graduate medical training at a second-year level under the authority of a graduate license, the licensee shall first secure a passing score on FLEX I or Part I of the National Boards or Step

1 of the USMLE plus Part II of the National Boards or Step 2 of the USMLE; a passing score on a licensing examination acceptable to the Board as set forth in § 17.1(a)(1)(iii), (viii) and (ix) (relating to license without restriction), or, hold a license to practice medicine without restriction in this Commonwealth or an equivalent license granted by another state, territory or possession of the United States or the Dominion of Canada.

(e) To participate in graduate medical training at a third-year level or higher, the licensee shall secure a passing score on both FLEX I and FLEX II; Part I of the National Boards or Step 1 of the USMLE plus Part II of the National Boards or Step 2 of the USMLE plus Part III of the National Boards or Step 3 of the USMLE; Part I of the National Boards or Step 1 of the USMLE plus Part II of the National Boards or Step 2 of the USMLE plus FLEX II; or FLEX I plus Step 3 of the USMLE; a passing score on a licensing examination acceptable to the Board as set forth in § 17.1(a)(1)(iii), (viii) and (ix); or, hold a license to practice medicine without restriction in this Commonwealth or an equivalent license granted by another state, territory or possession of the United States or the Dominion of Canada.

(f) A graduate of an unaccredited medical college, who does not possess the qualifications for the issuance of a graduate license enumerated in subsections (a)—(e), but who desires to train in a hospital within this Commonwealth in an area of advanced graduate medical training, may have the unmet qualifications waived by the Board if the Board determines that the applicant possesses the technical skills and educational background to participate in the training and that the issuance of a graduate license to the applicant is beneficial to the health, safety and welfare of the people of this Commonwealth.

(g) A graduate license is only valid for a maximum of 12 consecutive months, but may be renewed by the Board to permit additional training.

(h) For a graduate license to be renewed, the Board has to receive, prior to the expiration of the previously issued license, the required renewal fee—see § 16.13 (relating to licensure, certification, examination and registration fees)—and a completed renewal form. Renewal forms are provided to hospitals in this Commonwealth that offer graduate medical training programs.

OSTEOPATHIC LICENSURE REQUIREMENTS

Temporary license

(a) A temporary license is required of an osteopathic medical college graduate for permission to participate in an approved graduate osteopathic or medical training program in this Commonwealth.

(b) Specific requirements for temporary training licensure are as follows. The applicant shall have:

(1) Graduated from an approved osteopathic medical college.

(2) Submitted an application obtained from the Board, together with the required fee.

(c) The temporary training license permits the graduate to train only within the complex of the hospital and its affiliates where the graduate is engaged in an approved graduate osteopathic or medical training program.

(d) The temporary training license is valid for 1 year, after which it shall be surrendered to the Board. The Board may extend the validity of the temporary training license within its discretion.

Please Note: Proof of securing a passing score on the appropriate exams must be submitted to the Board before a graduate license can be issued. It is advisable for residents to sit for the appropriate exam in December or a prior date so a break in training can be avoided.

COMPETENCIES

Kindly refer to the STRP website (www.strpweb.org) for the detailed **Competency Based Curriculum**. The following is just a summary of the competencies:

1. PATIENT CARE

Residents must be able to provide patient centered care that is compassionate, appropriate and effective for the treatment of health problems and the promotion of health.

Competency: Demonstrate caring, respectful and effective communication skills when interacting with patients and families.

Knowledge/Skills/Attitudes Objectives:

- Interact in a culturally sensitive manner with all patients regardless of their socio-economic or insurance status.
- Demonstrate the ability to translate complex medical jargon to a level that the patient and his / her caretaker can understand.
- Demonstrate respectful recognition of patient capabilities, limitations and preferences.

Competency: Gather essential and accurate information about the patient.

Knowledge/Skills/Attitudes Objectives:

- Obtain an accurate comprehensive history from the patient.
- Access additional sources of information from family, caretakers, witnesses and previous medical encounters.
- Convey value of the caretaker's opinions regarding the patient's health and illness.
- Perform a detailed and accurate physical examination.

Competency: Formulate diagnostic and therapeutic interventions based on patient information and preferences, current scientific evidence and clinical judgment.

Knowledge/Skills/Attitudes Objectives:

- Formulate and prioritize a differential diagnosis.
- Recognize patients' comprehension and anxiety about their illness as well as their discomfort and financial stress related to testing.
- Obtain and interpret appropriate laboratory and radiological studies after the patient provides informed consent.
- Utilize data obtained to formulate diagnoses and synthesize an evidence-based management plan that is optimized by active patient participation.
- Recognize personal limitations and seek help aptly.
- Utilize subspecialty consultation appropriately.
- Demonstrate responsibility and accountability for decisions.

Competency: Develop and implement patient management plans that actively engage the patient.

Knowledge/Skills/Attitudes Objectives:

- Educate patients and families regarding diagnoses, available therapies and the entailed risks and benefits.
- Create a management plan that encompasses patient and caretaker capabilities and preferences.
- Ensure patient and caregiver comprehension of the management plan.
- Provide written discharge instructions that the patient / caretaker can clearly comprehend.

Competency: Counsel and educate patients and families.**Knowledge/Skills/Attitudes Objectives:**

- Empower patients and families to make educated decisions by providing accurate, up to date Information.
- Utilize nutritional, rehabilitative and other ancillary personnel to extend patient education.
- Provide both good and bad news in a professional and empathetic manner.
- Recognize patient and family emotional response and connect them to the appropriate psychosocial resources.

Competency: Use information technology to optimize patient care.**Knowledge/Skills/Attitudes Objectives:**

- Access and update Electronic Medical Records as a data gathering resource.
- Use information technology tools (e.g. PDA, interactive web sites, computer based order entry) to optimize patient care and minimize iatrogenic complications.
- Review clinical standards of care and evidence based medicine routinely to enhance patient care.

Competency: Perform competently appropriate medical and invasive procedures.**Knowledge/Skills/Attitudes Objectives:**

- Know the indications, potential complications and alternatives for a given procedure.
- Explain the procedure and the entailed risks and benefits to the patient and caretaker in a language that is appropriate to their educational, developmental, and emotional status.
- Ensure adequate supervision and patient comfort while performing the procedure.
- Demonstrate and document proficiency in the required procedures.

Competency: Promote health maintenance and disease prevention.**Knowledge/Skills/Attitudes Benchmarks:**

- Provide anticipatory guidance and promote standard health maintenance based on age, gender and risk factors.
- Inform the patient about the indications, potential complications and possible outcomes including incidental findings of recommended screening tests.
- Promote routine vaccination based on standard recommendations.
- Access and maintain health maintenance records as a routine aspect of patient care.

Competency: Work with other health professionals to provide patient focused care.**Knowledge/Skills/Attitudes Objectives:**

- Participate in inter-disciplinary teams to optimize patient care and education.

- Recognize the value and promote comprehensive in-patient sign-outs.
- Encourage communication intra-professionally with involved sub-specialists.
- Educate and connect patient to appropriate community resources.
- Transfer information to other providers when appropriate.

2. MEDICAL KNOWLEDGE

Residents must demonstrate knowledge about established and evolving biomedical, clinical, and cognate (e.g. epidemiological and social behavioral) sciences and the application of this knowledge to patient care and the education of others.

Competency: Demonstrate an investigatory and analytic approach to clinical situations.

Knowledge/Skills/Attitudes /Objectives:

- Ask relevant clinical questions and utilize information resources aptly.
- Utilize consultations appropriately and eagerly engage consultants in mutual education about standard and up to date medical practice issues.
- Apply an open-minded, analytical approach to acquiring new knowledge by utilizing evidence-based medicine skills and critically evaluating current medical information.
- Apply knowledge acquired effectively to the care of patients.
- Work actively with faculty preceptors at the beginning of rotations to identify prescribed as well as individual learning objectives.
- Demonstrate commitment to lifelong learning by implementing strategies to increase knowledge based on self assessment, faculty and peer feedback and performance on written exams.
- Utilize basic quality methods, such as root cause analysis, to assess sub-optimal patient outcomes and their precipitants within the current healthcare system.

Competency: Know, apply and teach the basic and clinically supportive sciences which are appropriate to internal medicine.

Knowledge/ Skills/Attitudes /Objectives:

- Develop informatics skills that foster the maintenance of a fundamental, current knowledge base for the practice of internal medicine.
- Remain current with new developments in internal medicine and the standard recommendations for quality care defined by large national professional organizations.
- Seek up to date medical information to augment one's knowledge base and support clinical problem solving and decision making.
- Attend and participate in all required conferences on a regular basis.
- Communicate actively with specialists and other professionals to maintain a fundamental knowledge of their skills / abilities to enhance patient care.
- Optimize clinical decision making by considering current scientific information, risk / benefits, potential clinical outcomes, cost-effectiveness and patient preference of available tests and therapies.
- Demonstrate commitment to life-long learning.
- Participate in programmatic and self directed education of peers, medical students, other healthcare professionals and patients.

3. PRACTICE-BASED LEARNING AND IMPROVEMENT

Residents must be able to investigate and evaluate their patient care practices, appraise and assimilate scientific evidence, and improve their patient care practices.

Competency: Analyze practice experience and perform practice based improvement activities using a systematic methodology.

Knowledge/Skills/Attitudes Objectives:

- Identify areas for improvement in the quality of patient care and implement strategies to augment one's knowledge base, procedural skills and decision making skills on a continuous basis.
- Maintain and develop a desire to learn from sub-optimal outcomes and errors and to use these experiences to improve the system and processes of care.
 - Familiarize with the process of population management and practice assessment.
- Utilize the necessary resources to complete the process of practice improvement including relevant medical literature, informatics and necessary personnel.
- Learn and apply basic quality techniques of root cause analysis and rapid cycle change as a member of a multidisciplinary team.

Competency: Locate, appraise and assimilate evidence from scientific studies related to their patients' health problems.

Knowledge/Skills/Attitudes Objectives:

- Learn the principles of evidence-based medicine and basic biostatistics (e.g. ARR, NNT, p values, risk ratios, meta-analyses, etc.)
- Access search engines (e.g., Ovid, MD Consult) to effectively explore the available literature.
- Incorporate evidence-based medicine into daily practice to optimize patient care.
- Disseminate educational material to promote patient education as the foundation for compliance with disease management and prevention.
- Develop a foundation of informatics skills to filter the medical literature and keep current with standards of care.

Competency: Obtain and use information about their own population of patients and the larger population from which the patients are drawn.

Knowledge/Skills/Attitudes Objectives:

- Learn the epidemiology of common diseases in the regional population including incidence, prevalence, risk factors and availability and utilization of resources.
- Apply epidemiologic information to improve health maintenance and disease management.

Competency: Apply knowledge of study designs and statistical methods to the appraisal of clinical studies and other information on diagnostic and therapeutic effectiveness.

Knowledge/Skills/Attitudes Objectives:

- Appraise the literature on selected topics utilizing basic biostatistics and principles of evidence-based medicine.

- Prepare and participate in Journal Club.
- Complete a scholarly activity (e.g. basic science or clinical research project, literature review, conference presentation etc.) utilizing informatics skills and faculty support.

Competency: Use information technology to manage information, access on-line medical information and support their own education.

Knowledge/Skills/Attitudes Objectives:

- Familiarize with practice management reports provided by payors and with the process of pay for performance.
- Access the current EMR system to generate practice performance reports to assess quality.
- Explore insurance based websites including CMS for available disease management resources and practice management / reimbursement guidelines.
- Seek opportunities to employ on line resources to maintain a current knowledge base, current CME certification and board certification status.

Competency: Facilitate the learning of students and other health care professionals.

Knowledge/Skills/Attitudes Objectives:

- Assess and address the educational needs and objectives of other members of the healthcare team.
- Engage others including students, colleagues and patients in bi-directional learning.
- Explore and employ the principles of adult learning to optimize education as a team leader.
- Provide constructive feedback to students and colleagues and to listen as they reciprocate.

4. INTERPERSONAL SKILLS AND COMMUNICATION

Residents must be able to demonstrate interpersonal and communication skills that result in effective information exchange and teaming with patients, their patients' families, and professional associates.

Competency: Create and sustain a therapeutic and ethically sound relationship with patients.

Knowledge/Skills/Attitudes Objectives:

- Establish and maintain open lines of communication with patients and their families.
- Demonstrate HIPAA compliance while dealing with families and friends.
- Empower patients to make knowledgeable decisions through effective education.
- Demonstrate value and compassion for patient preferences.
- Interact respectfully with difficult patients.
- Maintain a therapeutic relationship with patients over time.

Competency: Use effective listening skills and elicit and provide information using effective non-verbal, explanatory, questioning and writing skill.

Knowledge/Skills/Attitudes Objectives:

- Identify members of the health care team and explain their roles appropriately.
- Communicate with patient / caregiver in suitable, private settings.

- Elicit initial and interval histories from patients using effective verbal and non-verbal techniques.
- Provide verbal and written education keeping in mind the developmental and educational level of the patient and caregiver.
- Maintain legible, accurate, timely documentation and comply with EMR templates.

Competency: Work effectively with others as a member or leader of a health care team or other professional group.

Knowledge/Skills/Attitudes Objectives:

- Learn the names and roles of health care team members.
- Identify educational goals and objectives for team members when acting as the team leader.
- Facilitate team communication.
- Promote constructive reciprocal feedback amongst team members.
- Provide and obtain effective professional consultation to optimize patient care.
- Ensure seamless patient care by promoting effective communication across professions and systems of care.

5. PROFESSIONALISM

Residents must demonstrate a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population.

Competency: Demonstrate respect, compassion, and integrity; a responsiveness to the needs of patients and society that supersedes self-interest; accountability to patients, society, and the profession; and a commitment to excellence and on-going professional development.

Knowledge/Skills/Attitudes Objectives:

- Demonstrate honesty, integrity and reliability consistently.
- Seek, honor and complete assigned duties.
- Exhibit respect, compassion, and empathy in all interactions.
- Display self-awareness, recognize limitations, seek appropriate assistance and strive for self improvement.
- Demonstrate commitment to lifelong learning including regular attendance at conferences and reading medical literature.
- Respond positively to constructive criticism.
- Acknowledge error, demonstrate accountability and strive for system improvement and error prevention.
- Inspire accountability in others by promoting peer review in a blameless environment.
- Dress and behave appropriately.
- Validate the significant role physicians play in society.

Competency: Demonstrate a commitment to ethical principles pertaining to provision or withholding of clinical care, confidentiality of patient information, informed consent, and business practices.

Knowledge/Skills/Attitudes Objectives:

- Recognize ethical dilemmas and consult with the hospital's ethics committee appropriately.
- Adhere to the primacies of confidentiality, scientific integrity, and informed consent.
- Recognize the situational need for determining competence and healthcare proxies.
- Address end-of-life issues in a timely and compassionate manner.
- Engage in ethical business practices.
- Interact with the pharmaceutical industry in a professional and principled manner.

Competency: Demonstrate sensitivity and responsiveness to patients and colleagues' culture, age, gender, race, religion, and sexual preferences.

Knowledge/Skills/Attitudes Objectives:

- Recognize the impact of culture, experience, age, gender, and disability on patient perceptions, preferences, compliance, and outcomes.
- Display sensitivity to the significant interplay of issues related to cultural beliefs, socioeconomic status and health literacy and how they relate to patients' utilization and compliance.

6. SYSTEMS-BASED PRACTICE

Residents must 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.

Competency: Understand how their patient care and other professional practices affect other healthcare professionals, the healthcare organizations and the larger society and how these elements affect their practice.

Knowledge/Skills/Attitudes Objectives:

- Optimize interaction and communication with other health-care professionals, health-care organizations and community resources to promote quality patient care.
- Participate actively in quality initiatives undertaken by health care organizations.
- Optimize patient length of stay in acute care facilities by promoting appropriate transition to ancillary levels of care.
- Promote medication reconciliation across levels and systems of care.
- Familiarize with the epidemiology of major health issues in the local community.
- Understand how the local community demographics and socio-cultural beliefs affect health and disease.

Competency: Know how types of medical practice and delivery systems differ from one another, including methods of controlling health care costs and allocating resources.

Knowledge /Skills/Attitudes Objectives:

- Understand the fundamental differences between the various insurance plans including local PPOs and HMOs, fee-for-service, Medicare, and state Medical Assistance.
- Recognize the guidelines determining provider and institutional reimbursement including fee-for-service, capitation, hospital DRGs.
- Document appropriately for different levels of care.
- Become familiar with various formulary guidelines and pre-certification requirements.

Competency: Practice cost-effective health care and resource allocation that does not compromise quality of care.

Knowledge/Skills/Attitudes Objectives:

- Recognize resource limitation within the regional and global health care systems.
- Practice cost-effective medical care by considering cost / benefit analyses in all diagnostic and therapeutic decisions.
- Identify factors that contribute to rising health care costs and strive to contain costs by optimizing formulary compliance and avoiding unnecessary testing.
- Practice cost-effective patient care by optimizing length of stay in acute care facilities and promoting transition to sub-acute levels of care appropriately.

Competency: Advocate for quality patient care and assist patients in dealing with system complexities.

Knowledge/Skills/Attitudes Objectives:

- Minimize perceived conflicts of interest between individual patients and their health care organizations through patient education.
- Recognize true conflict of interest between individual patients and their health care organizations and always advocate actively on the patient's behalf.

Competency: Partner with health care managers and health care providers to assess, coordinate, and improve health care and know how these activities can affect system performance.

Knowledge /Skills/Attitudes Objectives:

- Identify and work with other health care professionals and organizations to optimize patient-centered care.
- Connect patients with established disease management programs offered through their insurances or local institutions.
- Utilize practice performance data to sharpen population management skills and understand how that improves global system performance.

7. OSTEOPATHIC PHILOSOPHY AND MANIPULATIVE MEDICINE (For DO's only)

Residents must demonstrate and apply knowledge of accepted standards in Osteopathic Manipulative Treatment (OMT) appropriate to Internal Medicine. The educational goal is to train a skilled and competent osteopathic practitioner who remains dedicated to life-long learning and to practice habits in osteopathic philosophy and manipulative medicine.

Competency: Demonstrate competency in his / her understanding and application of OMT in Internal Medicine..

Knowledge/Skills/Attitudes /Objectives:

- Participate actively in OMT training opportunities both in the in-patient and out-patient settings.
- Review major osteopathic journals on a regular basis.

- Perform a critical appraisal of medical literature related to OMT.
- Be observed and evaluated in the performance of OMT through the assessment of his / her diagnostic skills, medical knowledge, and problem solving abilities.

Competency: Integrate Osteopathic concepts and OMT into the medical care he / she provided to patients as appropriate.

Knowledge/ Skills/Attitudes /Objectives:

- Assume increased responsibility for the performance and incorporation of OMT in patient management.
- Document OMT timely and comprehensively.
- Promote OMT educational endeavors amongst peers and students.
- Participate in CME programs provided by COMS, AOA and the specialty colleges.
- Seek constructive feedback from osteopathic attendings.

Competency: Understand and integrate Osteopathic principles and philosophy into all clinical and patient care activities.

Knowledge/ Skills/Attitudes /Objectives:

- Utilize caring compassionate behavior with patients.
- Demonstrate the treatment of people rather than the symptoms.
- Demonstrate understanding of somato-visceral relationships and the role of the musculoskeletal system in disease.
- Demonstrate listening skills in interaction with patients.
- Demonstrate knowledge of and behavior in accordance with the osteopathic oath and AOA code of ethics.

PROGRESSIVE LEARNING OBJECTIVES

Kindly refer to the STRP website (www.strpweb.org) for the detailed **Competency Based Curriculum**. The following is just a summary of the Progressive Learning Objectives:

Patient Care

PGY-1

1. Perform a thorough history and physical examination
2. Synthesize data into a problem list and differential diagnosis
3. Recognize psychosocial issues that may effect patient compliance and outcomes
4. Formulate a diagnostic and therapeutic plan with some supervision
5. Optimize patient care plans by routine use of Uptodate
6. Demonstrate humanistic and professional behavior in patient, peer and staff interactions
7. Accept personal responsibility to follow-up on patient care plans and test results
8. Respond in person to nursing calls on patient issues and document problems, assessment and plans of care
9. Apply preventive care in an outpatient setting and recognize overdue preventative care needs in inpatients and the need for follow-up
8. Perform the majority of procedures required by ABIM

Assessment: mini-CEX, monthly global rating forms, patient surveys, record review (from global forms), procedure log

PGY-2

1. Coordinate patient care among all members of the health care team
2. Establish and identify oneself as a responsible and responsive team leader
3. Review the interns' history, physical exam and assessment
4. Formulate therapeutic and diagnostic plan independently
5. Use information technology to support patient care decisions
6. Counsel and educate patients and families
7. Engage the patient in management plans and address noncompliance
8. Develop skills for end of life and palliative care discussions and planning
9. Promote seamless patient care by optimizing discharge planning and follow-up
10. Perform and supervise procedures required by ABIM

Assessment: monthly global rating forms, patient and peer surveys, procedure logs

PGY-3

1. Efficiently evaluate and manage patients in the inpatient and outpatient setting at the level of a general internist
2. Function competently as an internal medicine consultant

3. Coordinate patient care among all members of the healthcare team and demonstrate leadership skills to promote multidisciplinary management for optimal patient outcomes
3. Demonstrate effective ability to lead end of life and palliative care discussions planning
4. Perform and supervise every procedure required by ABIM achieving full competence in all

Assessment: monthly global rating forms, patient/peer/nurse surveys, procedure logs

Medical Knowledge

PGY-1

1. Describe basic pathophysiology for common internal medicine conditions
2. Develop basic knowledge base for common inpatient and outpatient conditions
3. Demonstrate commitment to continued knowledge accrual
4. Utilize Up to Date routinely on a patient basis
5. Develop skills for effective review of the medical literature
6. Follow-up on questions regarding optimal, evidence based patient care
7. Develop skills for effective case presentation and discussion of optimizing medical care for common medical diseases

Assessment: In Training examination, monthly global rating forms, conference attendance log, evaluation of conference presentation1.

PGY-2

1. Demonstrate in-depth pathophysiology for common internal medicine conditions
2. Demonstrate knowledge of medical literature analysis
3. Demonstrate informatics skills to promote evidence based medicine and quality care application
4. Develop filter skills for keeping up with medical discovery and evolution of evidence based medicine guidelines and standards of care
5. Review MKSAP on a regular basis
6. Solidify knowledge base by educating others

Assessment: In Training examination, monthly global rating forms, conference attendance log, conference presentation evaluation, chart reviews

PGY-3

1. Demonstrate in-depth pathophysiology for common and uncommon internal medicine conditions
2. Apply critical reading skills to current internal medicine literature
3. Commit to intensive subspecialty medical review while on elective rotation
4. Read and review key journal publications on a regular basis
5. Demonstrate a systematic approach to acquiring and maintaining current medical knowledge

6. Complete and present a comprehensive literature review for a senior project of the resident's choice
7. Engage in scholarly activity and available research

Assessment: In Training examination, monthly global rating forms, completion of portfolio , scholarly activity, conference attendance log, conference presentation evaluation, senior project evaluation, chart reviews

Practice-Based Learning and Improvement

PGY-1

1. Keep a checklist of patient care needs from rounds and assume responsibility
2. Ask for help when needed
3. Seek and accept feedback
4. Participate in quality improvement activities and root cause analysis
5. Demonstrate continual improvement in clinical management and knowledge
6. Teach students effectively
7. Use Utodate regularly
8. Focus on improving medical knowledge deficits as demonstrated on the In Training exam and global rotation evaluations. Assume responsibility to “patch the gaps” in one's knowledge base and skills

Assessment: monthly global rating forms, conference attendance log, student evaluations, semi-annual self assessment in the competencies with comparison to actual performance assessment by others

PGY-2

1. Encourage intern requests for help and respond in a timely and patient centered fashion
2. Teach students, interns and peers effectively
3. Use patient care errors and near-misses to teach students, interns and peers
4. Promote continuous quality improvement with root cause analysis
5. Use information technology such as PubMed or Ovid to enhance patient care

Assessment: monthly global rating forms, peer evaluations, student evaluations Semi-annual self assessment in the competencies with comparison to actual performance assessment by others

PGY-3

1. Teach interns, students, and other residents effectively
2. Analyze own practice for needed improvement
3. Complete a QA/QI project under faculty direction

Assessment: portfolio (scholarly activity, critical reading skills test, QA/QI Activity), monthly

global rating forms, peer and student evaluations, semi-annual self assessment in the competencies with comparison to actual performance assessment by others

Systems-Based Practice

PGY-1

1. Recognize the systematic complexities that affect patient outcomes
2. Demonstrate ability to effectively sign out with maintenance of quality sign out sheets
3. Function as a physician within a multidisciplinary team
4. Serve as a patient advocate in the outpatient and inpatient setting
5. Work with ancillary team members (discharge planners, case managers, and social workers) to provide high quality, non-redundant and cost-effective care
6. Develop a working knowledge of various care systems and the most appropriate disposition for certain patients dependent on patient needs and system allowances

Assessment: monthly global rating forms, 360 degree evaluations, patient surveys

PGY-2

1. Direct care in inpatient and outpatient settings as a member of a multi-disciplinary team
2. Direct subspecialty, surgical, nutritional, podiatric and social service consultations
3. Demonstrate effective utilization of transitioning patients between systems of care for their benefit
3. Use systematic approaches to reduce errors and effectively transition patients between care settings
4. Strive to optimize patient follow-up by effective discharge planning
5. Promote medication reconciliation

Assessment: monthly global rating forms, 360 degree evaluations, patient surveys

PGY-3

1. Demonstrate knowledge of types of medical practice and health delivery systems
2. Practice effective allocation of health care resources to avoid compromising quality of care. Reduce unnecessary testing.
3. Demonstrate knowledge of business aspects of medical practice including coding and insurance
4. Recognize system deficiencies/complexities and strive for system improvement

Assessment: monthly global rating forms, 360 degree evaluations, patient surveys, portfolio (QA/QI project)

Interpersonal Skills and Communication

PGY-1

1. Present a case accurately and succinctly on rounds
2. Later in the first year, with supervision, present a case accurately and succinctly while on call to attendings
3. Provide timely, legible, thorough, succinct medical record documentation – histories and physical examinations, progress notes, and discharge summaries
4. Document all clinical responses to patient care needs legibly in the chart
5. Work well within team context relating to students, attendings, other housestaff, nurses, and patients
6. Communicate and establish a therapeutic relationship with patients and families
7. Develop skills to address frustration with our current healthcare system, residency scheduling or programmatic issues in a productive and constructive manner

Assessment: monthly global rating forms (with chart audits), mini-CEXes, 360 degree evaluations including patient and student surveys

PGY-2

1. Provide timely, legible, thorough and succinct resident admit and progress notes
2. Work effectively as a leader of the health care team
3. Establish the hierarchy of communication for the service team for the month
4. Demonstrate effective listening skills and reliable responsiveness to the needs of students and interns as well as the opinions and requests of multidisciplinary team members
5. Provide education and counseling to patients, families, and colleagues
6. Demonstrate skill in delivering end-of-life counseling to patients
5. Communicate effectively with consultants and primary care doctors to coordinate patient care and follow-up
6. Develop skills to address noncompliance and the frustrations of displeased patients

Assessment: monthly global rating forms (with chart audits), 360 degree evaluations including patient, peer, nurse and student surveys

PGY-3

1. Work effectively as a leader of the health care team including a team with potential dysfunction
2. Demonstrate skill in handling all difficult patient care situations
3. Promote involvement of necessary consultants, social services and patient advocacy teams
3. Communicate near misses or mismanagement issues with the healthcare providers involved in an educational and blameless manner
4. Function effectively as a consultant for specialty and subspecialty care

5. Demonstrate the ability to provide documentation of IM consultation and appropriate level of consultative billing

Assessment: monthly global rating forms, 360 degree evaluations

Professionalism

PGY-1

1. Establish trust with patients and staff
2. Demonstrate respect, compassion, and integrity
3. Demonstrate punctuality, reliability, and honesty
4. Recognize self limitations and ask for help
5. Recognize personal strengths and offer help
6. Show regard for the opinions of others
7. Accept and seek out constructive criticism
8. Maintain patient confidentiality
9. Compassionately respond to issues of culture, age, gender, ethnicity, and disability in patient care
10. Complete medical record documentation in a timely fashion
11. Return student, peer and rotation evaluation in a timely fashion
12. Complete all necessary employee health mandates as directed

Assessment: monthly global rating forms, 360 degree evaluations, mini-CEXes

PGY-2

1. Display initiative and leadership
2. Demonstrate responsiveness to the needs of patients, interns and peers
3. Recognize the limitations and fears of interns and peers, offering help
2. Delegate responsibility to others effectively
3. Acknowledge errors and work to minimize them
4. Demonstrate commitment to life long learning and self-improvement
5. Commit and contribute to system improvement
6. Avoid engagement in non-constructive endeavors and lead positive system change
7. Promote professional accountability and enhance professional development and professionalism in peers and other healthcare providers

Assessment: monthly global rating forms, 360 degree evaluations

PGY-3

1. Demonstrate concern for educational development of students and residents
2. Remain responsive to patients, students, interns and peers
3. Stay wholeheartedly involved in daily program activities

4. Volunteer for activities for the good of the institution and community
5. Assume professional responsibility for our healthcare system and demonstrate commitment to system improvement
6. Demonstrate understanding of the ethical concerns about pharmaceutical and patient gifts

Assessment: monthly global rating forms, 360 degree evaluations

AMBULATORY CARE

Ambulatory care is an important aspect of the practice of medicine. During the residency training, increasing amounts of time will be devoted to developing skills in this area and the accumulation of a specific group of patients for whom the resident will be the primary physician.

For STRP residents this training is provided at two sites:

(1) *Scranton Temple Health Center (STHC)* – This is located at the corner of Madison and Pine Streets. It includes Mercy Clinic on the top floor and Moses Taylor Clinic on the bottom floor. Also, included is the HIV clinic.

(2) *Mid Valley Practice (MVP)* - Dr. Linda Thomas's practice has been incorporated into STRP as the Mid Valley Practice (MVP).

Residents have a half-day per week continuity clinic at STHC. They also do block rotations at MVP. The ambulatory care block is designed to be a more intense experience in ambulatory care. Residents and interns will be able to see patients in the morning and afternoons, in addition to their normal continuity clinics. They will also be able to spend several days/half days in ambulatory care related office practices, such as dermatology and rheumatology.

SCRANTON TEMPLE HEALTH CENTER

Director: John Guzek, M.D.

In order for the ambulatory care program to be effective, each resident must provide good service to his/her patients. This means being in the office on time, responding to pages promptly and returning patient calls promptly. Ambulatory care is as important as responsibilities to the hospitalized patient. It is the responsibility of the individual resident to notify the Scranton Temple Health Center of any change in their schedule. Final approval of clinic changes rests with the person in charge of the schedule.

The main office and the clinic receptionist must be informed of vacation dates, meetings, etc. at least three months in advance so appointments are not scheduled at these times. If ill, the resident is responsible for determining which patients can be rescheduled and which should be seen by another resident.

Continuity of care is key for the clinic to succeed. Therefore, notifying your fellow resident that his/her patient has been admitted or seen is crucial. It is expected that a resident visit his patients even when not on service.

MID VALLEY PRACTICE

Director: Linda Thomas, M.D.

Dr. Linda Thomas's practice has been incorporated into STRP as the Mid Valley Practice (MVP).

RESIDENT CLINIC SCHEDULE

Interns: PGY-1's will have one half-day per week clinic session at the STHC. They will also have one block of MVP.

Senior Residents: PGY-2s and PGY-3s will have one half-day per week clinic at STHC. They will also have ambulatory care block(s) at MVP.

The only exception to the half-day per week continuity clinic at STHC is when the resident is posted in the ICU (applicable only to senior residents) or ER or is on vacation or has gone for a CME conference.

RESIDENT PATIENT LOAD

PGY-1: 3 – 5 patients per half-day clinic (averaged over the year)

PGY-2: 4 – 6 patients per half-day clinic (averaged over the year)

PGY-3: More than 4 patients per half-day clinic (averaged over the year)

HEALTH CENTER SCHEDULING

Urgent cases will be managed in the following fashion:

Established patients - Established patients are those patients that have been seen in the Health Center (STHC) previously.

When a circumstance arrives where a patient needs to be seen prior to his/her resident's next scheduled clinic day, the STHC's secretaries will attempt to fit that patient into an available resident's time slot. There should be direct resident-to-resident communication as to the reasons for the visit and arrangements for follow-up.

New patients - New patients are those patients, which are referred from the Emergency Department or other outside sources and have yet to be seen by a STRP house officer.

When a new patient needs to be seen urgently and no appointments are available, the patient may be scheduled as a brief visit pertaining to the acute problem with any available resident. Thereafter, the patient will follow-up for a detailed, new-patient complete history and physical with the same resident.

APPOINTMENTS

Patients discharged from the hospital: Service resident or nurse (or the patient if he/she is discharged at a time when the Health Center is closed) may call for an appointment. The clinic telephone numbers are 941-0630 (for Mercy Hospital patients) and 961-5670 (for Moses Hospital patients). The service resident is expected to fax the discharge summary of the patient to the Health Center. The relevant fax numbers are 941-0648 (for Mercy Hospital patients) and 961-5991 (for Moses Hospital patients).

Patients seen in the Emergency Department: During the usual business day, either the emergency department staff or the patient may call the Health Center for an appointment. At other times, the patient should be given the phone number and told to call for an appointment. A copy of the emergency room record will be forwarded to the Health Center. If the patient has not called for an appointment, he/she will be contacted by the receptionist.

For interns, one hour is allowed for the initial visits of new patients and 30 minutes for return visits. For senior residents, 45 minutes for new patients and 20 minutes for return visits. If the need for more time is anticipated, the receptionist should be notified. The resident physician should be always be aware of his/her patient schedule.

OFFICE VISIT PROCEDURE

At each visit, the nurse will weigh the patient, record his/her temperature, pulse, respirations and blood pressure in the sitting and standing positions. This information will be recorded in the EMR.

Each resident will see and examine his/her patient and then discuss the case with the attending physician before the patient is discharged. This is vital for patient billing and is a federal requirement.

LABORATORY TESTS:

Most laboratory tests can be ordered by the EMR. If needed, blood for the test can be collected by the Health Center nurses.

ELECTROCARDIOGRAMS:

Electrocardiograms will also be performed in the Health Center.

X-RAYS:

Diagnostic x-ray studies are done at Mercy Hospital or Moses Taylor Hospital and are scheduled through the receptionist. The resident is responsible for providing the completed x-ray request form.

REPORTS OF X-RAYS AND LABORATORY STUDIES:

Reports that are received by the Health Center will be scanned into the EMR system and forwarded to the relevant preceptor. The preceptor will review the report, act on it if of urgent nature, and forward it to the resident taking care of the patient.

MEDICAL RECORDS:

Complete, appropriate medical records are the responsibility of the resident physician. On the first visit, a comprehensive history and physical examination will be recorded in the EMR. If the patient has been discharged from the hospital, copies of the initial history and physical and the discharge summary will be obtained and reviewed. Progress notes will be comprehensive. In addition to the resident's note, including his signature, the attending physician will annotate and sign each visit. All reports and consultations will be filed in the patient record by the staff.

AVAILABILITY OF RECORDS: Records will be available via MEDENT at computer terminals in the STHC during the normal business day and in specific computers kept in Mercy Hospital resident's lounge and Moses Taylor Hospital STRP lounge.

PRESCRIPTION FILLING POLICY: No prescriptions should be refilled at night or off hours when the ambulatory care record is not available for appropriate entry of type of medication given, dose strength and quantity dispensed. Every prescription refill should be entered by the filling physician in patient's EMR chart. There is almost no urgency to refill medications, especially a controlled drug, on an emergency basis. If patient's pain is sufficient to require medication, the patient should present at the emergency room where the call resident may evaluate the patient in person.

Controlled drugs should never be filled or refilled over the phone. Patients who require these medications should be directed to come to the ambulatory care for a written prescription, or advised that the prescription can be mailed to them during the normal clinic hours.

PATIENT CARE OTHER THAN DURING THE HOURS OF OPERATION: Each resident is responsible for providing continuing care. The intern on call in the hospital on nights and weekends will be responsible for covering the ambulatory care practice.

On nights, weekends and holidays, telephonic calls to the STHC will be forwarded to and picked up by an answering service. The answering service will take a message and page the intern on call in the respective

hospital. The message will then be conveyed to the intern when he calls back for the page. It is the duty of that intern to call back the conveyed telephone number and talk to the patient. He can take the help of his senior resident if he so feels.

If it is necessary to see a patient during the business day, the ambulatory care facilities or emergency room are available and may be used. Nights and weekends, the patient may be seen in the emergency room.

SUBSPECIALTY ROTATIONS

In each year of training, residents will have the opportunity to participate in subspecialty training during their elective blocks.

Subspecialty training is available in the following fields – Pulmonary Medicine, Gastroenterology, Neurology, Palliative Care, Hematology and Oncology, Geriatrics, Nephrology, Rheumatology, Cardiology, Endocrinology, Office Gynecology, Emergency Medicine (in addition to the compulsory 4 weeks rotation during the internship year) and Infectious Diseases (usually 4 weeks each) and Anesthesiology, Radiology, Psychiatry, Dermatology, Allergy and Immunology, Otorhinolaryngology, Urology, Non-Operative Orthopedics and Medical Ophthalmology (usually 2 weeks each).

Each elective will be planned and supervised by a responsible attending physician from that subspecialty. In general, the resident will be seeing hospital consultations and patients in the attending's office. If appropriate, he will assist in special diagnostic procedures.

While on elective rotations, the resident will attend all scheduled teaching conferences, morning reports, and office hours in the STHC. However, residents can be excused from morning reports and noon conferences if they obtain permission from the chief resident or coordinator in advance and state their reason for not being able to attend.

The sub-specialty rotations will be scheduled in advance based upon resident requests, availability, and necessity as determined by the STRP faculty.

Vacation and conference time can only be scheduled during sub-specialty rotations or ambulatory care block rotations.

INDIVIDUAL RESPONSIBILITY

SECOND AND THIRD YEAR RESIDENTS:

1. Direct care of each patient on his/her service under the supervision of the attending physician.
2. Organization, evaluation and instruction of the patient care team including intern, sub-intern, and medical students.
3. Resident admission notes including formulation and revision of plans for patient management. The admission notes should be on the chart within 12 hours of admission. Also, calling the attending physician on each admission is mandatory.
4. Review and completion of progress notes and problem lists, as well as writing and dictating discharge summaries during the first six months of the year.
5. Supervision of procedures performed by medical students and interns.
6. Attendance at conferences and rounds. Presentation of or supervision of appropriate case presentations by interns.
7. Care of assigned patients in the STHC.
8. Average night call is approximately every 5th night for second year residents, and approximately every 6th night for third year residents.
9. Daily progress notes on each patient reflecting graded responsibility on part of the upper year commenting on the sub-intern and intern's notes.
10. Perform consultative services at both hospitals with the attending on service.

INTERNS:

1. Direct care of each patient on his/her service under supervision of the senior resident and the attending physician
2. Instruction of sub-interns and medical students.
3. Intern admission notes including history and physical and formulation of plans for patient management and completion of admission orders. The admission note should be on the chart within 12 hours of admission
4. Formulation of complete problem list.
5. Daily progress notes on each patient, and discharge summaries to be dictated in the second half of the year.
6. Present cases at morning report while on medical service or ICU service.
7. Attendance at conferences and rounds.
8. Care of assigned patients in the STHC.
9. Average night call of approximately every 4th night as scheduled.

OSTEOPATHIC INTERNS:

In addition to the above nine listed –

10. Recording of musculoskeletal examinations on all history and physicals, on all patients admitted to the osteopathic attendings.
11. Recording in the chart of any osteopathic manipulative therapy given.
12. Keeping a detailed physician log as distributed and explained at orientation.

SUB-INTERNS/STUDENTS:

1. Direct care of assigned patients on his/her service under the supervision of the intern, senior resident and the attending physician.
2. Admission notes, including history and physical, on all assigned patients, as well as formulation of plans for patient management, completion of admission orders countersigned by supervising resident.
3. Daily progress notes countersigned by supervising resident.
4. Call as assigned by the program which may vary from month to month. On an average, sub-intern call is approximately every 5th night, and Med II call is at least once a week. While on call, sub-interns/students will be responsible for the care of all patients in their charge, under the supervision of the residents. Sub-interns/students will be called to evaluate all problems that do not require the immediate attention of a licensed physician, including fevers, abnormal test results, changes in patient status and other non-life threatening conditions. The residents will closely supervise sub-interns/medical students under all patient care areas.
5. Attendance at conferences and rounds.

MISCELLANEOUS BENEFITS/POLICIES

1. Holiday/long weekends are done in turns. Christmas and the New Years holidays will be split into two blocks, one of which every resident has to do. Considerations will be given for specific requests on a first come first served basis.
2. Second and third year residents get \$200.00 yearly for books. All receipts have to be presented for reimbursement.
3. Meals are provided free of charge at Mercy and Moses Taylor Hospitals' cafeteria.
4. Any resident/intern who requests a specific day not to be on call must follow the guidelines below:

All requests must be submitted to the STRP faculty in writing.

Vacations/conferences can only be taken during subspecialty or elective rotations.

5. Vacation policy is as follows:

R1 - 3 weeks

R2 - 3 weeks plus 1 week of conference

R3 - 3 weeks plus 1 week of conference

Osteopathic residents are allowed two weeks of vacation during the year and one week of self study, for which they will maintain logs.

EMPLOYMENT REFERENCE CHECKS

To ensure that individuals who join STRP are well qualified and have a strong potential to be productive and successful, it is the policy of STRP to check the employment references of all applicants.

The Program Coordinator will respond in writing only to those reference check inquiries that are submitted in writing. Responses to such inquiries will confirm only dates of employment, wage rates, and position(s) held. No employment data will be released without a written authorization and release signed by the individual who is the subject of inquiry.

PERSONNEL DATA CHANGES

It is the responsibility of each resident to promptly notify STRP of any changes in personal data.

HEALTH INSURANCE

Blue Cross-Blue Shield, Major Medical, and Dental insurance are available to all eligible residents. For residents and eligible dependents, the STRP will pay the cost of enrollment, provided the resident or eligible dependents are not covered, or have the opportunity for coverage, under another plan. Coverage will begin immediately upon start of employment. Residents will receive an identification card and booklet describing coverage when processing has been completed through the Blue Cross-Blue Shield of Northeastern Pennsylvania.

The federal Consolidated Omnibus Budget Reconciliation Act (COBRA) gives residents and their qualified beneficiaries the opportunity to continue health insurance coverage under STRP's health plan when a "qualifying event" would normally result in the loss of eligibility. Some common qualifying events are resignation, termination of employment, or death of a resident; a reduction in a residents hours or a leave of absence; residents divorce or legal separation; and a dependent child no longer meeting eligibility requirements.

Under COBRA, the resident or beneficiary pays the full cost of coverage at STRP's group rates. STRP provides each eligible resident with a written notice describing rights granted under COBRA when the resident becomes eligible for coverage under STRP's health insurance plan. The notice contains important information about the residents' rights and obligations.

DISABILITY INSURANCE

Eligible residents will receive disability insurance coverage upon start of their employment. The cost of this insurance will be paid entirely by STRP. A booklet describing coverage will be provided to residents when processing has been completed.

UNEMPLOYMENT COMPENSATION

In the event employment is terminated, under certain circumstances, you may be entitled to unemployment compensation. In order to determine if you are eligible for such benefits, you should inquire at the nearest office of the Bureau of Employment Security.

WORKERS' COMPENSATION INSURANCE

STRP provides a comprehensive workers' compensation insurance program at no cost to residents. This program covers any injury or illness sustained in the course of employment that requires medical, surgical, or hospital treatment. Subject to applicable legal requirements, workers' compensation insurance provides benefits after a short waiting period or, if the resident is hospitalized, immediately.

Since benefits under the law do not begin until after the seventh day of lost time from work, sick leave benefits, if eligibility requirements are met will be paid during the first seven days. Absence from work compensated for under the Workmen's Compensation Law is not deducted from sick leave.

Residents who sustain work-related injuries or illnesses should inform the program director immediately. No matter how minor an on-the-job injury may appear, it is important that it be reported immediately.

BEREAVEMENT LEAVE

Residents who wish to take time off due to the death of an immediate family member should notify their supervisor immediately. Up to three consecutive days of paid bereavement leave will be provided to eligible residents. Immediate family is defined as: mother, father, brother, sister, spouse and children.

JURY DUTY

If residents are required to serve jury duty beyond a period of paid jury duty leave, they may request an unpaid jury duty leave of absence. Residents must show the jury duty summons to the program director as soon as possible so that he may make arrangements to accommodate their absence. Of course, residents are expected to report for work whenever the court schedule permits.

Either STRP or the resident may request an excuse from jury duty if, in STRP's judgment, the residents absence would create serious operational difficulties. STRP will continue to provide health insurance benefits for the full term of the jury duty absence.

PAY DAYS

Residents are paid biweekly on every other Friday. Each paycheck will include earnings for all work performed through the end of the previous payroll period.

ADMINISTRATIVE PAY CORRECTIONS

STRP takes all reasonable steps to ensure that residents receive the correct amount of pay in each paycheck and that residents are paid promptly on the scheduled payday.

PAY DEDUCTIONS AND SETOFFS

The law requires that STRP make certain deductions from every resident's compensation. Among these are applicable federal, state, and local income taxes. STRP also must deduct Social Security taxes on each resident's earnings up to a specified limit that is called the social security "wage base". STRP matches the amount of Social Security taxes paid by each resident.

If you have questions concerning why deductions were made from your pay check or how they were calculated, the administrative office can assist in having your questions answered.

SAFETY

To assist in providing a safe and healthful work environment for residents, customers, and visitors, the hospitals in which STRP operates have established work place safety programs. These programs are a top priority for both STRP and the hospitals. The success of the programs depends on the alertness and personal commitment of all.

STRP provides information to residents about work place safety and health issues through regular internal communication channels such as housestaff meetings, bulletin board postings, memos, or other written communications.

EDUCATIONAL LEAVE

Eligible residents at the 2nd and 3rd year level, may be granted educational leave for a period of up to five (5) days per year. Requests will be evaluated based on a number of factors, including anticipated work load requirements and staffing considerations during the proposed period of absence. Residents in their first year of training are not eligible for educational leaves.

The conference stipend for R-2's and R-3's will be a maximum of \$1500.00 for a five day conference, with prior approval. Lesser amounts of conference time may be taken, for example, a three day conference. Only the conference, hotel and travel expenses, not to exceed the amount stated above, will be reimbursed for shorter conferences. Conferences will require prior approval by the program Director or Associate Program Director and should be presented to the office well in advance of the scheduled conference.

Subject to the terms, conditions, and limitations of the applicable plans, STRP will continue to provide health insurance benefits for the full period of the approved educational leave. Vacation, sick leave, and holiday benefits will continue to accrue during the approved educational leave.

MEDICAL LEAVE (INCL. MATERNITY LEAVE)

STRP provides medical leaves of absence without pay to eligible employees who are temporarily unable to work due to a serious health condition or disability. For purposes of this policy, serious health conditions or disabilities include inpatient care in a hospital, hospice, or residential medical care facility; continuing treatment by a health care provider; and temporary disabilities associated with pregnancy, childbirth, and related medical conditions. Employees will be required to first use any accrued paid leave time before taking unpaid leave.

Eligible employees may avail medical leave only after having completed 90 calendar days of service. Exceptions to the service requirement will be considered to accommodate disabilities.

A physician's statement must be submitted verifying the need for medical leave and its beginning and expected ending dates. Any changes in this information should be promptly reported to the STRP. Employees returning from medical leave must submit a physician's verification of their fitness to return to work.

Leave without make-up for residents will be guided by the policies and requirements of the American Board of Internal Medicine (ABIM) regarding leave of absence and board eligibility. (The ABIM policy is as follows: Up to one month of credit may be granted in any one year for vacation time or illness. Residents enrolled after July 1, 1999 are entitled to a maximum of 4 weeks leave without making up the lost time.)

Subject to the terms, conditions, and limitations of the applicable plans, health insurance benefits will be provided by the STRP until the end of the month in which the medical leave begins. At that time, employees will become responsible for the full costs of these benefits if they wish coverage to continue. When the employee returns from medical leave, benefits will again be provided by the STRP according to the applicable plans.

Benefit accruals, such as vacation, sick leave, or holiday benefits, will be suspended during the leave and will resume upon return to active employment.

FAMILY LEAVE (INCL. PATERNITY LEAVE)

The STRP provides family leaves of absence, without pay, to eligible employees who wish to take time off from work to fulfill family obligations directly related to child birth, adoption, or placement of a foster child. This provision is also available to care for a child, spouse or parent with a serious health condition. A serious health condition means an illness, injury, impairment or a physical/mental condition that involves in-patient care in a hospital, hospice, residential medical care facility; or continuing treatment by a health care provider.

All other requirements applicable under the medical leave policy will also apply to the family leave policy. Subject to the terms, conditions and limitations of the applicable plans, STRP will continue to provide health insurance benefits for the full period of the approved educational leave. Vacation, sick leave and holiday benefits will continue to accrue during the approved educational leave.

INTERVIEW LEAVE

Residents are permitted reasonable days off to allow them to appear for job and fellowship interviews. However, they need to put in a written request to the STRP office on the appropriate form along with a copy of the job or fellowship interview invitation ahead of time and duly signed by the Chief Resident and the person in charge of scheduling. It is the resident's responsibility to provide coverage for their missed calls and/or clinics.

RESIDENT CONDUCT AND WORK RULES

To ensure orderly operations and provide the best possible work environment, STRP expects residents to follow rules of conduct that will protect the interest and safety of all residents and the organization.

It is not possible to list all the forms of behavior that are considered unacceptable in the workplace. The following are examples of infractions of rules of conduct that may result in disciplinary action, up to and including termination of employment.

DRUG AND ALCOHOL USE

It is STRP's desire to provide a drug-free, healthful, and safe workplace. To promote this goal, residents are required to report to work in appropriate mental and physical condition to perform their jobs in a satisfactory manner.

While on STRP premises and while conducting business-related activities off STRP premises, no resident may use, possess, distribute, sell, or be under the influence of alcohol or illegal drugs.

ATTENDANCE AND PUNCTUALITY

To maintain a safe and productive work environment, STRP expects residents to be reliable and to be punctual in reporting for scheduled work. Absenteeism and tardiness place a burden on other residents and on STRP. In the rare instances when residents cannot avoid being late to work or are unable to work as scheduled, they should notify their attending as soon as possible in advance of the anticipated tardiness or absence.

Poor attendance and excessive tardiness are disruptive. Either may lead to disciplinary action, up to and including termination of employment.

PERSONAL APPEARANCE

Dress, grooming, and personal cleanliness standards contribute to the morale of all residents and affect the business image STRP presents to patients and visitors. During business hours, residents are expected to present a clean and neat appearance and to dress according to the requirements of their positions. Consult your Program Director if you have questions as to what constitutes appropriate attire. Scrub suits should not be worn during the day.

RETURN OF PROPERTY

Residents are responsible for all property, materials, or written information issued to them or in their possession or control. Residents must return all STRP property immediately upon request or upon termination of employment.

SCHEDULING

1. Call schedule is available online at www.amion.com. Password to access the schedule will be provided during the orientation.
2. Yearly schedule will be made up of thirteen four week blocks.
3. All requests for days off or vacation must be submitted in writing to the STRP office prior to the start of the academic year by the date specified. Conference time can be scheduled at a later date, but no later than 60 days prior to the conference.
4. Making block schedules ahead of time will allow you more opportunity to be aware of your schedules. Requests made after the schedule is made will not be honored except under special circumstances.
5. In general, no more than two residents will be allowed to be on vacation or conference during a given time. Exceptions can be made to this rule only for extreme circumstances.
6. One week of vacation may be taken continuously. Longer vacation blocks will be allowed only under special circumstances and with prior approval. Vacation can even be split into individual days.

CALL SCHEDULE FOR MERCY AND MOSES TAYLOR HOSPITALS

Interns & Senior Residents

a) When there is no night float:

Weekdays: 5:00 pm to 8:00 am the next morning

Sat. & Sun.: 8:00 am to 8:00 am the next morning

b) When there is a night float:

Weekdays: 5:00 pm to 9:00 pm the same day

Friday: 5:00 pm to 8:00 am the next day

Saturday: 8:00 am to 8:00 am the next day

Sunday: 8:00 am to 9:00 pm the same day

ON CALL RESPONSIBILITIES

MERCY HOSPITAL - TEACHING SERVICES

The senior resident on call will receive the first call regarding any admissions from an attending or via the emergency room. He/she will then assign the case to the on call intern. Once the intern has done the history and physical, the senior resident will review the admission with the intern and also write an admit note. The senior resident will then call the attending involved in the care of the case and discuss the case with him/her.

Accommodations for residents on call at Mercy Hospital are provided on 3 Center (3R on the elevator).

MOSES TAYLOR HOSPITAL - TEACHING SERVICES AND ICU

One intern on call for the floor.

One senior resident on call for the ICU.

Accommodations for residents on call at Moses Taylor Hospital are on the 4th floor.

Interns are responsible for first call coverage of all patients on their assigned floor service. Interns will be responsible for the work-up of all admissions at Mercy Hospital and the floor admissions at Moses Taylor Hospital. Senior residents are responsible for supervising the interns on call.

On call outpatient calls reporting sheet

Patient's name:

Allergies:

Key medications: Coumadin / Ativan / Xanax / Pain meds

Reason for call: Refill of:

Other:

Diagnosis:

Your response:

Resident's Name:

Date:

Please report under Triage in Medent or if not accessible fax to:

Mercy patients: 570-941-0648

Moses patients: 570-961-5991

POLICY ON CARE OF NON-TEACHING SERVICE PATIENTS

Teaching Service Patients are defined as those patients at Mercy and Moses Taylor Hospitals who are:

1. Admitted to the Services A, B, C, D, E and F.
2. Admitted to the ICU at Moses Taylor Hospital and are under the care of a STRP faculty internist.

STRP residents are responsible for the care of all teaching service patients during their entire hospitalization (unless such patients are transferred / discharged from the teaching service).

STRP residents are expected to respond to calls for cardiopulmonary resuscitation, whether or not the patients are on teaching service.

STRP residents are expected to provide care for patients on the service of sub-specialists while the residents are rotating on the subspecialty electives and during the regular duty hours of the resident on the particular elective.

STRP residents are not required to provide care to patients who are not on the teaching service. It is the sole responsibility of the private attending physician to provide comprehensive medical care, 24 hours a day, to all patients on his or her service.

STRP RESIDENT COVERAGE

STRP residents always need to act under the direct supervision of the STRP faculty. If a non-teaching service patient would benefit from resident involvement, it has to be explicitly under the guidance of the STRP faculty in the form of a consultation.

The only exception is that of the ICU residents at Moses Taylor Hospital who will evaluate non-teaching service floor patients for potential transfer to the ICU. Even in these cases there should be a supervising internist on the case to guide and teach the resident. In Moses Taylor ICU there is resident coverage 24/7 for medical patients under the supervision of internists (with the exception of Dr. Michelle Hazzouri whose patients residents do not cover). In the event that a surgical or family practice case would benefit from resident assessment or involvement, this should be requested in the form of an internal medicine consult by the surgeon or family practitioner.

STRP residents care for STRP associated patients, unattached (“no doc”) patients and also those patients whose doctors do not have admitting privileges to Mercy or Moses Taylor Hospitals. Residents cannot be called to take care of patients whose provider has hospital privileges but is unavailable or is not appropriately covered. All providers with hospital privileges have a responsibility to ensure adequate competent coverage of their patients in their absence.

Resident activities should always be educational, not service driven, with the rare exception of an emergency which threatens patient’s survival. The residents are instructed to strictly adhere to these guidelines.

WEEKEND COVERAGE

WEEKEND ROUNDING SYSTEM FOR SERVICES AT MERCY HOSPITAL

1. One senior resident or intern from each of the service teams, in each of the two hospitals, will make rounds on Saturday starting at 8:00 am of that day, leaving their partner free to have the day off. Sign out for each team to the on call resident will be when rounds are completed on Saturday. **The on call resident**, however, must be present from 8:00 am on Saturday and **will help the service residents in rounding on the admitted patients**. The patients must be reviewed with the on call attending before signing out for the day.
2. On Sunday, the alternate residents (one from each service team) will round on all patients on their services from 8:00 am of that day, leaving their partner free to have the day off. This system will allow each resident, on each team, to have one weekend day off. Sign out to the on call resident on Sunday will be when the rounds are completed. **The on call resident**, however, must be present in the hospital from 8:00 am on Sunday and **will help the service residents in rounding on the admitted patients**. The patients must be reviewed with the on call attending before signing out for the day.
3. **If senior resident/intern on call is not on service he/she should help in rounding.**
4. On Sunday the post call senior resident/intern should leave at 8:00 am in order to have the full 24 hrs off.

WEEKEND ROUNDING SYSTEM FOR SERVICES AT MOSES TAYLOR HOSPITAL

1. The system for weekend rounding at Moses Taylor Hospital for Service C is similar to that described above.
2. Weekend rounds in the ICU at Moses Taylor Hospital will be split evenly among the ICU team members. Even in the initial months of the year when ICU is staffed by only two senior residents, each resident must average one day in seven off. During those months ICU rounds will be helped by the senior residents on call or post call on weekend days. After the initial months, once three residents are posted in the ICU, two residents (including a back up to help in case of large numbers of ICU patients) should be allotted for each weekend round day.
3. On Sunday the post call senior resident/intern should leave at 8:00 am in order to have the full 24 hrs off.

Private arrangements for sign out and coverage is not permitted without prior approval.

ORDER WRITING

All patients are the responsibility of their respective staff physicians. In order to encourage and improve personal communication between the attending physician and housestaff and, thereby, improve the educational experience, all orders are to be written by the resident, except surgical orders and orders for procedures written by sub-specialists.

The attending physician may incorporate suggestions into his progress notes which will be written as orders by the residents. For more urgent problems, the attending should call the resident and advise him of what needs to be done and vice versa. Overall frequent communication between residents and attending is essential and is to be encouraged. Telephone verbal orders should be limited to emergency and laboratory requests whenever possible.

In emergency situations, orders may be written by the attending or consulting physician.

Orders written by medical students will neither be noted nor carried out until countersigned by a house officer. Both admission orders and discharge orders are to be countersigned by the attending physician.

In a well-managed case, all orders are written in a timely manner and only once a day. This should be done when the patient is seen on morning rounds. We all recognize that changes in the patient's status or the return of results from laboratory or x-ray studies can make it necessary to write additional orders. Even in these instances, all the new orders should be written at one time. Orders should always be dated, timed and signed, followed by your pager number.

After orders are written, the chart should be flagged to call the new orders to the attention of the charge nurse. This is customarily done by folding the order sheet diagonally so that the bottom protrudes from the side of the chart and then the chart is kept on the rack in front of the charge nurse.

In urgent situations, the resident should personally call orders to the attention of the charge nurse.

The Medical Staff Bylaws state that:

1. All orders for treatment be in writing. A verbal order is valid only when dictated to an on-duty registered nurse and signed by the responsible physician. Orders given over the telephone should be signed within 24 hours.
2. The use of "renew", "repeat" and "continue" orders is acceptable only when they designate specific treatment.
3. Automatic stop orders:
 - a. Narcotics and amphetamines - 72 hours
 - b. Sedatives, hypnotics, tranquilizers - 120 hours
 - c. Antibiotics - 120 hours
4. Renal function must be measured within 24 hours of starting nephrotoxic drugs and at 48 hour intervals thereafter.

ROUNDS

PRE-ROUNDS: Interns on service will see their patients **prior to the morning report**. They will gather overnight data, examine the patient, and get a preliminary patient care plan organized for the work rounds. Progress notes can be written at this time as time allows. Pre-rounds will also be performed by the sub-interns and medical students on the patients allotted to them. **Pre-rounds may NOT start before 6:30 am.**

WORK ROUNDS: Each patient on service is seen by the senior resident, intern and medical student as a team. At this time, evaluation of the patient's status is made and therapeutic and diagnostic plans are formulated. These rounds start at the beginning of the work day, immediately after the morning report, and should be completed expeditiously. In-depth teaching discussion with students is not appropriate at this time, nor is writing progress notes.

ATTENDING ROUNDS: The Residency Review Committee distinguishes between work (or patient management rounds) and teaching rounds. The attending is intended to provide the latter, so questions of academic interest with reference to past medical literature should be a prime focus as well as discussions of specific problems. The requirement is for one and one-half hour of attending teaching rounds three times a week. It is strongly encouraged that an hour be spent on Monday, Tuesday, Wednesday, Thursday and Friday with the best time found by experience to be between 11:00 am and 12:00 noon. The first patients presented and discussed will be the medical service patients. The next group will be the private patients of the attending physician. If time permits, patients of other physicians who are on the resident service will be presented.

VISITING PROFESSOR ROUNDS: The last week of each month an invited professor will make teaching rounds.

Inpatient rounds with the visiting professor will be on Wednesday at 9:30 am at Moses Taylor Hospital and on Fridays at 9:30 am at Mercy Hospital.

Case presentations will follow the same format as for attending rounds. History and physical examinations will be presented at the bedside or in a conference room. Presentation of hospital course and laboratory data is expected. The resident should be well versed in the basic information concerning the clinical manifestations, pathophysiology, differential diagnosis, etc. All x-rays, scans, etc., should be available. All residents are expected to attend.

When the visiting professor is a sub-specialist, the residents should make every effort to schedule patients with problems in his/her particular area of interest. All appropriate x-rays, scans, etc., should be available for review by the visiting professor. Office hours during VP day start at 3:00 pm at Scranton-Temple Health Center and will be cancelled at the MVP.

SIGN-OUT ROUNDS: When leaving the service, nights and weekends, in the charge of a covering resident, the service resident will meet with the covering resident and provide him with a list of patients and give him a detailed sign-out on each patient. He will also discuss in depth any problem patients and outline any therapeutic regiment he wishes to be followed on his patients.

CHART ROUNDS: On a weekly basis, each resident should set aside sufficient time to review each of his patient's charts. These will be designed to review the progress of patient problems as reflected in the medical record. A review of all standing orders, with the nurse-in-charge, should be made at this time.

CONFERENCES

Attendance at conferences is obligatory. Absence is justified for interns when post-call. Other emergency situations include vacation, CME conference, or the ICU rotation (see page 17).

NOON CONFERENCES

1. **CARDIOTHORACIC CONFERENCE** - Mercy Hospital - Monday - 12:00 noon.
2. **STHC LECTURE/WORKSHOP** – STHC – Tuesday – 12:00 noon. For residents and medical students only.
DEPARTMENT OF MEDICINE MEETING - Mercy Hospital - 4th Tuesday of every month – 12:00 noon.
3. **GRAND ROUNDS** - Moses Taylor Hospital - Wednesday - 12:00 noon. These sessions consist of presentations by residents, attending physicians as well as guest lecturers.

All third year residents are required to give a grand rounds presentation during their final year (“**Senior Presentation**”). These will be scheduled by the STRP faculty and given at Moses Taylor Hospital. The resident is responsible for choosing a topic and designating an appropriate faculty advisor for the talk by January of their third year. Slides and other materials should be prepared appropriate to the formal grand rounds.

4. **TUMOR BOARD** - Mercy Hospital - Thursday - 12:00 noon. Clinical-pathological correlation in patients with known or suspected malignancies is discussed. Residents are expected to participate in the presentation and discussion.
5. **GRAND ROUNDS** - Mercy Hospital - Friday - 12:00 noon. These sessions consist of presentations by staff physicians and invited guest lecturers. Topics cover a broad range of medical and surgical problems.

Conferences will be scheduled according to the needs of the STRP curriculum as developed by the core faculty and as outlined by the ABIM.

MORNING REPORTS

Morning Report is the primary teaching conference of the Scranton-Temple Residency Program. It is held every weekday from 8:00 am to 9:00 am. All residents (except the senior residents on call at Mercy Hospital on Tuesdays, Wednesdays and Thursdays who do not attend the Wednesday, Thursday and Friday morning reports respectively) regardless of which hospital you were on call the night before are required to attend. The ICU residents only attend the Thursday’s ICU morning report.

Specific requests for an exemption related to an elective rotation or extenuating circumstances is to be cleared through the STRP office in advance.

The purpose of these morning reports is to develop skills in case presentation, and critically review the case material. Each day, new patients with particularly interesting diagnostic or therapeutic problems will be presented by the residents. Conferences will be moderated by an attending physician in conjunction with the Chief Resident, if available.

Morning report schedule is as follows:

- Monday: Ambulatory Care Conference – Ambulatory care coordinators and residents will discuss specific ambulatory care topics. Senior residents and interns will be expected to participate in the presentations and the ensuing discussion.
- Tuesday: Two cases are presented by the residents on service at Mercy Hospital in the 7 east conference room.
- Wednesday: Morning reports are held on the first floor of the School of Nursing building at Community Medical Center.
- Thursday: Two cases are presented by the ICU residents at Moses Taylor Hospital in the dialysis conference room on the second floor.
- Friday: Two cases are presented by the residents on service at Moses Taylor Hospital in the dialysis conference room on the second floor.

CONFERENCE SCHEDULE

DAY	8:00 am – 9:00 am	12:00 noon – 1:00 pm
MONDAY	AMBULATORY CARE CONFERENCE Scranton-Temple Health Center	CARDIOTHORACIC CONFERENCE Mercy Hospital 2 nd Floor Conference Room
TUESDAY	MERCY MORNING REPORT Mercy Hospital 7 th Floor Conference Room	STHC LECTURE Scranton-Temple Health Center
WEDNESDAY	MKSAP CLUB Mercy Hospital 7 th Floor Conference Room	GRAND ROUNDS Moses Taylor Hospital 2 nd Floor Meeting Room
THURSDAY	ICU MORNING REPORT Moses Taylor Hospital Dialysis Conference Room	TUMOR BOARD Mercy Hospital 2 nd Floor Conference Room
FRIDAY	MOSES MORNING REPORT Moses Taylor Hospital Dialysis Conference Room	GRAND ROUNDS Mercy Hospital 2 nd Floor Conference Room

MORNING REPORT AND NOON CONFERENCE ATTENDANCE

Morning Report and Noon Conference attendance is mandatory for every resident except the following who are **excused**:

1. Night float ICU senior resident from all morning reports and noon conferences except for Thursday and Friday morning reports.
2. Night float intern from all noon conferences.
3. ICU senior residents and interns from all conferences except for Thursday morning report and Wednesday noon conference.
4. Anesthesia rotation resident from morning reports only.
5. MVP residents from all noon conferences except on Thursday.
6. Interns excused from noon conferences when post-call.
7. Senior residents on call at Mercy excused from morning report if it is at clinic or Moses or CMC as they have to be at Mercy for any code. (They need to be present at Mercy morning reports). Code beeper carrying Mercy senior resident is excused from Wednesday noon conference at Moses Taylor Hospital.
8. ER residents / interns excused from all morning reports and noon conferences.

If you miss a morning report or noon conference for one of the above reasons, it is YOUR responsibility to call the program secretary up and let her know which of the above reason applies to your excuse.

Any other excuses need to be brought to the attention of and approved by the faculty.

PROCESS OF TRACKING AND REPORTING:

(1) Morning Reports:

Chiefs take the attendance at the morning reports. They mark excused **mentioning the reason** for residents they know are in a rotation where they are not expected to come / on vacation / gone for CME etc.

Program secretary crosschecks this and also marks excused **mentioning the reason** the residents who call and give one of the accepted excuses (as listed below).

For those who still cannot be accounted for, she informs the Chiefs who follow up with the resident.

(2) Noon Conferences:

Program secretary goes over the attendance sheet, marking excused, **mentioning the reason**, the interns who are post call or the residents who call and give one of the accepted excuses (as listed).

For those who still cannot be accounted for, she informs the Chiefs who follow up with the resident.

ACCOUNTABILITY:

Anyone who is supposed to attend a morning report or a noon conference and is not present there will have to give a written explanation for his/her absence to the Chief Resident who will forward it to the Program Director.

With 1st non attendance, he/she will have to present an extra case in the morning report, either on Tuesday or Friday.

With the 2nd unaccounted absence, he/she will have to present an ICU case.

With the 3rd unaccounted absence, he/she will have to present a noon conference case.

With the 4th unaccounted absence, a meeting with the program director for an explanation for repeated absences is held.

MEDICAL RECORDS

The medical record provides a comprehensive, up-to-date, legible and lucid account of all information pertinent to the clinical course of the patient. The problem-oriented record is the only uniform system of medical record keeping currently available, and its use is required by the American Board of Internal Medicine. All members of the health care team should share the conviction that complete, high-quality medical records are essential to, and are a direct reflection of, high standards of patient care.

All clinical entries in the patient's medical record shall be accurately dated and authenticated by written signature or identifiable initials.

Symbols and abbreviations may be used only when they have been approved by the Medical Staff. An official record of approved abbreviation is kept on file in the record room of each institution.

HISTORY AND PHYSICAL

A complete history and physical examination must be performed and charted and dictated within 24 hours, on every patient admitted. The results of rectal and pelvic exams must also be charted within 24 hours. If not, the reason for deferral must be stated on the chart. Osteopathic physicians must document the musculoskeletal exam.

Residents are responsible for establishing phone contact with physicians caring for the patient and requesting all data from previous hospital admissions.

The admission note (history and physical) must be in the problem-oriented form. The usual sequence is:

- Chief Complaint
- History of Present Illness
- Past Medical History
- Past Surgical History
- Family History
- Social History
- Medications
- Allergies
- Review of Systems
- Physical Examination
- Admission Laboratory Studies, EKGs, Radiological Studies
- Assessment
- Plan

In many instances clinical decisions must be based upon timely basic laboratory work. Laboratory facilities available in the teaching clinical area are:

Hematocrit

Peripheral Blood Smear

Urinalysis

Stool Guaiac

Gram Stain of secretions and body fluids and indicated studies will be done on admission and as required during the hospital stay. Results of these tests will be recorded in the admission note

The admission history and physical must be dictated within 24 hours of the admission and definitely before discharge of the patient. Since such notes will not be on the chart for many hours, a written note is required. This will be of sufficient length to identify major problems, and diagnostic and therapeutic goals.

The supervisory physician should personally note in the patient's medical record that he saw the patient on admission or within a reasonable period thereafter.

PROGRESS NOTES

A. Housestaff

Progress notes are the responsibility of the residents and should be written daily in the problem-oriented format (**SOAP note**) by both the senior and junior residents. The resident should summarize the progress made in diagnosis and therapy and outline future plans. Visits made by the attending physician should be noted and specific advice or orders given by the attending should be emphasized. In addition, progress notes should be dated, timed, signed and should be **LEGIBLE**. Covering residents should write a brief note for any significant change in the condition or management of the patient they are called to evaluate.

B. Attending Physician

The attending physician should write progress notes daily. The emphasis in all progress notes should be to convey a summary of the current diagnostic and therapeutic approval to the patient rather than a repetition data recorded elsewhere in the chart. The problem list should be re-examined and revised frequently to reflect the patient's current status.

DIAGNOSTIC OPERATIVE PROCEDURES

Diagnostic procedures such as joint aspiration, lumbar puncture, thoracentesis and minor operative procedures should be entered in the progress notes and should be in the following format:

Operators

Indication

Procedure

Complications Results

The American Board of Internal Medicine has recently revised requirements for procedures necessary for certification of completion of training. The list of required procedures includes advanced cardiac life support, nasogastric tube insertion, central venous line placement, arterial puncture, thoracentesis, arthrocentesis, lumbar puncture, abdominal paracentesis, Pap smear.

It is important for your certification of competency in these procedures be recorded and signed off by the supervising attending in the procedure log page of www.myevaluations.com.

PROBLEM LIST

The problem list is the key or index to the medical record. It also serves to help the physician effectively organize his thoughts, resolve diagnostic problems and effectively plan therapeutic intervention.

A well conceived problem list includes:

1. All problems past and present are defined.
2. Social, psychiatric and medical problems are included.
3. Each problem is defined at your level of understanding and may be defined in terms of -
 - a. an observation
 - b. a sign
 - c. a symptom
 - d. a specific diagnosis.
4. When one problem is a major diagnosis but has various manifestations, the latter are listed as separate problems and are so indicated, e.g. #1 cirrhosis; #2 ascites due to #1.
5. Entries are revised as necessary.
6. When several individual problems are found to constitute a diagnosis, add this as a new problem and indicate that the earlier problems are secondary to this major diagnosis.
7. Transient problems are listed as temporary.
8. The status of each entry is kept current.

DISCHARGE SUMMARY

The discharge summary is also an important element of the medical record. In general, it will be the only document concerning the hospitalization that will be placed in the out-patient record. It must be concise, but complete.

At the time of discharge, the housestaff is responsible for completion of the face sheet and discharge summary. If the discharge summary is not done at discharge, at least the summary sheet should be completed documenting the final diagnosis explaining admission. At Mercy Hospital all charts have a DRG work through and the resident has the option of either documenting the final diagnosis on this sheet or the summary sheet. The summary must be completed within three weeks of discharge. Summaries should be dictated in the following format:

This is Dr.....(your name)
Dictating the Discharge Summary
On.....(patient's name)
MR #.....
Attending.....(specific name rather than TS)

Date of admission.....

Date of discharge.....

Primary admission diagnosis.....(cause of admission eg CP R/o MI)

Discharge diagnoses.....(main diagnosis first, followed by the full problem list)

Medications.....(list all meds given on discharge and their duration of use)

Hospital course....(briefly explain what was done from admission to discharge during the course of his stay; not H&P)

Physical exam.....(at the time of discharge)

Consults....(mention name and speciality)

Procedures.....(if any and outcome; eg appendectomy)

Labs and Special studies.....(admission and discharge labs and any significant changes in between. Special studies like ERCP)

Discharge plan.....(rehab, duration of therapy, home health, labs to be done etc)

Finally, mention who you need a copy sent to eg PCP or STHC attention so and so resident.

No graduation from STRP will be granted and the last paycheck will not be released to any resident who has incomplete charts at Mercy Hospital, Moses Taylor Hospital or Community Medical Center.

The responsibility for medical record completion will be as follows:

1. Moses Taylor Hospital: Senior residents are responsible for all patients' charts that present for admission and are placed on the teaching service. The charts of private attendings' patients will also be dictated on patients admitted to the teaching service.
2. Mercy Hospital: Senior residents are responsible for all patients' charts that present to Mercy Hospital and are placed on teaching services.

3. Interns and senior residents should share dictation responsibilities during the second six months of the year, with the interns being primarily responsible.
4. Please note that it is the upper-year resident's responsibility to ensure that one of the last orders on the physician order sheet at both hospitals will designate who is responsible for that chart (i.e., attending, upper-year resident or intern). Also note that if by chance there is no notification of chart responsibility on the physician order sheet, questions should be addressed to the upper-year resident in charge of that patient.
5. The intern is responsible for signing all medical student progress notes, and the senior resident is responsible for signing sub-intern notes.
6. Each service team is responsible for ensuring that the last progress note (i.e. discharge note) listing all pertinent diagnosis, drugs, diet and follow-up instructions is copied by Medical Records and forwarded to the appropriate physician's office. This is requested on the last physician order sheet. For STHC patients, the team has to ensure that the discharge summary is faxed to the clinic at the time of discharge.
7. Interns are responsible for completion of all summary sheets regardless of who is designated to do the discharge summary.

DOCUMENTATION OF RECORDS REQUIRED FOR REIMBURSEMENT

As medical post-graduate education faces a challenge to its very existence deriving in large part to the rising costs of hospital care, it is incumbent upon everyone to do what is necessary to help support the teaching program. Central to this goal is optimal recovery of justifiable charges to third-party payers. Adequate documentation of services rendered is the sine quo non of the payment process.

The following information is intended to outline the requirements. A supervising physician in a teaching setting may receive payment for any direct patient care that he personally provides the patient. The documentation of this service in the record should be made by the supervising physician and should clearly show that he provided the service.

MEDENT – THE ELECTRONIC MEDICAL RECORD

The Scranton-Temple Residency Program utilizes an electronic medical record (EMR) system known as MEDENT in its ambulatory clinics to document all instances of patient care. Further training with MEDENT will occur at orientation and through individual services.

HOUSESTAFF DELINQUENT RECORDS

PURPOSE

House Officers are required to complete medical records at all participating institutions in order to avoid delinquency as outlined in Medical Staff bylaws of the participating institutions of the Scranton-Temple Residency Program (STRP).

POLICY

Delinquency in completion of medical records at all participating institutions constitutes grounds for withholding House Officer compensation.

The Scranton-Temple Residency Program Resident Agreement contains a statement outlining institutional requirements for completion of medical records. A signed contract is obtained from each member of the STRP housestaff.

On the first weekday of each month, Medical Records publishes a list of housestaff delinquent in completion of medical records.

Correspondence is addressed to each delinquent housestaff member notifying them of delinquency and instructing them to complete delinquent records.

The housestaff member must complete his/her delinquent records by the second pay period after notification. Medical Records publishes a list of housestaff who remain delinquent in completion of medical records. This list is forwarded to the Graduate Medical Education Office and to payroll. Direct deposits and checks for any individuals on the delinquent list are held, and the housestaff. Member is notified.

Upon notification of record completion from Medical Records, housestaff's paycheck will be released.

EVALUATION MECHANISMS

Evaluation is an important and useful educational tool, providing a means of identifying both strengths and weaknesses. Such information aids the faculty in directing its efforts toward program improvement and correction of individual deficiencies.

Evaluations are filled out online at www.myevaluations.com. You will receive information on using the program during your orientation. There are a set of standards for each level of training and tools by which to measure each resident's accomplishments in meeting these standards. These are discussed in detail in the Competency Based Curriculum available online at the STRP website (www.strpweb.org).

STANDARDS AND GOALS

First Year Residents: During the first year, the resident will be exposed to the basic teaching areas involved in the specialty of internal medicine. The resident is expected to develop competence in taking histories, performing physical examinations and completing medical records. Problem solving skills involved in differential diagnosis and clinical management will be stressed. Each resident will gain experience in the medical subspecialties. He/She will also develop skills such as putting in a central line, measuring central venous pressure, doing thoracentesis, paracentesis, and lumbar puncture.

Second Year Residents: By the completion of the second year, the resident will have gained a greater depth of knowledge in internal medicine. He/she will be more practiced in his use of the laboratory and radiological services. In addition, the resident will develop more technical skills, especially those useful in cardiopulmonary resuscitation and intensive care. He/she will be able to use the current medical literature more efficiently and effectively.

Third Year Residents: As a third-year senior resident, the physician will gain further depth of knowledge. He will serve in the roles of consultant, administrator, teaching coordinator and educator. The third year will serve to complete the development of the fully trained internist. He will be capable as a diagnostician, consultant, teacher, and practitioner in ambulatory and inpatient environments.

EVALUATION

The evaluation program is under the direction of the Clinical Competence Committee.

Attending's Evaluation: Each month the attending physician will complete a detailed evaluation form. The purpose of this evaluation is to assess how the resident functions in the day-to-day care of patients, interpersonal relationships and ability to learn new information.

Coordinator's Evaluation: The Coordinators will periodically assess each resident's competence in record keeping. This will be accomplished by both formal and informal chart reviews. Abilities in history taking,

physical diagnosis and differential diagnosis will be evaluated by recording resident's performance on a medical record review form for inpatient records.

Clinical Evaluation Exercise: R-1's will be required to successfully complete a history and physical examination exercise done during the first 6 months. This will consist of the resident conducting a history and physical examination on someone he has never seen before the exercise. It will be done in the presence of a member of the Clinical Competence Committee.

The resident will be graded on ability to establish a patient/physician relationship, to interview the patient, to perform a complete physical examination and to collate the case into meaningful form. This will include adequate definition of the problems including the differential diagnosis, the diagnostic work-up and therapy. Cost control will be an important element. If the resident's performance is unsatisfactory, then the exercise will be repeated with a new patient and another member of the Clinical Competence Committee.

The resident must supply the evaluator with the written patient work-up for evaluation. Upon completion of the exercise, the evaluator will submit the CEX evaluation form and the patient work-up to the Program Director for review.

Resident Evaluation of Rotation: After each rotation, the resident will complete an evaluation form. This will be reviewed by the Program Director and referred to the appropriate Residency Program Committee for implementation of corrective action as required. The senior and junior residents and attending physicians will evaluate each other. All evaluations must be returned within 5 days of the allocation of the evaluation.

Evaluation Conferences: Residents are required to meet with the Program Director or his delegate once every six months. The resident's file is reviewed and strengths, weaknesses, and any personal or professional problems the resident may be encountering are discussed.

Ambulatory Care Evaluation: Evaluation of the residents is submitted quarterly by the attending physicians from the Scranton Temple Health Center.

DISMISSAL OF RESIDENTS

The Program Director and the Board of Directors of the STRP have the authority to take corrective action regarding the temporary suspension of a resident physician.

Grounds for the temporary suspension of a resident physician shall include the following:

1. Evidence which strongly suggests clinical, mental or physical incompetence.
2. Inappropriate care, treatment and management of a patient by the resident physician.
3. Suspected or known violation of policies and/or standards of the STRP, Mercy Hospital or Moses Taylor Hospital relating to the professional activity and/or conduct of the resident physician.

A resident physician who incurs a temporary suspension from the Program shall be entitled to a hearing with the Grievance Committee. At the hearing the resident physician shall be informed of the alleged charges and shall be given the opportunity to explain, discuss, or refute them.

The Grievance Committee will report the findings of the hearing to the Board of Directors with a recommendation for appropriate action.

NON-RENEWAL OF CONTRACT

PURPOSE

Provide House Officer's with A written notice of intent not to renew annual contract with the Scranton-Temple Residency Program.

POLICY

The Scranton-Temple Residency Program must ensure that Programs provide their House Officers with a written notice of intent not to renew a House Officer's contract no later than four months prior to the end of the House Officers current contract. However, if the primary reason(s) for the non-renewal occurs within the four months prior to the end of the contract, the Scranton-Temple Residency Program must provide the House Officer with as much written notice of the intent not to renew as the circumstances will reasonably allow, prior to the end of the contract. House Officer's must be allowed to implement the Institution's grievance procedures as described in HS Policy Manual, once they have received a written notice of intent not to renew their contracts.

The term House Officer is used as a generic term to include interns, residents, and fellows in an approved ACGME Residency Training Program at the Scranton-Temple Residency Program.

RESTRICTIVE COVENANTS

Residents in the training program sponsored by the Scranton-Temple Residency Program are not required to sign any type of non-competitive guarantee.

REDUCTION IN SIZE/CLOSURE OF GME TRAINING PROGRAMS

The intent of this policy is to promote the fair and equitable treatment of trainees affected by institutional decision to close or reduce the number of trainees in a GME program sponsored by the Scranton-Temple Residency Program.

Circumstances and considerations that may lead to closure or reduction in the size of a training program include, but are not limited to:

1. Failure of the training program to correct concerns and/or comply with recommendations of the GME Committee based on the internal review of the program;
2. Failure of the training program to correct citations of the Accreditation Council for Graduate Medical Education;
3. Decreased financial or educational resources to support the training program; and
4. Reallocation of positions among the postgraduate programs.

The following procedure will be followed in the event that the Scranton-Temple Residency Program and/or the training program director decides to reduce the number of positions in or close a training program:

1. Trainees currently in the program will be notified immediately, in writing. The notification will include specific date(s) and the terms by which the program is closing or downsizing.
2. Every attempt will be made to reduce the number of positions over a period of time and/or by reducing entry level positions through decreased recruitment so that enrolled trainees can complete their training.
3. If completing the program is not possible, the program director and the Medical Staff and Residency Office will assist displaced trainee(s) in securing an appointment to another training program in which they can continue their education.
4. The institution will protect remaining trainees from inappropriate duty hours and service obligations resulting from closures/reductions.

DUE PROCESS

I. Conditions Mandating Enactment of Due Process

- A. The resident physician's professional performance and/or conduct does not meet the standards of the STRP, and/or the medical staff of the integrated hospitals, Mercy and Moses Taylor.
- B. The professional conduct and/or activities of a resident physician are deemed disruptive to the operation of the integrated hospitals, Mercy and Moses Taylor.
- C. A resident physician initiates a grievance procedure against the STRP and/or aspects of the program, alleging that the program does not meet the needs of his/her professional growth and development as the program may have purported.

II. Procedures

- A. All requests for the initiation of due process procedures must be communicated in writing, supported by reference to the specific activity and/or conduct which constitute grounds for the request. Written acknowledgment of the notification of initiation of due process is required of the parties involved.
 - (1) The resident physician against whom the due process procedure has been requested will be informed of that request by the Program Director. Written acknowledgment of receipt of the request is required of the resident physician.
 - (2) If a resident physician is initiating a grievance procedure against the STRP, the notification is to be sent to the Program Director. Written acknowledgment of receipt of the request is required of the Program Director.
- B. It is the responsibility of the Program Director to inform the Grievance Committee of the initiation of due process procedures.
- C. Within seven days of the receipt of notification for due process procedures, the Grievance Committee will select a date for a hearing and notify all parties involved.
- D. The scheduled hearing is a guarantee for both parties of an equitable mechanism for the redress of grievances involving professional and educational matters.

III. Grievance Committee

- A. Membership in the Grievance Committee is determined by the Board of Directors. Representatives to this committee include designated individuals as follows:
 - 1. STRP administration
 - 2. STRP teaching staff
 - 3. Curriculum and Evaluation Committee
 - 4. Recruitment and Resident Selection Committee
 - 5. Administration of the Integrated Hospitals
 - 6. Resident Housestaff Representatives

- B. The Grievance Committee will make recommendations to the STRP Board of Directors. Final determination of grievances is the responsibility of the STRP Board of Directors.

PROGRESSIVE DISCIPLINE AND REMEDIAL ACTIONS

House officers in graduate training programs are considered to be students although they enjoy most of the rights and privileges that are accorded to the medical staff of the integrated hospitals.

STRP has supervisory and evaluative mechanisms to identify clinical performance and educational problems prior to those problems becoming serious. The objective is to assist the house officer through educational opportunities and supervision, in the correction of the difficulties. House officers will be offered a variety of supervised experiences tailored to the deficiencies identified. Problems, steps developed to remedy the problems, anticipated outcomes, and a time frame within which improvements to occur will be clearly defined.

In accordance with the severity of the problem(s) identified, remedial actions may call for any of four steps - verbal warning, written warning, suspension with or without pay, or termination of employment - depending on severity of the problem and the number of occurrences. There may be circumstances when one or more steps are bypassed.

Progressive discipline means that, with respect to most disciplinary problems, these steps will normally be followed: a first offense may call for a verbal warning; a next offense may be followed by a written warning; another offense may lead to a suspension; and, still another offense may then lead to termination of employment. Problems are dealt with in the least stringent manner necessary, taking more severe actions if initial remedial efforts do not succeed.

STRP recognizes that there are certain types of resident problems that are serious enough to justify either a suspension, or, in extreme situations, termination of employment, without going through the usual progressive discipline steps.

It is expected that remedial actions involving non-clinical/educational offenses will be similar to those actions that will be taken with staff of the integrated hospitals. It is incumbent upon the STRP preceptors,

attendings and/or coordinators to inform the Program Director when such instances occur, prior to the taking of any remedial actions, to assure consistency in the application of remedial actions.

An important element to success in remedial efforts is to document all plans and actions taken and efforts to obtain the house officer's agreement to these actions. Such documentation will also serve as written record of past efforts, if more stringent actions, suspension or termination, must be considered. In those cases where more stringent forms of discipline are taken by the Program Director, it is important that the house officer be informed by the Program Director that a fair hearing can be requested if the house officer disagrees with these actions.

It is recognized that the rigors of fulfilling the responsibilities of a house officer may cause emotional stress requiring the support of psychological services. Should a house officer display evidence of the need for such support and if deemed necessary by the department chairman, psychological evaluation may be mandated. Additionally, a house officer may identify a need for psychological support in order for him/her to continue his/her responsibilities in a satisfactory manner. STRP has established a program whereby the resources of the hospital and the community are made available to the resident physician in need of psychological support.

It is expected that every house officer will observe basic rules of good conduct. While it is impossible to list every type of behavior that may be deemed a serious offense, the RESIDENT CONDUCT AND WORK RULES policy includes examples of problems that are not all necessarily serious offenses, but may be examples of unsatisfactory conduct that will trigger progressive discipline.

By using progressive discipline, we hope that most resident problems can be corrected at an early stage benefiting both the resident and STRP.

Most of these are common sense rules which serve to maintain a professional atmosphere. Listed below are some non-clinical/educational offenses which could also result in disciplinary action ranging from verbal counseling to immediate discharge from all duties and responsibilities as a house officer:

1. Chronic or habitual lateness or absenteeism.
2. Deliberate violation of posted health, safety, fire prevention or security rules.
3. Deliberate false, fraudulent, or malicious statement or action involving relations with a patient, the hospital, co-workers, or the public.
4. Falsification of residency application or records.
5. Theft or inappropriate removal or possession of property of a patient or visitor, an employee, the hospital, or an independent contractor.
6. Actual or threatened physical violence, profane, or abusive language.
7. Possession, distribution, sale, transfer, or use of alcohol or illegal drugs in the workplace, while on duty.

8. Disorderly, immoral, or disruptive conduct while on hospital premises.
9. Inappropriate appearance, improper wearing of uniform. gross inattention to good grooming and personal hygiene.
10. Insubordination or other disrespectful conduct.
11. Smoking in prohibited areas.
12. Sexual or other unlawful or unwelcome harassment.
13. Possession of dangerous or unauthorized materials, such as explosives or firearms, in the workplace.
14. Unauthorized absence from work station during the workday.
15. Unauthorized use of telephones, mail system, or other employer-owned equipment.
16. Unauthorized disclosure of confidential information.
17. Violation of personnel policies.
18. Unsatisfactory performance or conduct.

If the circumstances are determined to be so serious as to warrant immediate dismissal from the program, the circumstances must be documented in writing, presented to the Program Director, and the information presented to the house officer and the Grievance Committee.

If the house officer disagrees with the action that has been taken, and the problem cannot be resolved within the program, a request for a hearing may be made to the Program Director. The Program Director will inform the Grievance Committee of the initiation of due process procedures.

OSTEOPATHIC INTERNSHIP - ADDITIONAL GUIDELINES

All osteopathic interns are expected to follow the guidelines for the osteopathic internship as outlined by the AOA. These guidelines include everything in this Housestaff Policy Manual. There are, however, special considerations that apply only to our osteopathic interns, which must be followed and are outlined below.

1. Intern Logs-

At the end of each service, each intern is required to present to the Director of Medical Education (DME), a log of activity performed during that service. Logs should be maintained daily. They must be signed by the intern and the rotation coordinator to verify accuracy of numbers presented. Logs are not only a program requirement of the training institution and the AOA, but should be accurately maintained for requesting future hospital privileges. Logs will be distributed at the beginning of the academic year and as needed, depending upon the rotation. No intern will receive credit for a rotation until the log is submitted to the DME. Please see Schedule D for sample logs.

2. Osteopathic structural exams-

All interns are required to document a complete musculoskeletal exam on all patients admitted to their hospital service when being supervised by a DO attending. The official form of the AOA and the Educational Council on Osteopathic Principles will be used. These forms will be distributed to all osteopathic interns at the beginning of the academic year and can be obtained from the program office. A completed form must be placed in the H & P section of the patient's chart. Compliance with this will be regularly assessed, as this is a strict requirement for continued AOA certification of this program. Please see Schedule D for sample log forms.

3. Osteopathic Manipulative Therapy (OMT)-

All interns are encouraged to perform OMT on as many patients as possible. All OMT given should be documented in the patient record. In addition to OMT given at the bedside, OMT tables will be available in both hospitals and in the Health Center for practice or personal use. At regular intervals DO faculty will be giving periodic lectures and demonstrations of OMT. All osteopathic interns must attend these sessions.

REQUIREMENTS FOR APPROVAL OF OSTEOPATHIC INTERNSHIP

To receive credit for AOA-approved rotating internship, interns shall:

- b. Have graduated from an AOA-accredited college of osteopathic medicine and remain members in good standing of the AOA.
- c. Satisfactorily complete the internship, as described in the *AOA Policies and Procedures for Intern Training*.

LIBRARY FACILITIES

Reference to the medical literature is an essential feature of practice. The resident is expected to develop skill and facility in the use of the current literature and to apply the knowledge to resolution of his patient's problems. Libraries are maintained at both hospitals and directed by medical librarians. The collections at each library contain current textbooks and a wide selection of journals. Through special sharing agreements between local hospitals and reference libraries in Philadelphia, a copy of almost any article can be quickly obtained.

Computer training will be in the form of practical lectures and hands on experience. The Mercy Hospital Medical Library and its librarian provide ample opportunity for all residents to acquaint themselves with computer operations. The resident's lounge also has computers, which can be used for literature searches, educational programs and word processing.

At both Mercy and Moses Taylor Hospitals there are computer terminals, which provide access to MEDLINE, OVID and POL. The librarian should be consulted for assistance in using these valuable tools for literature searches. Current audio-visual aids are also part of the libraries collection. The telephone numbers of the librarians are as follows - Moses Taylor Hospital: 963-2125; Mercy Hospital: 348-7800, 348-7171.

Familiarity with the use of a medical library is essential for a well-rounded physician. It is hoped that each resident will avail themselves of the opportunity to become personally familiar with the procedure of a literature search regarding patient care questions.

HOUSESTAFF LABORATORIES

At both the hospitals and in each ambulatory care facility, basic laboratory equipment is available. In general, there is a table-top centrifuge, microscope and refractometer. In the hospital laboratories, stains for blood smears and gram stain are also available. It is expected that the housestaff will use these facilities to complete the necessary studies on their patients. Each resident will be responsible for cleaning up after themselves, by discarding unused specimens and protecting all equipment. If additional supplies or reagents are required, the charge nurse in each area is to be notified.

INFORMATICS

All residents will have computer access to the internet provided by the program. This will include individual e-mail accounts. **Please be aware that your internet activities may be monitored.** Dr. Jay Vanston is the Director of Informatics and is available for ongoing computer training assistance.

ELECTRONIC ACCESS AND USAGE POLICY

The Scranton Temple Residency Program (STRP) recognizes the professional and business need for some, if not all, of its residents to have electronic access while on the job using STRP computers. This electronic access normally consists of an e-mail account, a network connection, and Internet/Intranet access. In all cases this access has been made available for STRP business purposes only.

E-MAIL POLICY

STRP's e-mail system is designed to improve service to our patients, enhance internal communications, and reduce paperwork. Residents using the e-mail system must adhere to the following policies and procedures:

1. The STRP e-mail system is intended for business-use only. Employees may not use their STRP e-mail account for personal use. However accessing personal e-mail accounts during non-working hours via the Internet is acceptable but only in strict compliance with the terms of this policy.
2. E-mail messages must contain professional and appropriate language at all times. Sending abusive, harassing, intimidating, or threatening messages via STRP e-mail is strictly prohibited.
3. All information created, sent, or received via STRP's e-mail system, including all e-mail messages and electronic files, is the property of STRP. **Residents should have no expectation of privacy regarding this information.**

NETWORK AND INTERNET POLICY

By accepting an account or by using a "general account" and accessing the STRP network to access the Internet/Intranet system, STRP residents agree to adhere to the STRP policies regarding their use.

1. Use of the network extends throughout the term of employment, providing access is not terminated for cause.
2. STRP at its sole discretion will determine what materials, files, information, software, communications, and other content and/or activity will be permitted or prohibited.
3. STRP reserves the right to monitor, inspect, copy, review, and store at any time, without prior notice, any and all usage of the network and the Internet/Intranet, as well as any and all materials, files, information, software, communications, and other content transmitted, received or stored in connection with this usage. All such information, content, and files are the property of STRP. Residents should have no expectation of privacy regarding them.

4. Files downloaded from the Internet must be scanned with virus detection software before being opened. (STRP licensed anti-virus software will do this automatically.) Remember, information obtained from the Internet is only as good as its source.
5. **STRP specifically prohibits its residents from accessing the following types of sites using company computers:**
 - a. **Gambling sites**
 - b. **Auction sites**
 - c. **Hate sites**
 - d. **Pornographic sites**
 - e. **Any site engaging in or encouraging illegal activity.**

SOFTWARE USAGE POLICY

Software piracy is both a crime and a violation of the STRP software usage policy. Residents are to use software strictly in accordance with its license agreement. Unless otherwise provided in the license, the duplication of copyrighted software (except for backup and archival purposes by designated personnel) is a violation of copyright law. In addition to being in violation of the law, unauthorized duplication of software is contrary to the STRP standard of employee conduct.

1. Residents will use only the software licensed for use by STRP on STRP computers.
2. Anyone who knowingly places or uses unauthorized software on STRP computers shall be subject to disciplinary action.
3. Residents are not permitted to install their personal software onto STRP computer systems.
4. In cases that require use of STRP licensed software at home, STRP will purchase an additional copy or license.
5. All software used on STRP-owned computers will be purchased through appropriate procedures. Consult your supervisor, Chief Operating Officer or Chief Information Officer for proper procedures.

COMPUTER HARDWARE USAGE POLICY

Quality computer hardware is provided to the STRP community. Although normal wear and tear is expected, every attempt should be made to maximize the usable life of the equipment. Users are responsible for helping maintain the quality of computer hardware by taking reasonable precautions with the equipment and avoiding situations in which the equipment could be damaged, lost or stolen.

1. Computer equipment is deployed in working order with the standard supported hardware and software.
2. An inventory of STRP owned desktop, laptop, and mobile computers, monitors and printers is maintained. The inventory protects the assets in the case of a disaster such a fire, flood, or other incidents of loss by providing information for warranty and insurance claims.
3. Residents are not to relocate or modify STRP owned computer hardware.
4. In cases that require access to the STRP information system from home, or on the road, STRP may at its discretion, purchase the hardware as well as the software to access the STRP information system remotely.
5. All computer hardware used by STRP will be purchased through appropriate procedures. Consult your supervisor, Chief Operating Officer or Chief Information Officer for proper procedures.

ACKNOWLEDGEMENT OF RECEIPT AND UNDERSTANDING

I hereby certify that I have read and fully understand the contents of the Electronic Access and Usage Policy. Furthermore, I have been given the opportunity to discuss any information contained therein or any concerns that I may have. I understand that my employment and continued employment is based in part upon my willingness to abide by and follow the STRP policies, rules, regulations and procedures. I acknowledge that STRP reserves the right to modify or amend its policies at any time, without prior notice. These policies do not create any promises or contractual obligations between STRP and its residents. My signature below certifies my knowledge, acceptance and adherence to the STRP policies, rules, regulations and procedures regarding Electronic Access and Usage.

Signature _____ Date _____

Printed name _____

HOLIDAY POLICY

The following days will be STRP housestaff's official holidays:

Independence Day
Labor Day
Thanksgiving Day
Friday after Thanksgiving Day
Memorial Day
*Christmas Day
*New Year's Day

On Good Friday, the outpatient practice will be closed, but otherwise the regular schedule will be followed.

Call coverage for these holidays will be as on Sunday and will be arranged at the beginning of the year.

Residents who work on any of the above holidays (excluding Christmas and New Year) are entitled to a day off, provided an appropriate form is filled out. Of note, this day can be taken only when suitable coverage is arranged.

Religious holidays will be honored as the need arises. At present, individuals involved will make separate arrangements for coverage and inform the Program Director.

All conferences stemming from the residency program will be canceled Christmas week and the day after Thanksgiving. Individual check-out rounds and attending rounds will take place as scheduled in modified form.

MORBIDITY AND MORTALITY CONFERENCES

PURPOSE

- ~~Improve patient care~~ improvement.
- To draw attention to all six of the ACGME core competencies and to integrate it into learning opportunity that also encourages leadership, and academic activity.
- Encourage an environment of openness in discussion about medical errors.

EDUCATIONAL APPROACH

In addition to addressing *medical knowledge* and *patient care* aspects of the case, residents and faculty should be stimulated to think of details of systems failures, with focus on *systems-based practice* and *practice-based learning and improvement*. Faculty and residents should detail the *communication* between the team, patients, and families, and draw attention to acts of *professionalism* in the face of untoward events.

PROCEDURE

a) Case selection and preparation

- Faculty screens names of all deaths on service or in the ICU and of suggestions on cases to review from faculty and nurses.
- The teaching attending supervise one of the residents to prepare the case.
- Teaching attending moderates the conference with the intention of encouragement of high-quality discussions.
- Faculty assist residents in preparing a professional presentation that compares evidence-based medicine to actual clinical practice, identifies gaps in medical knowledge, and coaches the team on how to lead and focus the discussion.
- Contact in advance faculty members involved in the care of the patients as well as those with special expertise in specific content areas, to ask them to prepare comments.

b) Put learning plan in advance, based on the case

c) Participants

- Faculty and residents
- Risk Management representative
- Nurses
- Pathologist
- Pharmacist

d) Conference rules

- No finger-pointing – focus on systems of care rather than individual error
- Keep it practical – focus on what can be changed
- Confidentiality – avoid patient identifiers (e.g., names, dates, record numbers) and do not discuss casually outside the conference
- Residents are not expected to answer questions related to errors or untoward events. . The Faculty member carefully moderates this portion of the discussion to avoid any insinuation of blame or implication of personal

e) In mortality cases, the pathologist educates the residents about the autopsy finding.

f) One hour long conference. To be held 4 to 6 times each year, typically on the 4th Tuesday of that month. Each resident is required to present a case at least once during their 3 years.

g) Every mortality on teaching service should be presented briefly in the M&M conference.

AUTOPSIES

Autopsies are a vital component of continuing medical education. The information obtained increases the general fund of medical knowledge. The results of autopsies may also furnish an indication of the standard of medical practice in the hospital. Residents should try to obtain autopsies whenever possible and then follow up on their results.

PROCEDURE FOR OBTAINING AUTOPSY

As soon as possible after a patient's death, an attempt should be made to obtain permission from the next of kin for an autopsy. If the resident is unsuccessful in obtaining permission, the attending physician or any other staff physician should be asked to assist in obtaining consent. Autopsy permits should be signed in person by the next of kin. Telephone permits will be acceptable only in the following circumstances:

1. When the next of kin does not live in the area and is unable to come to the hospital.
2. When the next of kin is too ill to come to the hospital.

Residents are required to put the date and time of death only on death certificate for patients that they pronounced dead.

EXTRAMURAL PROFESSIONAL ACTIVITIES ("MOONLIGHTING")

It is the position of the Scranton-Temple Residency Program that residency training should be a fulltime educational experience. Housestaff members should not be diverted from their primary responsibilities to their own educational activities and to the management of patients charged to their care by engaging in unauthorized extramural professional activities. The Scranton-Temple Residency Program believes that "moonlighting" by Housestaff members is generally inconsistent with the educational objectives of their training.

The following guidelines are means by which extramural professional activities by Housestaff members are authorized and monitored:

1. The Program Director has the final responsibility for determining which extramural professional activities are approved. The Housestaff member will be informed of specific circumstances under which these activities are allowed or prohibited and the procedure for requesting Program Director approval.
2. **Interns are prohibited from moonlighting activities.**
3. Any authorization of individual extramural professional activities must include a written statement which clearly outlines the requirement for the individual to provide their own professional liability insurance and have a permanent license to practice medicine in the Commonwealth of Pennsylvania. The Housestaff member is required to acknowledge this policy statement by signing an endorsement to the effect that he/she understands the personal liability implications of individual "moonlighting" and agrees to inform the director of these activities.
4. In view of the serious legal implications of Housestaff members engaging in unauthorized extramural professional activities, the Scranton-Temple Residency Program concludes that noncompliance with this policy may result in certain penalties or severe disciplinary action, including dismissal from the residency training program. This is not to stipulate that dismissal must be uniformly applied in every case, but to ensure that Housestaff members understand that this is a possible penalty for engaging in unauthorized "moonlighting". Specific penalties or disciplinary action will be determined by the Program Director.
5. The program director is responsible for maintaining written documentation on moonlighting residents. An acknowledgment of moonlighting activities should be kept in the residents' files.

MOONLIGHTING AND VISA ISSUES

Those training with a J-1 or H-1B visa are not eligible for moonlighting. Trainees must be US citizens or have a permanent residency card in order to moonlight.

The only approved moonlighting is limited to 24 hrs per month and must be in Mercy or Moses Taylor Emergency Room. This is subject to the approval of the Program Director according to the guidelines, which may be reviewed periodically by the STRP and does not mean the individual will be hired by either

ER, as each ER will have its own hiring criteria. Approvals for moonlighting elsewhere must be obtained in writing from the Program Director.

- A. The resident must be in good academic standing with the program. Residents on probation for any reason will not be permitted to moonlight. **Interns are prohibited from moonlighting.**
- B. The resident must be progressing toward satisfactory completion of the residency and the ABIM exam. Residents not felt to be actively participating in their assigned rotations, or with unexplained absences from required events will be denied privileges to moonlight.
- C. Residents scoring poorly on yearly in-training examinations will be prohibited from moonlighting until they have demonstrated an ability to improve their study habits. Passing the boards will be a key to being allowed to practice medicine in the future and must be viewed as more important than short-term financial gain. Demonstrations of the ability to improve would be:
 - 1. A significant improvement in the in-training examination score to greater than 50th percentile.
 - 2. Satisfactory completion of an approved board review course, or monthly segments of a board review course.
- D. Residents who are granted permission to moonlight elsewhere should be aware that they must obtain their own liability coverage.
- E. Of note, the hours spent moonlighting will be counted towards “work hours”.

SCRANTON-TEMPLE-RESIDENCY PROGRAM
MOONLIGHTING (extra work shift) REQUEST FORM

I, _____, am requesting permission to moonlight.

I recognize the following:

- My moonlighting activities cannot interfere with my regular training program responsibilities.
- I must accurately report moonlighting hours in MyEvaluations.com software program.
- My total work hours must be in accordance ACGME standards.
- I cannot work more than eighty (80) hours per week (averaged over a one-month period).
- I cannot work longer than 24 consecutive hours (plus 6 hours of transfer of care time).
- I should have at least ten (10) hours of non-work time between shifts.
- I must have one 24-hour period free from clinical duties each week.
- I will inform my Program Director of my moonlighting shifts so that this activity may be monitored by my program.
- I understand that professional liability insurance provided to me for my residency program duties will not cover moonlighting activities.
- I possess a current unrestricted Pennsylvania medical license.
- I understand that if I do not have my own Federal DEA number that I must use the institutional DEA number assigned to the hospital at which I am moonlighting.
- I will not report any cases done during moonlighting on an ACGME case log system because I understand these cases to have been done outside of my standard training program.
- I understand that approval to moonlight is granted through the end of the current academic year and must be requested for each subsequent year.

Failure to comply with the above may result in withdrawal of permission to moonlight or other disciplinary actions. I further understand that if I am placed on probation by the residency program, or if my program director is concerned that my clinical performance has been negatively affected I will no longer be allowed to moonlight.

I understand the number of hours that need to be reported to the program and will not knowingly put myself and my program in violation of the ACGME regulations.

Signature of Resident

Date

I have reviewed with the trainee his/her plans to moonlight. The planned activities will not violate the New York State Health Care Code Section 405 and ACGME regulations, and I approve of this trainee's request. I will monitor and maintain records of these activities.

Signature of Program Director

Date

cc: Departmental File

Office for Graduate Medical Education



MEMORANDUM

TO: Associate Program Director

FROM: Robert E. Wright, M.D., F.A.C.P.
Program Director

RE: Housestaff Moonlighting

DATE:

I have approved (name of the house officer) to engage in moonlighting at (place moonlighting will take place) during the time frame of (dates House Officer expects to be employed) .

The House Officer understands that he/she must be licensed for unsupervised medical practice in the state where the moonlighting occurs and it *is the responsibility of the House officer and the Institution hiring the House Officer* to moonlight, to determine whether such licensure is in place, adequate liability coverage is provided, and if the House Officer has the appropriate training and skills to carry out the assigned duties.

The Scranton-Temple Residency Program cannot insure the activities of the House Officer while they are moonlighting.

Associate Program Director

Date:

Program Director

Date:

House Officer

Date:

OFF-SITE ELECTIVE POLICY

1. An off-site elective is only allowed ONCE during the residency training and only R2s or R3s can do an off-site elective.
2. It has to be a 4 week rotation.
3. Resident is responsible for arranging the rotation with prior clearance from the Program Director.
4. The resident has to let the Program Administrator (Ms. Marlene Karam) know of the physician (name, address, contact telephone number, e-mail address) he/she is going to rotate with at least 2 months in advance so that she can get the paperwork done.
5. Resident is responsible to let the attending be aware of our curriculum for the rotation which can, however, be modified, within the ACGME parameters, to suit that particular practice.
6. Resident is to make sure that he/she gets the signed Learning Objectives and Evaluations back to the Program Secretary (Ms. Laura Jones).
7. Adherence to the duty hours is a must. Driving time needs to be considered in light of the duty hours.
8. Any accommodation for staying overnight is the financial responsibility of the resident.
9. Malpractice insurance needs to be provided by the site/group of rotation. Affiliation agreement needs to specify this.
10. Continuity clinic needs to be covered. Resident cannot miss the continuity clinic two blocks in a row.
11. Rotation in a different state will require a new state licence and is therefore discouraged.

ANSWERING SERVICE FUNCTIONS

1. After regular office hours and on holidays and weekends, telephonic calls to the STHC are forwarded to an answering service.
2. After regular office hours and on holidays and weekends, telephonic calls to the residency program (343-2383) are also forwarded to an answering service.
3. The answering service will have a list of the responsible residents on call. The answering service will inquire as to whether the patient is a Moses Taylor or a Mercy patient and will then page the on call resident of the particular hospital to convey the message until the following morning.
4. The answering service must, therefore, have an up-to-date list of the residents' call schedule. All changes and substitutions must be relayed to the answering service as early as possible.

HOSPITAL SAFETY PLAN

Every department is supplied with a copy of the **Employee Safety Manual**. All residents are required to familiarize themselves with the policies and procedures outlined in the manual.

HOSPITAL DISASTER PLAN

Every department is supplied with a copy of the **Hospital Disaster Plan**. All residents are required to familiarize with policies outlined in the plan.

REPORTING INCIDENTS

Every department of the hospital is supplied with **Incident Report Sheets**. A confidential report of an incident concerning a patient is to be filled out, signed and submitted to the Director of Nursing. A confidential report of an incident concerning a visitor, employee or others is to be filled out, signed and submitted to Administration.

The definition of an incident is as follows - "An incident is any happening which is not consistent with the routine operation of the hospital or the routine care of a particular patient. It may be an accident or a situation, which might result in an accident. This might involve patient, visitor, employee or other."

SCHEDULE A

MEDICAL RECORD KEEPING

Progress notes should be dated, signed and timed.

Orders should be dated, signed and timed. Osteopathic interns MUST document the musculoskeletal exam.

Pelvic exam should be done and recorded on every female patient unless done within the last two years or refused by the patient. These reasons, if given, should be specifically recorded.

Rectal examination should be done on every adult patient. If not done, the reason should be explicitly recorded.

Functional status of patient at home should be recorded in the history.

Discharge summaries should be done within three weeks and a discharge note documented on the chart on the day of the discharge. Preferably, discharge summaries should be done on the day of discharge.

Progress notes should reveal graded responsibility on the part of the residents.

All x-ray requests should be accompanied by a specific reason for the particular study and the diagnosis list on the order sheet.

Problem lists, located in front of the progress notes, should be completed on the day of admission and updated daily.

The chart is an integrated document compiled by a team, which include attending and housestaff, medical students, nurses and allied health personnel. It should reflect the close working relationship, which must exist to provide coherent medical care. Redundancy should be kept to a minimum.

SCHEDULE B

ATTENDING PHYSICIAN PEER REVIEW

Attending physicians are being scrutinized by Kepro. When you are involved in managing a case you must remember to document the reasons for your approach to patient care.

e.g., Microscopic pyuria - you may or may not wish to investigate it, but you must document why you take a particular course of action.

e.g., Anemia - you should clearly state why you think a patient is anemic and not just gloss over it.

e.g., Abnormalities on imaging reports - you may disagree with a report, but you should document the reasons why you did not react appropriately to what is written on a report.

e.g., Vital signs - if you discharge someone with elevation of temperature, make sure you state, clearly, why.

Please remember that the attending physicians will have to spend hours reviewing the record and responding to Kepro in order to try to avoid getting quality points against him/her. Being an attending is challenging and enjoyable, but quite stressful in terms of time expenditures. In order to maintain the morale of our entirely volunteer attending staff, STRP needs complete cooperation from the housestaff.

SCHEDULE C

OSTEOPATHIC INTERNSHIP

GOALS AND OBJECTIVES

EMERGENCY MEDICINE

GOALS: Goals of the rotation include interns being able to:

1. Demonstrate an understanding of the organization, use, and functioning of a medical facility designed to provide emergency and/or urgent medical care to patients.
2. Demonstrate the knowledge required to diagnose medical, surgical, and psychiatric problems with which patients present to a typical emergency department.
3. Identify and demonstrate the skills necessary for either the management or the stabilization prior to referral of life-threatening or urgent conditions.

OBJECTIVES: Learning objectives represent minimal learning requirements:

1. Appropriately triage (i.e., prioritize based on condition) emergency department patients.
2. Perform an initial history and physical examination on assigned emergency department patients, with emphasis on completeness, accuracy, and efficiency.
3. Select appropriate diagnostic tests or procedures to be performed, justifying each with rationale for its selection.
4. Diagnose and initiate treatment for common acute, emergency conditions, which present to a hospital emergency department or other primary care setting.
5. Diagnose and initiate treatment for common acute, non-emergency, but serious conditions which frequently present to a hospital emergency department or other primary care setting.
6. Determine which patients seen in the emergency department need to be referred to other specialists for further care either through admission to the hospital, by transfer to another health care facility, or by out-patient follow-up care.
7. Identify the indications, risks, and potential complications for:
 - a. venipuncture for an intravenous infusion and/or obtaining blood specimens
 - b. arterial puncture for arterial blood gasses (ABG's)
 - c. intramuscular injections
 - d. intravenous administration of medications
 - e. nasogastric/orogastric tube placement
 - f. urinary bladder catheterization (male)
 - g. urinary bladder catheterization (female)
 - h. acute Osteopathic Manipulative Therapy
 - i. laceration repair

8. Understand the indications, risks, and potential complications for the following procedures and observe the procedures demonstrated by the Attending.
 - a. cardiopulmonary resuscitation
 - b. endotracheal intubation
 - c. removal of superficial ocular foreign bodies
 - d. removal of foreign bodies from ear, nose, or throat
 - e. nasal packing
 - f. splint and cast application
 - g. incision and drainage of abscesses
 - h. administration of blood and blood products
 - i. gastric lavage
 - j. chest tube insertion
 - k. peritoneal lavage

OBSTETRICS/GYNECOLOGY

GOALS: Goals of the rotation include interns being able to:

1. Evaluate the various stages of labor in the pregnant patient.
2. Evaluate, diagnose, and treat the complications of pregnancy.
3. Develop specific motor skills and aptitudes relative to the delivery of an infant and care of the newborn in the delivery room.
4. Evaluate and manage the post-partum patient.
5. Apply osteopathic manipulative techniques to the pre- and post-partum patient as indicated.
6. Evaluate, diagnose, and treat a variety of gynecologic problems within the hospital setting.

LEARNING OBJECTIVES: The following learning objectives represent minimal learning requirements:

1. Examination of the Female Patient
 - a. When assigned a patient, obstetric or gynecologic, take a complete history, particularly menstrual and pregnancy related.
 - b. Do a general physical examination and a pelvic examination.
 - c. Display proper technique of taking a Pap smear, evaluating a vaginal discharge and cervical mucus, etc.
 - d. Perform clinical pelvimetry and an evaluation of the pregnant uterus and fetus in utero.
2. General Obstetric Care
 - a. Describe symptoms, signs, and various diagnostic aids to confirm pregnancy,.
 - b. Describe the significant changes in the reproductive organs, gastrointestinal tract, cardiopulmonary and renal functions.
 - c. Describe the functional anatomic structure of the placenta, the transport mechanisms for gas exchange and important nutrients, and fetal mechanisms for the production of amniotic fluid.
 - d. Discuss the importance of prenatal care and the procedure of following pregnant women; describe the nutritional requirements and the content of prenatal education programs and the programs of educated childbirth.
 - e. Describe the correlation between fetal, placental, and maternal compartments; assess fetal growth and maturation by history and physical examination, the interpretation of steroid assays as well as analysis of amniotic fluid, ultrasound scanning, oxytocin challenge test as an indicator of fetal status.

- f. Describe various factors, which influence the occurrence of multiple gestations, the differentiation of monozygotic and dizygotic twins, the diagnosis of multiple gestation, and the management of multiple pregnancies.
 - g. Describe the changes occurring in the reproductive system as well as circulatory system in the postpartum period, the mechanisms for lactation and hormonal changes during the postpartum in relation to the time of resumption of ovulation.
3. Management of Labor and Delivery
- a. Describe the structural and functioning changes of myometrial activity during pregnancy, the changes in the cervix, the definition of the different stages of labor, and advantages of performing an episiotomy. List the various drugs effecting the myometrial contractions and drugs used for the induction of labor.
 - b. List the different methods of delivering an infant (Spontaneous delivery, forcep delivery, breech extraction, and Cesarean section).
 - c. Determine if a patient's labor is normal or abnormal, interpret the progress of labor in order to conclude it as dysfunctional, interpret the monitoring of fetal heart tones, and uterine contractions, and identify etiological factors in dysfunctional labor.
 - d. Describe the immediate care of the newborn at delivery, the pathophysiologic aspects of fetal respiration and asphyxia and the emergency management of the newborn; score the infant's condition according to the APGAR score system.
 - e. Describe the mechanisms of pain during labor, the indication of pain relief and the methods of pain relief (particularly paracervical block and other regional anesthesia and analgesia), and the palpation of fetal and neonatal effects secondary to the analgesic and anesthesia during labor and delivery.
4. High Risk Pregnancy
- a. Define immaturity, prematurity, term, and postmature pregnancies; dysmaturity and the etiologies of dysmaturity and abnormal maturity during pregnancy.
 - b. Make a differential diagnosis between placenta previa, placental abruption, other placental complications by describing the incidence and classical symptoms.
 - c. Describe the mechanism of developing isoimmunization and the steps of following such patients as well as management; identify which patients are candidates to receive Rh (D) immune globular called Rho-Gam at the termination of a pregnancy.
 - d. Define the classification of hypertensive diseases of pregnancy.
 - e. Identify other high risk conditions such as infections during pregnancy, diabetes, heart disease, thyroid disease, thromboembolic disorders, chronic anemia, etc., and describe the clinical functional classifications and steps of following these patients, and formulate the therapeutic management of different and vas conditions.
5. Benign Gynecological Problems
- a. Advise frequency for preventive gynecologic examination and Pap smear and breast examination.

- b. Identify the epidemiologic aspects of venereal diseases and other sexually transmitted diseases.
 - c. List clinical features of benign uterine lesions such as leiomyoma, adenomyosis, endometriosis, and endometrial polyps.
 - d. Describe a differential diagnosis of various adnexal masses and their incidences, identify growth and microscopic appearance of benign ovarian lesions, and functional aspects of these tumors as well as general principle of treatment of benign ovarian enlargements.
 - e. Discuss current knowledge concerning the frequency, etiology and pathogenesis of ectopic pregnancy as well as clinical signs and symptoms, describing the steps of diagnosis and treatment of ectopic pregnancies.
 - f. Describe the common surgical procedures and their indications such as D&C, biopsies of various organs, laparoscopy and operations for pelvic relaxation and urinary stress incontinence, vaginal and abdominal hysterectomies and other procedures involving the fallopian tubes and the ovaries.
6. Family Planning and Control of Fertility
- a. Discuss the basic aspects of reproduction, describing the process of fertilization and implantation as well as demographic aspects of population control.
 - b. Describe the various methods of temporary and permanent fertility control currently available, and the effectiveness of various methods of preventing pregnancy.
 - c. Identify appropriate management for patients with unwanted pregnancy.
7. Reproductive Endocrinology and Infertility
- a. Describe the control mechanisms in the differentiation of the gonad, internal, and external genital organs.
 - b. Name various sex hormones (natural and synthetic, estrogens, progesterone and androgens).
 - c. Describe the basic pathology of the hypothalamic-pituitary-ovarian axis and apply this knowledge to identify the etiologies of primary and secondary amenorrhea, the functional basis of dysfunctional uterine bleeding, and the syndromes consisting of amenorrhea and galactorrhea.
 - d. Discuss the various conditions causing hyperandrogenic manifestations and the current concept of evaluation endocrinology aspects of hirsutism and virilization in the female.
 - e. Discuss the diagnosis and management of intersexual problems and hypogonadism, identifying hormonal profile in the various clinical conditions.
 - f. Describe the incidence and definition of infertility and the major cases of male and female infertility; tell how to interpret semen analysis; and outline the basic steps of evaluating and managing the infertile couple.
 - g. Describe the physiologic, psychologic, and anatomic changes of the climacteric.
8. Gynecologic Oncology

- a. Describe basic epidemiology of malignancy in female population, discussing the methods and skills of gynecologic cancer detection.
- b. Discuss the concept of premalignant and malignant lesions of the cervix.
- c. Outline the epidemiology aspects of the uterine cancer including adenocarcinoma of the endometrium as well as the leiomyosarcoma.
- d. Discuss clinical symptoms and findings of ovarian neoplasia, the staging of the ovarian cancer, and the incidence, prognosis, and management of different ovarian malignancies.
- e. Discuss the incidence and epidemiology statistics of vulvo-vaginal cancer.
- f. Define the hydatidiform mole, chorio-adenoma destruens, and choriocarcinoma.
- g. Describe the basic knowledge of surgical therapy, chemotherapy, and immunology aspects of cancer, identifying advantages and disadvantages and immunology aspects of cancer, identifying advantages and disadvantages and possible complications of each form of therapy.

PEDIATRICS

GOALS: Goals of the rotation include interns being able to:

1. Develop the ability to acquire data from history and physical examination of pediatric patients and to assimilate, record and present those data in an orderly, complete, concise and professional manner.
2. Determine appropriate laboratory and other diagnostic studies for evaluating pediatric problems as well as to recognize alterations in results or interpretations that are age-related.
3. Acquire analytic and problem-solving skills necessary for the prevention, diagnosis and treatment of diseases in children and for the promotion of health throughout childhood.
4. Participate in the team approach to clinical patient care, supporting the medical, social and psychological needs of children and their families.

OBJECTIVES: The following learning objectives represent minimal learning requirements:

1. Obtain and record an age-appropriate medical, social and psychological history including details of the present problem, past medical problems, pregnancy and delivery, nutrition, growth and development, immunizations, family history, social history, and other concerns of the parents.
2. Utilize appropriate techniques in interviewing children and parents.
3. Perform an age-appropriate physical examination and recognize all significant deviations from normal, including those of growth and development.
4. Record the complete history and physical examination using the problem-oriented format.
5. Formulate a clinical assessment (problem list, differential diagnosis) and establish a plan for initial assessment and therapy for each problem identified.
6. Integrate biologic, psychological, social, legal, ethical, and cultural aspects of health care into a comprehensive diagnostic approach and treatment plan.
7. Succinctly present the chief complaint, relevant data from history and physical examination, a problem list, differential diagnosis, and initial plan for assessment.
8. Retrieve independently current information from books, literature and other sources and to evaluate the reliability and validity of that information and its application to patient care needs.
9. Educate the patient and parents about the significance and impact of illness on their unique family situation.

10. Utilize community agencies and institutions supporting the medical, social and psychological needs of children and their families.
11. Identify and interpret the normal ranges in children (as compared with adults) for the following basic laboratory values: CBC, urinalysis, electrolytes, blood gasses.
12. Plot accurately height, weight, and head circumference measurement on growth charts; discuss the significance of growth percentiles; and interpret whether a patient is growing appropriately from the data available on growth curves.
13. Identify the indications for and possible complications of venipuncture, lumbar puncture, bladder catheterization, injections, skin tests, sutures.
14. Perform simple technical procedures: drawing blood, starting intravenous fluids.

FAMILY MEDICINE

GOALS: Goals of the rotation include interns being able to:

1. Understand how patients enter the health care delivery system as well as progress through it.
2. Demonstrate an approach to the patient as a whole person, and provide personal care for individuals and families as the physician of first contact.
3. Demonstrate an understanding and appreciation of the unique, continuous, comprehensive approach to health care delivery by the primary care physician with patients and their families.
4. Be familiar with basic diagnoses and management of diseases and conditions commonly presented by conditions and their families in the primary care setting.
5. Use skills in utilizing the biopsychosocial approach in diagnosing and managing patients with diseases and conditions commonly presented in the primary care setting.
6. Explain the family systems model of patient care.
7. Recognize the value of the physician's role and responsibilities in disease prevention, health promotion, and patient education.

LEARNING OBJECTIVES: The following learning objectives represent minimal learning requirements.

1. Continuity of Care
 - a. Understand the importance of total patient management including preventive care, patient education, episodic illness care, and chronic illness care.
 - b. Value the importance of longitudinal care, including health screenings, growth and development assessments, and the management of chronic problems.
 - c. Respect the importance of appropriate referral systems and support for non- medical problems for patients in ambulatory care.
2. Clinical Knowledge and Skills
 - a. Describe the importance of the medical history, physical examination, laboratory findings, and diagnosis in the ambulatory care setting.
 - b. Explain the principles of a therapeutic plan in treating illness in the ambulatory care setting (i.e., instructions, prescriptions, antibiotics, supportive and symptomatic therapy).
 - c. Know the effects of prescription drug intervention and changes in drug regimen.
 - d. Know the principles of managing the noncompliant patient.

- e. Recognize the development of physical manifestations of the interposition of short term and chronic disease.
- f. Understand the guidelines for preventive procedures and lifestyle changes for the well and high risk patient.
- g. Appreciate the psychological impact of chronic and acute disease states of the patient's family and resulting interactions.
- h. Understand the principles of patient interviewing skills in the ambulatory care setting.
- i. Demonstrate an ability to perform a complete medical history and perform a thorough physical examination.
- j. Demonstrate appropriate interviewing skills in the ambulatory care setting.
- k. Demonstrate the ability to formulate a differential diagnosis using the general skills of history collection and physical examination.
- l. Perform and/or participate in the following technical and clinical skills for the management of problems found in ambulatory care:
 - medical history taking with appropriate interviewing skills
 - physical examinations
 - preventive procedures (immunizations, auditory and visual testing, health education)
 - office diagnostic and laboratory procedures (CBC, H&H and urine-analysis)

3. Clinical Attitudes

- a. Acknowledge the psychosocial factor present in the care of the ambulatory patient.
- b. Demonstrate compassion and empathy towards patients and their families with episodic and chronic illness.
- c. Establish effective relationships with patients, families, attending physicians, nurses, and other health professionals.
- d. Appreciate the cost and cost-effectiveness of ambulatory care.
- e. Appreciate the moral and ethical implications of the problems found in ambulatory care.

SURGERY

GOALS: Goals for this rotation include interns being able to:

1. Evaluate, diagnose, and treat patients with problems requiring surgical intervention, taking into account:
 - a. recognition of surgical problems
 - b. knowledge of alternative treatments
 - c. how and when to refer a surgical patient
 - d. the scope of responsibility of the surgeon to whom you have made the referral
 - e. the scope of responsibility you as the referring physician assume
 - f. how to care for the patient in the immediate post-operative period
 - g. how to recognize post operative complications needing further surgical care
 - h. cost/risk/benefit as it applies to patient care
2. Comprehend and apply specific surgical protocol in the operating room, i.e., scrubbing, gowning, gloving, draping, and prepping.
3. Develop specific motor skills utilized in surgery.
4. Comprehend and apply osteopathic medical concepts in the diagnosis and treatment of the surgical patient.

OBJECTIVES: The following learning objectives represent minimal learning requirements.

1. For each condition or disease assigned by the Attending/Preceptor be expected to know (as applicable):
 - a. anatomy
 - b. pathophysiology
 - c. presenting symptoms
 - d. positive physical findings
 - e. differential diagnosis
 - f. treatment
 - medical/surgical alternatives
 - when treated medically, indications for surgical intervention
 - risk factor assessment
 - pre-operative management
 - post operative management
 - complications – recognition and treatment
 - g. adjuvant therapies – indications and outcome
 - h. prognosis
 - i. discharge
 - when appropriate
 - patient education
 - follow-up care
 - resumption of normal activities
2. Demonstrate and discuss proper isolation technique.

3. Demonstrate ability to scrub, gown, and glove and maintain proper sterile techniques in the surgical setting.
4. Demonstrate knowledge of and proper usage of commonly used surgical instruments.
5. Perform simple surgical procedures
 - a. suturing lacerations and surgical wounds
 - b. stapling of lacerations and surgical wounds
 - c. removal of sutures and skin staples
 - d. steristrip use in laceration and surgical wounds
 - e. drainage of abscesses
 - f. surgical dressings
 - g. placement and management of drains – opened and closed.
6. Demonstrate indications for and insertion of nasogastric tube and daily care.
7. Demonstrate indications for insertion of urinary catheter and daily care.
8. Demonstrate methods of giving injections.
 - a. intradermal
 - b. subcutaneous
 - c. intramuscular
 - d. Z-track
9. Demonstrate knowledge of equipment and technique for starting peripheral IV therapy.
10. Have knowledge of and have observed arterial puncture technique.
11. Have knowledge of and have observed placement of central venous line.
12. Have knowledge of and have observed placement of long-term central venous catheters.
13. Have knowledge of and have implanting of chronic IV access.

SCHEDULE D

**AMERICAN OSTEOPATHIC ASSOCIATION
INTERN LOGS**

Intern Logs

Intern's Name (print or type)	Date
Service Rotation	Location
Intern's Signature	Date
DME's Signature	Date
Rotation Director's Signature	Date

Intern Log Requirements

At the end of each service, each intern is required to present to the Director of Medical Education (DME), a log of activity performed during that service. Logs should be maintained daily. They must be signed by the intern and rotation coordinator to verify accuracy of numbers presented. Logs are submitted to the DME on request and shall be reviewed on a monthly basis. Logs will be available for review and chart audit during intern program inspections. Logs are not only a requirement of the training institution and the AOA, but should be accurately maintained for requesting future privileges as well as potential requirements of hospitals or liability insurance carriers to verify areas and levels of training. While DMEs are to maintain logs for three years, it is recommended that interns maintain copies of logs for their personal records. (Copies are not kept by the AOA).

Logs will consist of the following:

1. Name of service and dates.
2. Case participation (by medical record number and diagnosis), history and physical examinations performed, level of participation, record of osteopathic manipulative treatment.
3. Surgery attended (by case number, operation, and level of participation).
4. Special procedures (such as endotracheal intubations, cutdowns, liver biopsies, cardiac resuscitations, lumbar punctures, and thoracentesis).
5. Lectures, clinical pathological conferences, and clinical conferences attended and presented.
6. Reading performed (list books, journal, title of article or scope of reading).
7. Autopsies attended.
8. Obstetrical assists (by case number and type of delivery).

The Council on Postdoctoral Training (COPT) officially endorsed use of the attached logs for all approved intern training, starting in Summer, 1988. The original draft of these logs was developed by DMEs in the State of Michigan and endorsed by the Association of Osteopathic Directors and Medical Educators (AODME). Please send suggestions for revision to the Division of Postdoctoral Training, American Osteopathic Association, 142 East Ontario Street, Chicago, IL 60611.

Intern Log – Case Participation

Name:

Date: / /

Rotation:

Location:

	Medical Record #	Date Admitted	Diagnosis	*Level of Participation	H & P	Attending Physician	OMT
1							
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							
13							
14							
15							
16							
17							
18							
19							
20							
21							
22							
23							
24							
25							
26							

***Level of Participation (1) Observed, (2) Assisted, (3) Managed Under Supervision**

Intern Log – Special Procedures

Name:

Date: / /

Rotation:

Location:

	Medical Record #	Date	Diagnosis	Procedure	*Level of Participation
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					
11					
12					
13					
14					
15					
16					
17					
18					
19					
20					
21					
22					
23					
24					
25					
26					

***Level of Participation (1) Observed, (2) Assisted, (3) Managed Under Supervision**

Intern Log – Educational Programs

(Meetings, CPC’s Workshops, Grand Rounds, Morning Reports)

Name:

Date: / /

Rotation:

Location:

	Date	Title/Topic	Lecturer	*Level of Participation
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				
14				
15				
16				
17				
18				
19				
20				
21				
22				
23				
24				
25				
26				

***Level of Participation (1) Observed, (2) Assisted, (3) Managed Under Supervision**

Intern Log – Autopsies Attended

Name:

Date: / /

Rotation:

Location:

	Medical Record #	Date Attended	Admitting Diagnosis	Final Diagnosis
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				
14				
15				
16				
17				
18				
19				
20				
21				
22				
23				
24				
25				
26				
28				

Intern Log – Reading Program

Name: _____

	Date	Journal/Text	Topic/Subject
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			
14			
15			
16			
17			
18			
19			
20			
21			
22			
23			
24			
25			
28			

Intern Log – Surgery

Name:

Date: / /

Rotation:

Location:

	Medical Record #	Date	Admit. Diagnosis	Surgical Procedure	*Level of Participation	Final Diagnosis	In/Out Patient
1							
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							
13							
14							
15							
16							
17							
18							
19							
20							
21							
22							
23							
24							
25							

***Level of Participation (1) Observed, (2) Assisted, (3) Managed Under Supervision**

Intern Log – Ambulatory Rotations

Name: _____

Date: / /

Rotation: _____

Location: _____

	Date	Medical Record #	Seen Before?	Diagnosis	Procedure(s)
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					
11					
12					
13					
14					
15					
16					
17					
18					
19					
20					
21					
22					
23					
24					
25					
26					

Supervisor: _____ Date: _____

OB Intern Log

Name: _____ Date: / / Location: _____

Anesthetic

	Medical Record #	Date	Type Anesthetic (Pudental, Epidural, Other)	*Level of Participation
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				

Circumcision

	Medical Record #	Date	*Level of Participation
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			

***Level of Participation (1) Observed, (2) Assisted, (3) Managed Under Supervision**

Supervisor: _____ Date: _____

OB Intern Log – Management of Patients in Labor

Name: _____ Date: / / Location: _____

	Medical Record #	Date	Complications of Labor (if any)	Attending Physician
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				
14				
15				
16				
17				
18				

Medical Record #	Date	Medical Record #	Date
1		8	
2		9	
3		10	
4		11	
5		12	
6		13	
7		14	

Supervisor: _____ Date: _____

OB Intern Log -- Delivery

Name: _____

Date: / /

Location: _____

	Medical Record #	Date	Type of Delivery (Breech, Spont., Rotation, Forceps, etc.)	*Level of Participation	Attending Physician	Episiotomy Repair?
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						
11						
12						
13						
14						
15						
16						
17						
18						
19						
20						
21						
22						
23						
24						
25						
26						
27						

***Level of Participation (1) Observed, (2) Assisted, (3) Managed Under Supervision**

Supervisor: _____ Date: _____

OB Intern Log - C-Sections

Name: _____

Date: / /

Location: _____

	Medical Record #	Date	Operating Surgeon	Reason
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				
14				
15				

Supervisor: _____ Date: _____