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*Attachment 1 Residency Requirements for Academic Appeal Process  
**Attachment 2 University Employee Protection Against Liability
INTRODUCTION

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

PROGRAM GOALS AND OBJECTIVES

Goals:

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

Objectives:

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

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

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

CLINICAL SETTINGS
AMBULATORY MEDICINE
The major experience in ambulatory medicine is the general medicine continuity clinic. Each house officer is assigned to clinic one half day per week in which he/she will be exposed to a variety of patients typical of an internist’s practice. Teaching is patient-centered with care directed at acute problems as well as primary prevention and maintenance of wellness. All patients seen in the clinic must be discussed with the attending physician prior to discharge. Additionally, an ambulatory medicine curriculum featuring clinic “small talks” will be used which will be led by the attending physician at the start of clinic. Reading for this clinic experience should include the use of the Yale Office-Based Curriculum and is accessible at yobm.yale.edu. The ambulatory syllabus is also available online.

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

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

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

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

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

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

Responsibilities:

- The intern is expected to arrive at the hospital in time to evaluate all assigned patients prior to morning work/attending rounds. It is impossible to conduct effective work rounds if you have not seen your patients before rounds begin. The appropriate time for the intern to arrive at work in order to be prepared for the day will depend on the work load and schedule of the service.
- The intern is expected to attend all noon conferences and morning report while on inpatient services.
- The intern must perform and document a complete history and physical examination (using old records), develop a differential diagnosis, and implement a diagnostic and therapeutic plan. A complete ROS (10+ systems) must be part of this evaluation. The completed H and P must be charted within 24 hours of admission and may not be completed by a third year medical student.
- The intern must write the admission orders. He must read the resident admission note and discuss the assessment and plan with the resident or attending prior to any major interventions.
- The intern must provide daily care for each patient on the service including a daily assessment, progress note, and daily orders.
- The intern must supervise and instruct medical students on the proper way to perform and document a history and physical examination. The intern must supervise and teach invasive procedures to the student and supervise, instruct, and sign medical student orders. To summarize, the intern is responsible for the instruction of the M3 medical student.
- The intern must maintain close communication with family members and guardians, especially when a change in the condition or prognosis of a patient occurs. Thorough documentation of all discussions with the patient and family is essential.
- The intern must follow-up all laboratory, radiological, and other diagnostic test results with documentation in the chart in a timely manner. This includes test results that return after patient discharge.
- The intern must communicate with colleagues concerning each patient’s test results, plans of investigation or treatment, and other relative aspects of their care.
- When on long-call the intern must perform all cross-cover on assigned patients and must attend all codes and assist as directed by the ward resident.
- The intern should complete all discharge summary dictations on the day of discharge. Delinquency will result in extra call and, suspension from duty and/or a disciplinary letter in the houseofficer’s GME file. See other sections of this manual for medical record information.
- Prior to changing services at the end of the rotation, the intern must write a comprehensive off-service note. For particularly lengthy hospital courses, this may be accomplished as a stat discharge summary to be placed on the chart.
- The intern on consult services must respond in a timely fashion to the request for a consult and communicate with fellows and attendings so they may also judge the level of urgency.
- The intern should participate in consult service clinics, conferences, and meetings that do not conflict with fixed educational and outpatient responsibilities (such as medicine noon conference and continuity clinic).
- Since interns change services at the first of the month (often with attendings and fellows) the continuing care of service patients must be communicated with the houseofficers who are rotating onto the service. Interns should write off-service notes summarizing the patient’s hospital course and future plan of care.

Outpatient Clinics:

- All interns are assigned 1/2 day per week of continuity clinic. Clinic attending physicians teach outpatient diagnosis and management of chronic medical illnesses here as well as prevention and screening.
- Morning clinic starts promptly at 8AM, with the exception of Wednesdays which start at 9AM after Grand Rounds. All afternoon clinics begin at 1PM. A 15 minute curriculum-based lecture will be given at the beginning of the clinic session. On-time attendance is required, and penalties will be assessed for persistent tardiness.
• Clinic is a required experience that is not pre-empted by any event other than emergency inpatient care. In case of an emergency, the resident or attending should be notified of the situation and your need to go to clinic.
• Interns assigned to MICU and nightfloat rotations are exempt from weekly continuity clinic.
• It is the intern’s responsibility twelve weeks in advance to notify the chief residents of vacations or post-call clinics that need to be cancelled. In the event of insufficient notice, patients will not be rescheduled and the resident is required to find another intern or resident to see the scheduled patients.
• Clinic cancellations for urgent/emergent reasons (serious illness, family emergency, etc.) must have the approval of the clinic attending physician. The intern/resident should make every effort to arrange clinic coverage with one of their colleagues if possible.

**RESIDENT JOB DESCRIPTION (PGY 2-4)**

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

**Responsibilities:**

- Teach the intern how to work-up and care for patients and ensure that all patients on the service receive appropriate care.
- Oversee each medicine admission, supervising the interns and students.
- Write legible and educational resident admission notes (RAN) on new patients including a brief differential diagnosis and a plan outlining the work-up and treatment.
- Hold work rounds. These are morning work rounds with interns conducted daily prior to attending rounds. Interns should have seen their patients, reviewed labs, obtained reports of diagnostic studies and have their notes on the chart prior to morning work rounds.
- Provide direct patient care when the PGY-1 has exceeded the ten patient maximum.
- Conduct didactic sessions with the interns and students at least three days a week.
- Supervise and teach fourth year medical students serving as junior interns.
- Supervise all procedures performed by the intern or M4 on the service.
- Coordinate attending rounds assuring timely initiation and completion of teaching rounds.
- Assure all team members attend morning report and are well prepared when presenting cases.
- Assure that team members are present and adequately prepared for rounds.
- Assure interns conduct daily sign-out rounds with a thorough checkout list.
- Assure that all team members have the correct number of days off each month. This must be done at the start of each rotation. Each team member may require either four or five days off (1 of every 7).
- Review daily student and intern notes for quality assurance (i.e. check for legible notes which define an accurate problem list and plan of action, review lab data, and coordinate discharge planning). The frequency of resident notes required for the chart will be dictated by the attending for the service.
- Ensure that all patients are evaluated when an intern or M4 is absent and that a daily note is written on that patient.
- Review the level of care daily when patients are in the units or on telemetry to see if a lower level of care is appropriate.
- Provide a complete list of all patients on service with their problems and pending work-up to the oncoming supervisory resident at the time of monthly switch-over.
- Respond to and lead resuscitation teams. The on-call resident (and ICU resident) will carry a dedicated pager for rapid response to codes. If the on call resident has clinic, he/she should hand the pager off to a colleague during clinic. All residents in the vicinity of a code, especially senior-level residents, should report to see if they can provide assistance.
- The on-call resident must assist with cross-cover issues, procedures and ICU transfers as needed.

**Consult and Subspecialty Rotations**

- The resident must complete a full review of the chart (and medical record if necessary) with an interview & examination of the patient.
- The resident must respond in a timely fashion to requests for consultation and communicate with fellows and attendings so they may also judge the level of urgency.
The resident should participate in consult service clinics, conferences and meetings that do not conflict with other fixed educational and outpatient responsibilities (such as medicine noon conference and continuity clinic).

When at the end of the rotation, the resident must communicate patient information to housestaff rotating onto the service.

The resident is required to take a written test given by the subspecialty attending at the end of the consult rotation.

Outpatient Clinics

All residents will continue their previously scheduled weekly continuity clinic throughout their residency. Categorical PGY2 and PGY3 residents and Medicine-Pediatric PGY4 residents are required to attend an additional secondary clinic. Secondary clinics can be primary care or specialty clinics that the resident is particularly interested in. Secondary clinics will be attended during elective and selective months. Residents are exempt from secondary clinic when they are on wards, night float, MICU, or CICU.

Every resident will be assigned a primary continuity clinic at either the Medplex, MTP, or VA. The resident will remain in this clinic throughout your residency and will assume longitudinal care of the patients seen there.

Starting times at clinic are 8 am and 1 pm, with the exception of Wednesdays which start at 9AM after Grand Rounds. Please plan your day accordingly.

Residents rotating through MICU rotations will be required to attend one continuity clinic during the rotation. During MICU, night float, and ED months, residents are excused from secondary and subspecialty clinics. Med/Peds residents are required to attend their pediatric clinics during MICU rotations, unless they are post-call.

During ED rotations, residents will be required to attend continuity clinic but not secondary or subspecialty clinics. If the resident has an overnight shift prior to continuity clinic, they must leave in time to ensure 10 hours before their continuity clinic starts, to maintain 10 hours between shifts.

SUPERVISION

Supervision is defined at three levels: Oversight, Indirect, and Direct

Oversight supervision means that the care or procedure is conducted under the staff member’s overall direction and control but the physician’s presence is not required at the time of care.

Indirect supervision requires that the physician must be immediately available to furnish assistance/direction.

Direct supervision means that the staff physician must be in attendance in the room during the procedure.

GENERAL SUPERVISION POLICY

The program director and chairman of the department are responsible for supervising the resident. Responsibility for the specific supervision may be assigned to a staff member on various academic rotations. Residents are members of the medical staff as defined in the hospital by-laws. They provide care to patients assigned to their attending physician.

All patients receiving care at this institution are assigned to a member of the attending staff. The staff member responsible for the care of the patient will provide the appropriate level of supervision based on the nature of the patient’s condition, the likelihood of major changes in the management plan, the complexity of care, and the experience and judgment demonstrated by the residents being supervised.

As part of the training program, residents are given progressive responsibility for the care of patients and to act in a teaching capacity and provide supervision to less experienced residents and students. It is the decision of the staff member, with advice from the program director, as to which activities the resident will be allowed to perform within the context of the assigned levels of responsibility. The overriding consideration must be the safe and effective care of the patient.

Documentation of supervision will be by progress note or signature by the attending physician or reflected within the resident’s progress notes at a frequency appropriate to the patient’s condition.

Inpatient Supervision: In general, patients admitted by residents to the hospital who are in stable condition will receive Oversight supervision. The resident should immediately notify the attending physician at the discretion of that attending (e.g. for every patient admitted or for selected patients). The attending physician will be expected to see the patient and review the management plan within 24 hours.

Outpatient Clinic: Residents seeing patients in an outpatient clinic will receive Indirect supervision. Management plans for new patients or revision of management plans will be reviewed before the patients have left the clinic.
CONFERENCES

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

CONFERENCES

- Morning Report is held at 8am on Tuesday and Thursday at the VA (4th floor conference room) and at the MED (5th floor library) after turnover rounds. Morning Report at Methodist is in the Education office at 8am every day except Wednesday. The format will generally be the presentation of a patient by the medical student, intern, or resident on the service who is caring for the patient. The presentation should be succinct, lasting no longer than five minutes and emphasize the pertinent points of the history and physical examination. The discussion, which follows, typically led by the upper level resident, will address important aspects of the history and physical examination, formulation of a complete differential diagnosis, and management of the disease process in the individual patient. In order to effectively discuss each case, the presenter should prepare to answer pertinent questions concerning the patient’s work-up, including lab values and test results. Any available radiology studies, EKGs, or slides should be brought to the conference when possible. The presenter should also have a basic knowledge, obtainable from a textbook of medicine or UpToDate, about the patient’s diagnosis and give a brief presentation of that disorder. Attendance at morning report is required for residents on ward services and encouraged for all others.
- “Noon conference” begins at 12:15 PM on Monday, Tuesday, Thursday and Fridays in the Coleman North Auditorium for the MED/VA, in the Education Classroom at Methodist, and in a seminar room at Baptist. Lunch is often provided; this will be reflected on the conference schedule that is posted on the UT Internal Medicine website. The noon conferences consist of forty-five minute didactic sessions on both general medicine and subspecialty topics. Lecturers are faculty members who present topics from a planned 12-month curriculum designed to provide each resident with a broad knowledge base of Internal Medicine. In addition, the noon conferences cover topics in preventive medicine, pain management, adolescent medicine, end-of-life care, substance abuse, QA/QL, critical reading skills, law and public policy, physician impairment, medical genetics, and domestic violence. The conferences are directed at providing information pertinent to the American Board of Internal Medicine (ABIM) certification examination. Conferences are also available for review on-line at the Internal Medicine website. Sixty percent conference attendance is required for all Medicine, Med/Peds, and med-neuro residents during their medicine rotations.
- Medicine Grand Rounds begins at 8am on Wednesdays. The presenter is either a member of our faculty or a visiting faculty lecturer. Attendance is taken separately from noon conference, with 60% required. The housestaff has the opportunity to evaluate lecturers anonymously through GME.
- Morbidity and Mortality (M&M) is held monthly on a Friday at noon as part of our commitment to quality improvement. Senior residents present cases with unexpected or unusual outcomes with the intent to avoid future adverse outcomes and improve the quality of patient care.
- Clinical Pathology Conference occurs in conjunction with M&M and is presented by a senior resident. It consists of a case presentation with review of the histologic findings by a pathologist.
- Journal club consists of a resident critically reviewing a recent journal article, emphasizing the importance of evidence based medicine. A faculty member with expertise in critical literature analysis assists with the selection
and review of the journal articles. All residents are required to participate in the journal club series. Med/Peds residents have a separate monthly journal club which fulfills the required scholarly activity. The chief residents make the resident journal club assignments and yearly schedule.

- House Staff meetings occur in the Coleman Building on the second or third Friday of each month. Their purpose is to discuss issues and problems that pertain to the residency.
- MKSAP occurs weekly on Wednesdays at noon all hospitals—all housestaff are required to attend, unless on MICU or Nightfloat months. The goal of the MKSAP program is to prepare residents for the ABIM certifying examination. The program provides all housestaff except preliminary interns with a complete set of MKSAP books near the start of their residency. Prior to the conference, housestaff read a brief section of MKSAP. Attendance is expected to be at least 75% for each houseofficer. Failure to complete the MKSAP requirements will result in the resident failing to qualify to take the ABIM certifying examination.

**CURRICULUM/EDUCATION**

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

**READING**

- Self-education is the most successful method to achieve a strong knowledge base in Internal Medicine. To foster this goal, the program strongly encourages all house officers to read a textbook of medicine in its entirety during their residency. Stipends to purchase such books are made available annually. The recommended texts are *Cecil’s Textbook of Medicine* or *Harrison’s Textbook of Medicine*. Reading an entire text is a daunting task. It must be done on a daily basis starting during internship. Additionally, the house officer is expected to remain up to date with the current Internal Medicine literature, especially that relevant to his current patients. *The New England Journal of Medicine* and the *Annals of Internal Medicine* are both highly recommended. UpToDate is the best computer-based resource available and is purchased by the program office for all house officers.

**TEACHING**

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

**RESEARCH**

- Clinical and/or basic science research is strongly recommended and many research opportunities are available for housestaff. Housestaff may elect to perform up to two months of research during their residency. All proposals for research electives must be presented in writing to the Program Director or Chief Residents.

**SCHOLARLY ACTIVITY**

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

**PROCEDURES**

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

The following are the required procedures for Categorical Medicine residents. Medicine/Pediatric requirements can be found in the Med/Peds handbook.

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<td>Arthrocentesis</td>
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<td>Breast Exam</td>
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<td>Central Venous Line</td>
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<td>Thoracentesis</td>
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<td>Lumbar Puncture</td>
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<td>NG Tube</td>
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<td>Paracentesis</td>
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<td>Pelvic Exam</td>
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<td>Rectal Exam</td>
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All elective procedures require:

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

**PAGERS**

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

CHARTING

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

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

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

ORDERS

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

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

MEDICAL RECORDS

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

MED:

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

MED Discharge Summaries:

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

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

VAMC Discharge Summary:

- Discharge summaries should be completed prior to the patient’s actual discharge. At the time of discharge, the house officer should make a quick review of the chart to co-sign verbal orders, consults, and student notes.

*The discharge summaries at the VA are done on CPRS. Discharge summaries can be dictated. Contact medical records for specific instructions.

MUH: Please refer to the MUH Housestaff Manual for all information about medical records at MUH.

**YEARLY SCHEDULE**

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<thead>
<tr>
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* To include a total of 2 months cardiology and 2 months CICU
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* Primary Care Track residents may substitute a Baptist Minor Med rotation as one of their ER required months.

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**CHANGE OVER DAYS**

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

**DUTY HOUR RESTRICTIONS**

- The internal medicine residency program adheres strictly to the RRC guidelines. They are summarized below and the entire policy can be viewed online at www.acgme.org under resident duty hours.
- The program will assure each housestaff officer has at least one 24-hour period away from the hospital per 7 days, averaged over a four week period for a minimum of four days off per four weeks. If a resident has consecutive ward months or consecutive ICU and ward months then he or she should receive five days off in the second month.
- The resident’s duty hours will be limited to 80 hours per week averaged over a four week period. Residents may not be on duty more than 28 continuous hours and must have at least 10 hours off between shifts. Post-overnight call residents must leave the hospital premises promptly at 11 am or earlier if they started the previous day before 7 a.m. Teamwork is essential in order to comply with the RRC guidelines.
- Residents must have 14 hours free of duty after 24 hours of in-house duty.
- Interns can work for no more than 16 hours in duration. They must have 10 hours between shifts as well.
- Following an overnight call, housestaff must not care for any new inpatients, but can participate in the continuity of care.
• The ward team should work together in assigning days off for the month. This should be done on the first day of the rotation to assure that all team members get the required number of days off. Any problems with arranging adequate numbers of days off should be communicated to the Chief Medicine Resident. Days off should be avoided on switch days.
• Interns should cover for each other on their days off. The resident may offer to be the primary provider if patient volume or complexity dictates since interns may not round on more than 10 patients. The resident is generally expected to cover the junior intern’s patients but may assign their care to another intern at his discretion.
• Housestaff on consult services and other electives are off on weekends.
• Days off are built into the ED schedules.
• Hours spent moonlighting at any of our training facilities must be counted toward the 80-hour work week.

VACATION/LEAVE

• Vacations are allowed only during elective/selective rotations.
• Each PGY 1, 2, 3, and 4 receives three weeks of vacation.
• Medicine-Pediatrics PGY1s receive 1 week of vacation during the Medicine block and 2 weeks of vacation during the Pediatrics block. Med-Peds PGY2 & PGY4 residents have 1 week of vacation during the Medicine block and 2 weeks during the Pediatrics block. Med-Peds PGY3 residents have 2 weeks of vacation during the Medicine block and 1 week during the Pediatrics block.
• Vacations in the last week of June for PGY 1’s, 2’s, 3’s, and 4’s will be subject to approval (i.e. proven need to move during that time period). Vacations can will require special approval for the last two weeks in June and vacations will be granted, as permitted, prioritizing residents who will be relocating.
• A vacation is considered 5 working days. If the 5 days are taken as Monday-Friday, then a surrounding weekend will also generally be granted for a total of 7 days.
• Any unusual vacation requests will require program director approval. No vacation greater than 3 weeks in duration will be granted, including those that entail foreign travel. Vacations of 2 weeks or more duration must be taken during back to back elective months, with part of the vacation occurring at the end of one elective and the remainder at the start of the next elective. Any other arrangements must be approved by the program director. Remember that you must have 10 working days of a rotation to receive credit. If foreign travel is anticipated, it is the resident’s responsibility to have complied with all visa restrictions and rules. Questions concerning foreign travel by international medical graduates must be resolved and answered prior to leaving this country.
• International graduates who are considering foreign travel must Mr. Aaron Haynes, the Assistant Dean for Graduate Medical Education prior to making travel plans.
• For those who take extended vacations it is expected that he or she returns exactly on the planned return date. For those who extend their vacation, an additional night call will be assigned for each day late with a minimum of two extra night calls plus a week of back-up call.
• For those residents who must renew their visa status, this should be accomplished during planned vacations. Additional time off or educational leave will not be granted to accomplish visa renewal.
• Vacation requests must be submitted when requested by the chief residents, generally 2 to 3 months prior to the month for which vacation is requested. Requests should be submitted via email to the chiefs. Late requests may be considered but are not guaranteed. Given the size of our program, changes to the call schedule are often difficult to arrange and may negatively impact your colleagues. Once the monthly call schedule is released, changes will only be made to correct errors made by the chief residents. Residents are responsible for rearranging their call schedule by trading with colleagues if needed, except in emergencies when the backup call system is utilized. If a resident changes a previously scheduled vacation, he/she is responsible for finding coverage of any assigned calls and any un-cancelled clinics (since clinic requires a 60 day cancellation notice). The chief residents must be notified immediately of any changes to the call schedule, and all changes are subject to approval. The chief residents will make every effort to grant scheduling requests but rarely the number of vacations during a particular week or month may have to be limited.
• Vacation requests are due two months in advance by the 1st day of the month at midnight. If requests are submitted late, the resident is responsible for canceling his own clinic or arranging coverage.
• Note that scheduled vacations and requests not to be on call for specified days do have an impact on the generation of a call schedule. If your call schedule seems to be unusual or unfair, the most likely explanation is that the chief medicine residents have attempted to accommodate a large number of schedule requests. Therefore you should limit the number of requests that you have and prioritize those that are of significant importance to
you. We will endeavor to have the monthly schedule completed early enough so that you can make any necessary plans.

- Residents should verify the approval of their vacation requests prior to making any non-refundable purchases such as airline tickets. Do not purchase airline tickets for the mid-year holidays until the holiday schedule is completed.
- Time away from the program that involves health care delivery to an underserved population will generally count as an elective academic credit, not vacation, but must be approved in advance by the program director.

Educational leave:

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

Sick leave / personal leave:

- All residents are allowed 21 days throughout each year for legitimate illness (brief or under the care of a physician) or illness/death in close family members. Periods of time longer than this may be covered under the Family Leave Act and are handled on a case by case basis. While leave under these circumstances may cause no loss in standing, it may necessitate additional time to satisfy completion of the minimum months required by the resident’s training program. Remember that despite illnesses or family emergencies, the care of our patients does not disappear. The back-up call system will be used to provide continuity of care to our patients. Please work closely with the chief residents upon your return to determine the impact of any obligations created by your absence. It is necessary to repay the call to those who assisted the resident while he/she was taking leave. This could be a 1-to-1 payback or a 2-for-1 payback depending on the circumstances of the situation and will be at the chief’s discretion.

Time off for interviews:

- Although it is recognized that days off for interviewing for fellowship training or securing employment after your residency may be necessary, these should be kept to a minimum. All requests for days off for interviewing must be approved by the Program Director. Interview days should not be scheduled during ward or intensive care months.

Maternity & Paternity Leave:

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

Maximum Leave Time:

- The American Board of Internal Medicine mandates a maximum of 12 weeks for all types of Leave of Absences (LOA). This includes all types of vacation and leave during a 36-month internal medicine residency. Leave in excess of 12 weeks will need to be made up with additional training time for residents to be eligible to take the certifying examination in Internal Medicine. The ABIM discourages more than one month of leave per year. Any additional (“make-up”) time must be completed by August 31 of your final year to take the certifying examination on schedule. The policy for combined residencies has not been decided by ABIM.
DAILY WARD SCHEDULE

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

- Usual workday for interns:
  - <7:30 pre-rounds. Average time to report to the hospital is 6:30, but this must be tailored to the complexity and number of patients being seen.
  - 7:30 AM - 8:30 AM: Intake Rounds/Morning Report
  - 8:30 AM - 10:00 AM: Morning Work Rounds
  - 10:00 AM - 12:00 PM: Attending Rounds (variable) w/ post-round work
  - 12:15 PM - 1:00 PM: Noon conference
  - 1:15 PM - 4:00 PM: Ward work
  - 4:30 PM: Sign-out rounds

- All call schedules are available online at https://www.new-innov.com/Login

MED WARDS

- There are 3 teaching teams (Medicine A, B, C) at the MED with each team consisting of an attending physician, a resident, 2 interns and medical students.
- “Long call” will be every third day, except weekends from 7:30am to 4:30pm. During this time, the “long call” team is responsible for admissions, transfers and codes.
- From 4:30 pm until 7:30 pm, admissions are taken by the “dayfloat resident” (see details in separate section). One of the two interns remains until 7:30pm to do cross cover for all 3 medicine services.
- From 7:30 pm until 7:30 am, admissions are taken by the nightfloat service.
- On weekdays, the long call team takes admissions from 7:30 AM to 7:30 PM
- Patient caps for both ward residents and night float residents during each respective admitting period will be 10 patients with an intern cap of 5 patients per 24 hour period.

- Turnover/redistribution of night float patients will occur at 7:30 am in the 5th floor MED library on weekdays and in the resident lounge on the 5th floor on weekends. All ward residents (or designated team intern if the resident is off), the night float team, and a chief resident are expected to attend.
- Limitations on Admissions and Patient Census:
  1. Admissions to ward interns are capped at 5 new admissions during an admitting day and 8 new admissions during a 48-hour period. Ward residents are capped at 10 new admissions per admitting day and 16 new admissions in a 48-hour period.
  2. Nightfloat interns may admit 5 per day and Nightfloat residents may admit 10 per day.
  3. Residents are responsible for the ongoing care of no more than 20 patients at a time, including the intern’s patients being supervised.
  4. Interns are responsible for the ongoing care of no more than 10 patients at a time.
- Readmissions:
  1. Any patient readmitted to the medicine service within the same calendar month will be transferred back to the intern who cared for the patient previously. This transfer should occur the day following admission including weekends and if the intern originally following the patient has the day off.
  2. It will be the responsibility of the transferring resident to make the original team aware of the transfer. Readmissions transferred between two medicine services will be counted as new admissions.
  3. Patients transferred to the ICU from a medicine service, then transferred back to a medicine service will also count as new admissions.

MUH WARDS

- The three ward teams at MUH are staffed by full-time clinical faculty hospitalists and are designated red, white, and blue. Each team consists of two residents and two interns.
- Morning report and turnover rounds occur between 7:30 and 8:30 a.m. daily at MUH and are mandatory for all internal medicine housestaff rotating at Methodist.
Short Call: 2:00pm-4:00pm (5 patient Cap) → On weekdays, the short call team will admit until 4:00pm or until 5 patients are admitted, whichever occurs first. On weekends, short call admits from 7:30-2:00 PM or until short call caps.

Long Call:
1. Holds code pager from 7:30 am until 7:30 pm (7:30 am on Friday/Saturday)
2. The long call team will start admitting patients at 4:00pm or once the short call team reaches its cap of 5. Call will end at 7:30pm when the Night Float team arrives. The long call interns will provide cross cover until 7:30pm and will receive check out from the other teams.

Night Float: The night float team will admit patients between 7:30pm and 7:30am. These patients will be distributed to the ward teams upon admission; the team with the fewest patients will be the first team to receive new admissions. NF resident can admit 10 patients. Overcaps are admitted by MICU resident on call. The night float interns will provide cross cover overnight and will receive check out from the long call interns.

MUH is divided into six areas. Interns will cross-cover these areas not only for the ward service patients but also for emergency situations occurring with private patients.

Patient caps are strictly enforced for all housestaff.

Residents and interns who will be taking guest calls at MUH starting at 4:30 p.m. need to page their fellow interns and residents at 7:00am so someone will take care of codes in their absence.

Guest call housestaff must report to medical education at 4:30 p.m. to receive their code pagers and attend check-out rounds.

When called upon for emergent care of a patient belonging to a private attending, the house officer must notify that attending about his evaluation. Chart all communications with that physician.

Teams are required to write names of admitted patients in Medical Education, on the white board, by 7am daily.

**VAMC WARDS**

- There are 5 teaching teams (Medicine A, B, C, D, E). Each team consists of an attending physician, one resident, two interns, and medical students.
- The call sequence will be LONG (max 10 admissions) → post call (no admissions) → Float 1 → Short (max 4 admissions) → Float 2 → Repeat
- Long call will be q5 for the team
- On long call, both interns and the residents stay until 7:30 PM to do admissions.
- There will be nightfloat intern Sunday – Saturday 7:30pm – 7:30am, who will come and relieve the interns at 7:30pm.
- It will be the ward resident’s responsibility to plan out days off for the team members, and it should be done within the first two days of the residents starting their rotation. Residents should honor the intern’s wishes; however, if they feel that it is not possible to accommodate specific requests they can ask the interns to choose alternate days off. The Resident cannot take a day off in the first three days of the month unless approved by the attending and the Chief Resident.
- Resident days off must be approved by attendings. Both Interns cannot take off the same day.
- Short call will be from 7:30am – 3pm throughout the week or 4 patients whichever is earlier and 7:30am-2:00pm on weekends.
- It is up to the ward resident on how they want to split patient admissions on call, between interns.
- Overcaps will be done by the MICU resident. Overcaps will be distributed between the teams.

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

**DAY FLOAT (DF) RESIDENT RESPONSIBILITIES**

The Day Float (DF) Resident is a senior resident who provides relief to both the consult and admitting residents.

Weekdays:
- 4:30 pm to 7:30 pm: At the MED, the day float resident is responsible for medicine admissions, medicine consults, and assisting intern with any cross cover issues. They will also carry the “code blue” pager in addition to the consult pager, which will subsequently be passed on to the nightfloat resident at 7:30 pm. They are expected
to admit patients until 7:30 pm, and should use their discretion in patients. The patients who are admitted by day float should be placed on the team lists and whiteboard in sign-out room.

- 7:30 pm: He/She will be relieved of all duties by the nightfloat resident.

NIGHT FLOAT RESPONSIBILITIES

- A night float system operates at the VA, MED and MUH and is responsible for admissions, medicine consults, and cross-cover between 7:30pm and 7:30am. The NF team consists of one resident and 1-2 interns and operates every day of the week. Patients are distributed at intake rounds the next morning based upon the team census of the services. During night float months, residents will attend one clinic on a Friday morning to provide continuity of care to those patients who require monthly follow-up.

MICU SERVICES - POLICIES AND EXPECTATIONS

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

MICU LIMITATIONS ON ADMISSIONS AND PATIENT CENSUS

- Admissions caps are the same as outlined for ward services. As per RRC guidelines, interns are capped at 5 new admissions during an admitting day and 8 new admissions during a 48-hour period.
- Residents are capped at 10 new admissions per admitting day and 16 new admissions in a 48-hour period, including the intern’s patients being supervised. However, these caps are generally not approached in the ICU setting.
- No intern should follow more than seven patients at the MED and VA and six at Methodist.
- The resident’s supervisory cap will vary depending on the number of interns and students on the service, but the most they can supervise is 14 patients.
- The resident is not allowed to be the primary provider for more than 3-4 patients.
- The most important RRC guidelines observed are the maximum 80-hour work week, the 28-hour work period, and the no new patient rule after 24 hours.

MEDICINE CONSULTS - POLICIES AND RECOMMENDATIONS

- Medicine Consult services exist at the MED and VA. Medicine consults at Methodist are covered by inpatient services.
- The consult resident and/or attending should be directly notified by a physician from the requesting service. From a professionalism and patient care standpoint, it is less desirable to be notified by a ward secretary.
- The physician requesting the consultation should define the urgency of the consult. When reasonable, a consult request received in the evening may be deferred to the Medicine Consult Team on the following day. However, if the consult is urgent or emergent, it must be carried out by the appropriate house officer and staffed over the phone immediately.
- After hours consults at the MED are performed by the Day Float resident from 4:30 pm-7:30pm and the Night Float resident from 7:30pm-7:30am.
- After hours consults at Methodist are performed by the Night Float resident from 7:30pm-7:30am.
- After hours consults at the VA are performed by the Night Float resident from 7:30pm-7:30am.
- Attending coverage is expected by the following calendar day for all consults completed by a medicine resident. Emergency cases must be staffed promptly by telephone or in person by the attending. Attendings on call must be available at any hour and on weekends.
The primary reason for patient admission should dictate what service receives the admission. For example, a patient who suffers an acute MI, a syncopal episode, and a subsequent hip fracture should be admitted to the medicine/cardiology service with an orthopedic consultant. However, the same patient with a new hip fracture, HTN, and DM should be admitted to Ortho. The Medicine Consult Team can in general provide better patient care perioperatively than can the ward team.

Postoperatively if medical problems predominate and extend the admission, the surgical service may appropriately request a transfer to a medicine ward team. The consulting medicine resident may elect to either transfer the patient to a ward team or to the consult attending's service. Any controversy about patient transfers should be settled at the attending level.

Some surgical services prefer follow-up care even when there are no active medical problems requiring intervention. The consult service may elect to follow these patients on a M-W-F or M-Th basis, but this decision needs to be carefully outlined in the chart so the surgery service knows who to call if a problem appears on an off day. The expectation is that unless otherwise defined in the chart, the consult service will see every patient every day.

Some consultations are unnecessary and can be handled by telephone. While the surgery service has the right to insist upon a written consult, the Medicine Consult Team may suggest telephone consultation in the following situations: need for a Medplex or VA medicine appointment and need to resume usual medications.

No vacation can be taken during the consult month.

SUBSPECIALTY SERVICES

The Department of Medicine offers selective and elective rotations as a part of the Internal Medicine curriculum. These rotations include all Internal Medicine subspecialties as well as the majority of other medical specialties. Residents rotating on these services should confer with the attending physician on the service and with the curriculum on the website for specifics regarding rounds, conferences, subspecialty clinics, and recommended reading.

PATIENT SIGN-OUT POLICY

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

PATIENT TRANSFER POLICY

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

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

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

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

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

**BACKUP CALL**

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

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

**MOONLIGHTING / SUNLIGHTING POLICY**

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

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

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

SUPERVISION

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

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

2. Consults -- The General Internal Medicine (GIM) Attending Physician on call should be called to discuss any questions regarding patient care and must be notified promptly for any consults that: are going to the operating room, are clinically unstable, are moved to a higher level of care, or have a major change in status, or need for discharge prior to staffing by the attending.

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

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

PROFESSIONAL CONDUCT

House officers are expected to maintain a high level of professional conduct. Professionalism is one of the six clinical competencies in which residents must demonstrate proficiency in order to successfully complete residency. Professionalism includes maintaining a professional appearance as well as demonstrating a high standard of moral and ethical behavior. Some examples of expected behavior that should be maintained throughout a physician’s career are listed below. Other examples are given in the Academic Appeals Process section.
Communication:
- Discuss treatment plans or changes in status with patients and families daily.
- Personally call all consultants at the time the consult order is written.
- Call the patient's primary care provider upon admission and discharge and send a copy of the discharge summary to the physician’s office.
- Discuss issues concerning patient management with fellow colleagues personally and in a professional manner. Do not write inflammatory or disparaging remarks about colleagues in the chart.
- Notify the appropriate personnel including hospital paging operators immediately about any call schedule changes.

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

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

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

Dedication:
- Possess a sound work ethic
- Judiciously use the back-up call system
- Follow a diligent reading regimen
- Ensure proper follow-up of inpatient and outpatients
- Develop a good working relationships with colleagues and consultants
- Teach fellow residents and medical students
- Comply with the 80 hour work week and 24+4 hour continuous duty rule (16 hrs for interns).
- Always be on time.
- Promptly respond to all pages.

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

GRIEVANCES

Residents may raise and resolve issues without fear of intimidation or retaliation. The Program Director, Chief Residents, and Coordinator maintain an open door policy. Additional mechanisms for communicating and resolving issues include the following:

- Grievances regarding academic or other disciplinary actions are processed according to the Graduate Medical Education Academic Appeal policy available on the GME website.
• Grievances related to the work environment or issues concerning the program or faculty that are not related to disciplinary or academic adverse actions can be addressed by discussing problems with a Chief Resident, Program Director, Coordinator, Departmental Chair, Resident Education Committee (REC), or resident members of the GME Committee.
• GMEC resident representatives host a Housestaff Association Open Forum twice a year. This resident-led forum provides an opportunity for all housestaff to discuss issues or topics of mutual concern. In addition, the Resident Advisory Council, consisting of the GMEC resident representatives and several other interested residents, has full access to GME institutional leadership. Residents are encouraged to contact members of the Advisory Council to express concerns or to provide input regarding educational issues, the work environment, or other areas of concern. The names of Council members are available on the GME website at www.uthsc.edu/gme.
• Residents may also submit comments or concerns anonymously through the Resident Comment Form on the GME website. http://www.uthsc.edu/GME/resident_comment-evau.php
• Individual programs may have more extensive grievance policies and procedures and will make them available to all residents and faculty.

Any complaints of illegal discrimination are processed in accordance with the University’s EEO/Affirmative Action policies and should be directed to the Office of Equity and Diversity, 920 Madison Avenue, Suite 420; 901-448-2112.

DISCIPLINARY ACTION

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

EVALUATION OF HOUSE OFFICERS

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

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

**EVALUATION AND IMPROVEMENT OF THE TRAINING PROGRAM**

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

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

Academic Appeal Process

Review Process for Disciplinary Actions

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

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

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

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

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

Performance Alert and Review (PAR)

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

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

Academic Deficiency & Remediation (ADR)

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

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

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

Repeat Academic Year

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

Denial of Certificate of Completion

A resident may be denied a certificate of completion of training as a result of overall unsatisfactory performance during the final academic year of residency training. This may include the entire year or overall unsatisfactory performance for at least 50% of rotations during final academic year. Additionally, some programs may deny a certificate of completion to a resident who fails to pass the annual written in-service examination during the final year of training. Each residency program is responsible for establishing specific written criteria for denial of certificate of completion. Residents denied a certificate of completion must be notified in writing of unsatisfactory performance by the program director at least 6 weeks prior to scheduled completion of program. In most situations, the resident should be notified of this pending action as soon as possible.
In certain situations, a resident denied a certificate of completion may be offered the option of repeating the academic year but only at the discretion of the program director.

**Disciplinary Actions**

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

**Suspension**

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

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

**Probation**

Probation is a disciplinary action that constitutes notification to the resident that dismissal from the program can occur at any time during or at the conclusion of probationary period. In most cases, remedial actions including but not limited to ADR are utilized prior to placement on probation, however, a resident may be placed on probation without prior remediation actions based upon individual program policies.

Probation is typically the final step before dismissal occurs. However, dismissal prior to the conclusion of a probationary period will occur if there is further deterioration in performance or additional deficiencies are identified. Additionally, dismissal prior to the end of the probationary period may occur if grounds for suspension or dismissal exist. Each residency program is responsible for establishing written criteria and thresholds for placing residents on probation. Examples include but are not limited to the following: failure to complete the requirements of ADR, not performing at an adequate level of competence, unprofessional or unethical behavior, misconduct, disruptive behavior, or failure to fulfill the responsibilities of the program in which he/she is enrolled.

**Dismissal**

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

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

- Department of Health and Human Services Office of the Inspector General's "List of Excluded Individuals/Entities", or
- General services Administration "List of Parties Excluded from Federal Procurement and Non-Procurement Programs"; or
- Convicted of a crime related to the provision of health care items or services for which one may be excluded under 42 USC 1320a-7(a)
STATEMENT ON -
UNIVERSITY EMPLOYEE PROTECTIONS AGAINST LIABILITY
Issued by the Office of the Vice President and General Counsel -
The University of Tennessee

Definition of Employee –

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

State Law Claims –

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

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

Federal Law Claims –

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

Reimbursement of Judgments and Settlements –

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

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

Office of the Vice President and General Counsel -

The Office of the Vice President and General Counsel represents the University and University employees sued in their official capacities for acts or omissions within the scope of their employment. In addition, the Attorney General for the State of Tennessee, pursuant to requirements of state law, designates the Office of the Vice President and General Counsel to represent a University employee in his or her personal capacity if the alleged acts or omissions were done within the scope of the employee’s employment with the University and if there is no conflict between the positions of the University and the employee.

Before undertaking representation of an employee in his or her personal capacity, the Office of the Vice President and General Counsel, in consultation with the Attorney General, will make an initial assessment of whether any allegations of willful, malicious, or criminal acts or omissions, or acts or omissions done for personal gain, are sufficiently well-founded to warrant declining representation of an employee in his or her personal capacity.

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

Private Counsel –

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

Representation in Criminal Cases –

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

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

Instructions to Follow when Sued –

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

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