WAYNE STATE UNIVERSITY

DEPARTMENT OF INTERNAL MEDICINE

RESIDENCY POLICY AND OPERATIONS MANUAL

2007-2008

Wilhelmine Wiese-Rometsch, M.D.
Residency Program Director

Diane Levine, M.D.
Vice Chair Education

A. TEACHING ASSIGNMENTS

	PGY 1	PGY 2	PGY 3
GENERAL MEDICINE			
Wards*	6	2	3
Night Floats	1	0-1	1
SUB SPECIALTY IN-PATIENT			
Coronary Care Unit **	1	1	1
Critical Care/ICU**	1	1	1
Hematology/Oncology**	0	2	1
Nephrology	0	1	0
EMERGENCY MEDICINE	1	0	1(elective)
REQUIRED ROTATIONS			
Ambulatory Medicine	0	0	1
Clinical Skills & Competency	1	0	0
Geriatrics			
ID/HIV			
Medicine Consults			
Neurology	0	0	1
ADDITIONAL ELECTIVES	2	4	4

*There is NO overnight call on wards except at the VA

**These rotations have overnight call

Geriatrics, ID/HIV, and Medicine Consults Are required electives but may be taken in any year of the residency

Recommended electives
Endocrinology, Cardiology, Gastroenterology, Hematology consults, Pulmonary, and Rheumatology

B. GOALS AND OBJECTIVES

Specific training goals for each rotation are included in curricula distributed to residents at the beginning of each rotation. In addition, all curricula are posted on the Internal Medicine website.

C. IN-PATIENT TEACHING SERVICES

1. General Medicine Wards

a. Team configuration

DRH, HUH	One PGY 2/3, Two PGY1's
Night Float	One PGY 2/3, One PGY 1
VAMC	One PGY 2/3, One PGY 1

b. Patient Allocation Guidelines

- Over any 24-hour period, a PGY-1 will admit no more than 5 patients to his/her service and accept no more than 2 transfer patients
- Over any 24-hour period, a PGY-2/3 will admit no more than 10 patients and 4 transfer patients
- Over any 7-day period, the PGY-1 patient load will average no more than 12 patients
- Over any 7-day period, the PGY-2 or PGY-3 patient load will average no more than 24 patients

c. Patient Care Responsibilities

The PGY-1 resident is responsible for evaluating and managing assigned patients. S/He will perform and record a complete history, physical examination documenting all pertinent positive and negative findings, review records, and pertinent studies. After discussion with the supervising resident, s/he will outline an assessment and plan for each patient. For transfer patients s/he will review current in-patient records and perform a complete physical examination and record a comprehensive on-service note.

The intern is responsible for knowing all details of their patient's condition including subjective complaints, vital signs, physical findings, laboratory and imaging studies, and consultations. S/He must notify his supervising resident if there is any significant change in his patient's status. S/he will record a daily progress note outlining the patient's status and plan of care. All patient notes will be dated and timed according to JAHCO regulations.

The intern is expected to arrive at the hospital early enough to see all patients before work rounds. S/he will then make work rounds with his or her supervising resident in preparation for attending rounds. Interns will present patients to their attending physician during teaching rounds. Presentations must be organized and contain all pertinent information. The intern should be prepared to answer questions relating to their patient's disease processes including underlying pathophysiology. The intern is expected to make end-of-day rounds with their supervising resident. During this time a plan is made for the following day and sign outs are reviewed. The intern will then sign-out face-to-face with the appropriate intern prior to leaving the hospital.

Interns are encouraged to perform procedures under the supervision of the senior resident or the attending physician. After obtaining informed consent the intern will complete the procedure and document a procedure note outlining the indications for the procedure, the technique, any complications, and the outcome. Upon discharge form the hospital the intern is expected to complete a discharge summary. Discharge summaries should be completed within forty-eight hours of discharge.

The PGY I is responsible for supervising and teaching of junior students as assigned by the supervising resident. S/He will review the student's H&P and with attention to physical findings. Interns are expected to rehearse students' presentations and provide an opportunity for students to develop problem lists, differential diagnoses and initial evaluation and treatment plans. In addition, interns will review student documentation and provide timely feedback and suggestions for improvement. Interns are not required to write progress notes on student's cases but will need to review documentation and co-sign notes. Interns are required to read daily about their patient's problems and to be prepared to teach their assigned junior students.

Finally, interns are expected to complete evaluations of their supervising resident and attending physician at the conclusion of the rotation.

The supervising (PGY 2, 3) resident is responsible for assigning and overseeing the care of patients admitted to the service and for ensuring the education of all team members. S/he will perform a history and physical examination on all new admissions reviewing the findings of the PGY-1 and sub-interns and recording his/her findings in the patient record as an Admit Note. The written Admit Note should be focused outlining the reason(s) for admission and synthesizing clinical data and the differential diagnosis into to a well constructed plan for evaluation and management. The supervising resident will discuss and supervise the work-up and plan for each patient with his interns and sub-inters.

The PGY 2/3 is expected to make daily work rounds with his or her interns and students in preparation for attending rounds. During work rounds the supervising resident will see all patients and review and discuss the day's plan. The supervising resident is expected to verify physical findings. The supervising resident will attend attending teaching rounds. The resident will also set aside time every day to make imaging rounds and then meet with his or her team to make end-of-the-day rounds. During this time the day's events will be reviewed and a plan will be made for each patient. Sign outs will be reviewed. The supervising resident will sign out his or her patient to the appropriate resident prior to leaving the hospital.

The supervising resident is responsible for the teaching of all interns and students. S/He is expected to read daily and to be knowledgeable about treatment guidelines and the evidence for the planned valuation and management of the patient problems.

The supervising resident should be familiar with the evaluation tools used to evaluate students, interns, and attending faculty and complete required evaluations in a timely fashion.

Finally, the supervising resident is responsible for ensuring discharge summaries are completed and reviewed for accuracy.

Internal Medicine residents and residents rotating on Internal Medicine rotations have no responsibility for the management of patients on "non-teaching" services. However, **residents should provide emergent care for life-threatening conditions until the appropriate assigned physician arrives.**

The attending physician will make daily teaching rounds with the team. During this time students and interns will present their patients' history, physical examination, pertinent studies, and discuss their assessment and evaluation and treatment plan. The attending physician will verify physical finding and use bedside rounds to teach and asses their students, interns, and residents' knowledge, patient care skills, professionalism, communication skills, and abilities to utilize the health care system and learn from their patients. The attending physician will review documentation and provide timely feedback to all trainees including formal midmonth feedback.

The attending physician will is ultimately responsible for each patient on the service. Attending faculty will discuss patient management on rounds. Private attendings must be contacted to discuss the management of each patient and ensuring it is acceptable to the attending of record.

The attending physician will complete evaluations on all members of the team at the conclusion of the month.

d. Patient Care Responsibilities--Night Float

Each night float team has the responsibility of admitting up to a maximum of 5 patients per call. The team is responsible for cross coverage issues. Each night float team will be working 6 days on with 3 days off. During the weekdays, the night float arrives at 7:00 pm and works until 8 am. During the weekends, the team comes in at 5 pm and works until 7:00 am.

2. Inpatient Subspecialty Ward Services Guidelines

Patient assignment guidelines for maximum numbers of admissions and transfers apply to all services including in-patient subspecialty services.

Residents will take overnight call on in-patient subspecialty rotations. Meal tickets will be provided to the team by the individual hospital Resident Offices.

Some in-patient subspecialty services do not always have PGY 1 residents. If there are no PGY-1 assigned to the rotation, the resident is responsible for evaluating and managing up to 10 new patients each call night. S/he will carry out patient care responsibilities as described for the PGY-1 resident on the general medical ward service under the supervision of the attending physician (and subspecialty fellow if one is on service).

On services where the PGY 2 or PGY 3 resident does the initial patient work-up because the intern has achieved his or her limit s/he must provide care for that patient for the duration of their hospitalization including writing all notes, and dictating the discharge summary.

On the post call day residents must leave the hospital no later than 1:00 PM.

ORDER WRITING POLICY

Goal: All orders on teaching patients will be routed through residents during normal working hours.

Attending physicians should page assigned resident to discuss any orders to be written between 7:30 a.m. and 5:30 p.m. week days and 8:00 a.m. and 12:00 noon on Saturdays.

During other hours, to facilitate patient care, it may be necessary for the attending to write orders. The attending should write a progress note detailing the need for changes in the care plan to facilitate student/resident learning.

Resident must contact the attending physician when major changes in patient care or condition occur. In an emergency, the attending physician must be contacted as soon as possible by one of the team members.

All student orders will be written under the immediate supervision of the supervising resident, rounder or attending physician and immediately co-signed.

D. ELECTIVE ROTATIONS

1. Subspecialty Electives

The subspecialty education coordinator will assign hospital sites to each resident.

Residents on consultation services are responsible for completing a comprehensive consultation on all assigned patients. This includes performing a complete history and physical examinations, reviewing current and past medical records, pertinent laboratories, imaging, and other special studies. The resident will outline an assessment and make recommendations to address the question(s) being asked by the primary physician. All findings and recommendations must be confirmed by the fellow (when present) and attending consultant physician before they are communicated to the primary physician. Residents will continue to follow these patients on a daily basis communicating findings and further recommendations on the hospital record and directly to the primary physician until the patient is discharged or the attending consultant physician signs off the case.
Residents are not responsible for direct inpatient management on assigned cases and will not write orders unless directed by the fellow or attending physician.

Residents are expected to read daily about their patients learning evidence based guidelines for the evaluation and management of patients. Additionally, it is expected that resident will pull primary articles on their patients' problems

2. Research Electives

The Department of Internal Medicine and the Internal Medicine Residency Program at Wayne State are committed to having our residents become not only excellent clinicians, but also productive academically as well. Opportunities for research are an important part of academic achievement. We are particularly interested in having our residents do clinical research in the form of chat review and/or clinical research accomplished under the supervision of an internal medicine faculty member. The criteria below are required for a person who wishes to do use 1-2 months research elective.

a. Specific Guidelines for Research

To quality for a research elective, resident must

- Be in good standing in the program (not on probation)
- Must have **overall satisfactory** performance during his/her PGY 1 year (overall evaluation of $\geq$5.0)
- Must have performed at or greater than the 40th percentile on the In-Training examination

b. Arranging Research Electives

- Residents must identify a faculty mentor to conduct the research project.
- The resident must meet with the mentor to develop an outline, protocol, or research plan.
- The resident must submit a letter of request and formal letter of support from their research mentor to the Director of Resident Research to be considered for a research month.
- The resident must meet with the Residency Research Director to review the written research plan. Additionally, a second meeting should be held at least two months in advance of the starting date (provide advice, ,review protocol, expectations, goals, review regulatory requirements, etc).
- The resident should meet with the research mentor prior to the initiation of the research rotation to assure that regulatory requirements (IRB training modules, forms, etc) have been completed and to discuss goals and expectations for the rotation (must be provided in writing by the faculty mentor with whom the resident is going to do research).
- The resident should meet with the Residency Director for Research at the end of the research rotation to receive feedback and have an evaluation completed.
- It is expected that the research should be presented at the Resident Research Day and it is hoped that at least an abstract submission to a regional or a national meeting is accomplished from the project.

c. Research presentations

- Residents who have completed a Research Elective are required to submit their work to the WSU Department of Internal Medicine Resident/Fellow Research Day
- Residents are encouraged to submit their research to regional and national meetings.

3 Away Rotations/Electives

a. Guidelines for consideration

- Away rotations will be considered in situations where the rotation is not available at the DMC/WSU
- Resident must have overall satisfactory performance in the residency program
- Resident must achieve 40 percentile on the In-Training Exam
- Resident must have met conference attendance requirement
- Resident must have current duty hour log
- Resident must have current procedure log
- Residents must be in good standing

b. Arranging Away Rotations

- Residents must present a request to the Program Director to do an outside elective rotation.
- Requests will be considered on an individual basis and written approval by the program director must be received. Usually only one month will be considered.
- Permission, in writing, must be provided by the program director or course director at site of rotation. Program must be fully accredited. Evaluations of performance must be provided after rotation.
- Issues such as salary source, state license and malpractice coverage must be clarified before leaving for the outside rotation. DMC malpractice insurance does not cover rotations outside of the State of Michigan and in some cases, outside of the Metro-Detroit area.
- Written request for the rotation must be completed and submitted to the Medical Education at least 6 weeks prior to dates of rotation.
- The Ambulatory Chief Resident and Clinic manager must be notified 6 weeks prior to the dates of the rotation. The clinic must be notified

E. OUT-PATIENT TEACHING SERVICES

1. Outpatient General Medicine Continuity Clinic

a. **Training Sites**

Internal Medicine outpatient practices are housed at GMAP (General Medicine Ambulatory Practice site), and at the University Health Center (UHC)-4A (Healthsource). Clinics conducted mornings and afternoons Monday thru Friday. Patients are seen by appointment through a Central Scheduling system.

In general, the practice experience consists of one half-day ambulatory continuity practice session each week. Residents will generally have 1-2 new patients and several return patients during a one-half day practice session in accordance with the level of training and ability.

b. **Patient Assignment Guidelines**

- PGY 1 residents will see 3-5 patients per scheduled 1/2-day session when averaged over the year.
- PGY 2 residents will see 4-6 patients per scheduled 1/2-day session when averaged over the year.
- PGY 3 residents will see no fewer than 4 per scheduled 1/2-day session.

c. **Patient care responsibilities**

Residents are expected to report to their ambulatory clinic assignments on time. Residents who are late to clinic without excuse on more than three (3) occasions over a six month period will referred to the Residency Operations Committee for placement on probation.

Residents are expected to and dress professionally. Appropriate dress should **does not** include scrubs, jeans, or flip flops.

Resident responsibilities in the outpatient setting include performing a complete history and physical examination on all new patients; review of all old and outside medical records; ordering and interpretation of laboratory, imaging, and other special studies as necessary. Residents will use all available data to formulate strategies for both disease management and health maintenance. S/He will then discuss with patient goals and preferences and develop a patient centered management plan. The resident will provide patient education. S/He will write appropriate prescriptions, order appropriate tests and will consult other specialties when necessary providing coordination of care. Residents will also complete all patient forms within one week of receipt. The resident is responsible for following up on all tests or imaging studies ordered in a timely fashion generally within 24-48 hours. Abnormalities should be discussed with the supervising physician. Residents are responsible for keeping updated records including problem lists, medication lists and the preventative care flow sheet. The patient will be followed in the practice at appropriate intervals.

Post-call primary care clinics are cancelled for inpatient rotations with overnight call. The schedule of cancellations is given to the clinic prior to the beginning of the month. If a resident changes his clinic and this affects the schedule, s/he will need to find alternative coverage. If a resident makes such a change, this must be communicated to the clinic preceptor, the Ambulatory Chief Resident, and Associate Program director.

Residents are expected to read about their clinic patients weekly.

d. Clinic Cancellation Policy

Residents do not have to attend **post overnight-call clinics**. At this time residents' clinic is cancelled post call. However, it is anticipated the Department will hire physician extenders (nurse practitioners) who will be able to see the patients when he or she is post call.

Residents are responsible for notifying clinics if they make any **changes** to their schedule.

It is the responsibility of the resident to notify the practice of any scheduled vacation or anticipated absence

(USMLE **exams, interviews, etc) <u>at least one month in advance</u>** so that patients will not be scheduled.

In the event of an **emergency absence**, the resident must try to obtain coverage for his/her patients. It is imperative that the Ambulatory Medicine Chief Resident be contacted immediately. S/he in turn will notify the Practice Manager and Medical Education Office (745-4896).

2. <u>"Second Clinic"</u>

PGY-2 and PGY 3 residents will be assigned a second one-half day clinic in six month blocks. Preferences will be accommodated when possible. Residents will not attend second clinics during Heme/Onc, in-patient nephrology, CCUs, ICUs, and night float rotations. Resident responsibilities during second clinics are defined by the subspecialty rotation and depend if the patient is a new or follow up patient. Residents will follow patients as long as active care is warranted (in the case of subspecialty rotation this may be limited by the 1 month rotation). Residents will communicate findings and management plan or recommendations to the referring physician when the situation arises. At all times, the resident will carry out these responsibilities under the supervision of a full time faculty attending physician (and a subspecialty fellow, if present).

F. DUTY HOURS

1. **<u>Overview</u>**

The Wayne State University Internal Medicine Residency is dedicated to providing residents with a sound academic and clinical education that must be carefully planned and balanced with concerns for patient safety and resident well-being. We ensure that the learning objectives of the program are not compromised by excessive reliance on residents to fulfill service obligations. Didactic and clinical education must have priority in the allotment of residents' time and energies. Finally, duty hour assignments must recognize that faculty and residents collectively have responsibility for the safety and welfare of patients.

2. **<u>Definitions</u>**

- **Duty hours are defined as** all clinical and academic activities related to the residency program, i.e., patient care (both inpatient and outpatient), administrative duties related to patient care, the provision for transfer of patient care, time spent in-house during call activities, and scheduled academic activities such as conferences. Duty hours do not include reading and preparation time spent away from the duty site.
- **On-Call** activities define patient care experiences throughout a 24-hour period.

3. **<u>Guidelines</u>**

- Residents are limited to a maximum of 80 duty hours per week, averaged over four weeks.
- Residents must be given one day out of seven free from all clinical and educational responsibilities, averaged over four weeks. The workweek begins on Sunday and ends on Saturday. A Saturday/Sunday constitutes a day off in two separate weeks.
- Residents cannot be scheduled for in-house call more than once every three nights, averaged over four weeks.
- Duty periods cannot last for more than 24 hours, although residents may remain on duty for six additional hours to transfer patients, maintain continuity of care or participate in educational activities.
- Residents should be given at least 10 hours for rest and personal activities between daily duty periods and after in-house call.

4. **<u>Documenting Duty Hours</u>**

- Each resident **must enter their duty hours via the New Innovation's on a daily and not more than weekly basis**.

- Non-compliance in recording of duty hours will result in referral to the Residency Operations Committee for placement on probation for professionalism and may result in the resident not being promoted to the next level and in the event of a PGY-3, not receiving graduation certificate.

5. Moon Lighting

Moonlighting that occurs within the residency program and/or the sponsoring institution or the non-hospital sponsor's primary clinical site(s); i.e., internal moonlighting, must count toward the 80-hour weekly limit and 30 hr rule on duty hours. To ensure compliance of the above requirements, the total number of moonlighting hours per week a resident is permitted to work can not exceed 24 hours per week. The Program Director is responsible to ensure that moonlighting does not interfere with the ability of the resident to achieve the goals and objectives of the educational program. See detailed policy on Moonlighting (page 22).

G. JEOPARDY CALL

1. **Overview**

- A Jeopardy Call Schedule is maintained to provide coverage for unplanned absences. Each month based upon their rotational schedule, residents, will be identified as being ""at jeopardy". The definition of "at jeopardy" is: "Available to take call for up to 24 hours in the event of an emergency preventing the regularly scheduled resident to fulfill his call obligation."

- A monthly rotational "back up" call schedule (known as the Jeopardy List) will be constructed by the program director or designee and distributed 2-3 weeks before the beginning of each month.

- Residents who are called in for jeopardy call will leave the following day in accordance with duty hour restriction.

- A "payback" system is in place whereby the resident unable to take call must pay back the resident who took the jeopardy call on a mutually agreed upon future rotation. The Medical Education Office (Shirley Kmetz) and the Chief Residents will assist in assuring that this payback occurs.

- All residents on "Jeopardy" rotations are expected to be available on assigned days. Unavailability will not be tolerated. It is the resident's responsibility to check the jeopardy list which is posted in the Medical Education office and on the Internal Medicine website.

- Residents may trade "Jeopardy" dates, but all trades must be cleared through the Resident Education Office.

- Any resident who fails to be appropriately available for an assigned "jeopardy" date will be given an additional scheduled call. Residents who are unavailable for two (2) jeopardy calls will be referred to the ROC for placement on probation.

- Jeopardy call for General Medicine Services:

- Weekday call begins at 7:00 am when pulled to cover for a General Medicine Service during the weekdays and lasts until 8 pm if the primary team is "on call" or 5 pm when not assigned long- call. For all other services, Jeopardy begins at 5 pm and includes overnight call.

- Weekend call begins at 7:00 am. For services requiring overnight call, the resident must stay for rounds the following day.

H. PROCEDURES

The most important "procedure" to be able to perform is a thorough and complete physical examination. Residents are required to have standard medical equipment including a functioning oto-ophthalmoscope, stethoscope, reflex hammer, mono-filament, and tuning fork.

1. Mandatory to Perform

Performance of the following procedures is **mandatory** for graduation. Furthermore, residents will not be able to sit for the American Board of Internal Medicine certifying examination without documentation that they are able to "perform the these procedures safely and competently" (ABIM requirement).

- ACLS (must be maintained throughout training)
- PAP Smear and endocervical culture
- Drawing venous blood
- Drawing arterial blood
- Placing a peripheral venous line

2. Mandatory to understand…

Residents must know, understand and be able to explain the indications, contraindications, recognition and management of complications, pain management and sterile techniques, specimen handling, interpretation of results, requirements and knowledge to obtain informed consent for the following procedures and tests (ABIM requirement)." **Residents are encouraged to perform these procedures** when possible as most hospitals require competency in these procedures for staff privileges.

- Abdominal Paracentesis
- Arthrocentesis (knee)
- Central Venous Lines
- Grams Stain
- Lumbar puncture
- Pulmonary Function Testing
- Thoracentesis
- Nasogastric intubation
- Chest X-ray interpretation
- EKG interpretation (must log 50)
- Pulmonary Function interpretation

3. Performing Procedures

- Prior to performing a procedure the resident must understand the indications, contraindications, and possible complications of the procedure.
- Consent must be obtained and documented (except for phlebotomy and arterial puncture) prior to performing any procedure.
- All procedures must be supervised (by attending faculty, Chief Residents, fellows or supervising residents) until the trainee has developed and demonstrate competency in that specific procedure.

4. Procedure Skill Logs

Residents must enter procedures into New Innovations to document procedures and procedural competency.

Hard copy Skill logs are provided to each resident as a back-up system for the resident's records. Residents are required to turn their logs into the Medical Education office every 6 months to confirm any procedures during that period of time. Procedures entered into the system after more than 6 months will not be recognized. In addition, confirmation of the procedure by the Medical Education staff will not be done if all information inputted into New Innovations and in the Procedure Log book does not match.

The Procedure Skill Log entered on New Innovations must be kept up-to-date and will be reviewed with the resident at their semi-annual and annual review. A report will be placed in the resident's file. This report will form the basis for future responses to questions from hospital credentialing departments.

Residents must provide verification of procedures performance. Verification may be obtained the attending faculty, Chief Resident, fellow, or senior resident (who themselves have demonstrated competency with the procedure being observed). Verification (by signature or electronically) attests to the following.

- The resident understands the indications, contraindications, and possible complications of the procedure.
- Consent (if applicable) was obtained in a correct manner.
- The procedure was performed in a technically satisfactory manner.
- The supervising physician directly observed the resident while the procedure was being done.

2. ACLS/BLS Requirements

- It is the responsibility of each resident to ensure that ACLS/BLS certification is obtained and maintained. As part of Intern Orientation, ACLS/BLS certification is provided and paid for by the Department.
- Re-certification will be paid for by the Department but recertification is the responsibility of each resident.

I. CONFERENCES

1. Attendance Requirements

The Accreditation Council on Graduate Medical Education (ACGME) mandates residents in training must attend a minimum of 60% of available conferences. At Wayne State University this is equivalent to attending 90 required residency conferences per year. Attendance at the following conferences will be counted toward the 90 hour requirement.

- **Autopsy Conference**: This conference will occur on the third Thursday of the month.
- **Ambulatory Grand Rounds:** The Ambulatory curriculum is under renovation. Further details regarding conferences will follow.
- **Board Review:** This conference takes place from 1:00-3:00 PM on Tuesdays.
- **Core Curriculum Conference**: This conference occurs every Monday. Documented attendance for a minimum of eighteen (18) conferences per year is required.
- **Journal Club/Evidence Based Medicine Conference**: This conference takes place the first and third Wednesday of the month. Documented attendance is required for a minimum of 12 journal clubs per year.
- **Medical Grand Rounds:** Attendance at Departmental Grand Rounds is required. Exceptions will be made for residents on night float and those carrying the Code Blue Pager.
- **Subspecialty Conferences**

2. Attendance Documentation

Each resident is responsible for attending the conferences listed above and for "signing in" and completing the conference evaluation form.

PGY 2 and 3 residents are required to attend <u>all</u> board review conferences. Exceptions will only be made for residents assigned to night float rotations, residents who are post overnight-call, and for those carrying the code blue pager for a different building. Residents who miss three (3) board reviews without cause **will be referred to the Residency Operations Committee for placement on probation.**

Attendance records are maintained in the Medical Education office and updated weekly. Attendance records will be review by the assigned Associate Program Director at resident's semi-annual review. Non-compliance **with attendance requirements will result in placement of the resident on probation.** Any resident fails to attend 90 hours of required conferences per year will not be promoted and will not be eligible to sit for the American Board of Internal Medicine certifying examination.

3. <u>Resident Meeting</u>

A resident meeting is scheduled with the Program Director and Vice Chair of Medicine monthly. Issus pertaining to the residency will be discussed. Attendance is highly encouraged.

J. ACGME COMPETENCY BASED EVALUATION

All residents will be evaluated in the six competencies as required by the ACGME including:

1. **<u>Patient Care</u>**: Residents are expected to provide patient care that is compassionate, appropriate and effective for the promotion of health, prevention of illness, treatment of disease and care at the end of life.

   - Gather accurate, essential information from all sources, including medical interviews, physical exam, records, and diagnostic/therapeutic procedures
   - Make informed recommendations about preventive, diagnostic and therapeutic options and interventions
   - Develop, negotiate and implement patient management plans
   - Perform competently the diagnostic procedures essential to practice

2. **<u>Medical Knowledge</u>**: Residents are expected to demonstrate knowledge of established and evolving biomedical, clinical and social sciences, and demonstrate application to patient care and education of others.

   - Apply an open minded and analytical approach to acquiring new knowledge
   - Develop clinically applicable knowledge of basic & clinical sciences that underline the practice of medicine
   - Apply this knowledge in developing critical thinking, clinical problem-solving, and clinical decision-making skills
   - Access and critically evaluate current medical information and scientific evidence and modify knowledge base accordingly

3. **<u>Practice Based Learning and Improvement</u>**: Residents are expected to be able to use scientific methods and evidence to investigate, evaluate and improve patient care practices

   - Identify areas for improvement and implement strategies to improve knowledge, skill, attitudes and processes of care
   - Analyze and evaluate practice experiences and implement strategies to continually improve quality of patient practice
   - Develop and maintain willingness to learn from errors and use errors to improve the system or processes of care
   - Uses information technology to access and manage information and support patient care decisions

4. **<u>Interpersonal Skills and Communication</u>**: Residents are expected to demonstrate interpersonal and communication skills that enable them to establish and maintain professional relationships with patients, families, and members of health care team.

- Provide effective and professional consultation to other physicians and health care professionals and sustain therapeutic and ethically sound professional relationships with patients, families and colleagues Use effective listening, nonverbal, questioning and narrative skills to communicate with patients and families
- Interact with consultants in a respectful and appropriate fashion
- Maintain comprehensive, timely, and legible medical records

5. **Professionalism**: Residents are expected to demonstrate behaviors that reflect a commitment to continuous professional development, ethical practice, an understanding and sensitivity to diversity and a responsible attitude towards patients, their profession and society.

   - Demonstrate respect, compassion, integrity, and altruism in relationships with patients, families and colleagues
   - Demonstrate sensitivity and responsiveness to patients and colleagues, including gender, age, culture, religion, sexual preference, socioeconomic status, behaviors and disabilities
   - Adhere to principle of confidentiality, scientific/academic integrity, and informed consent
   - Recognize and identify deficiencies in peer performance

6. **Systems-Based Practice**: Residents are expected to demonstrate an understanding of the contexts and systems in which health care is provided, and demonstrate the ability to apply this knowledge to improve and optimize health care.
   - Understand, access and utilize resources and providers necessary to provide optimal care
   - Understand limitations and opportunities inherent in various practice types and delivery systems, and develop strategies to optimize care for the individual patient
   - Apply evidence-based, cost-conscious strategies to prevention, diagnosis and disease management
   - Collaborate with other members of the health care team to assist patients in dealing effectively with complex system and to improve systematic processes of care

K. EVALUATION TOOLS

Component Skills Objectives	Recall, Discrimination, Definition	Psychomotor Skills	Attitudes/ Behavior	Higher Intellectual Skills
Patient Care	CMR Evaluation Observations Mini-CEX Chart review Rotation Exams ABIM-CE	Observation Mini-CEX	Mini-CEX Observation Nurse Eval Patient Eval Chart review	Observation Mini-CEX Chart review Rotation Exams ABIM-CE Evaluation
Medical Knowledge	Observation Rating Scales ITE Rotation Exams ABIM-CE			Observation Rating Scales ABIM Evaluation
Practice-Based Learning	Observation Integrative Med CQI Morning Report Journal Club			CQI Journal Club Morning Report Evaluation
Interpersonal Skills and Communication	Observation OSCE		Observation	Observation Evaluation
Professionalism			Observation	Observation Evaluation
System Based Learning	CQI Journal Club Observation Morning Report Presentation		Observation	CQI Journal Club Observation Evaluation Morning Report Presentation

1. **Mid-month Verbal Feedback** is provided by faculty on all rotations. Residents should actively seek feedback throughout the month to monitor and adjust performance.

2. **Chief Resident Feedback** is provided to residents rotating on in-patient wards. Feedback will be based on performance during Morning Report. In addition, Chief Residents will audit charts for documentation and discuss results with residents during their rotation.

3. **End of rotation evaluations**

   End-of-the month evaluations will be scored as follows:

   9 Outstanding
   8 Superior
   7 Good to very good
   6 Above average
   5 Satisfactory
   4 Marginal
   3, 2, 1 Unsatisfactory/Failure

- At the end of each month residents will evaluate in-patient rotations including general medicine wards, subspecialty in-patient services, elective consultative rotations, and monthly subspecialty rotations.
- At the end of each month residents will evaluate assigned faculty, fellows, and interns or supervising residents. NB. Student evaluations must be completed on the School of Medicine student evaluation form.
- The Continuity clinic and subspecialty clinic experiences will be evaluated biannually.
- Residents will evaluate attending clinic faculty biannually.

Timely and meaningful feedback is necessary for residents and students to identify strengths and weaknesses and improve performance. Likewise timely and meaningful feedback is necessary for faculty and for administration to identify strengths and weaknesses and improve the quality of rotations. Residents will be notified by email when they have evaluations to complete. Residents are expected to complete evaluations within 15 days of completing the rotation. Residents who do not complete evaluations by 30 days will be referred to the Residency Operations Committed for placement on probation. Residents may review evaluations on line. Residents will meet with their Associate Program Director biannually to review evaluations.

4. **End-of--month Chief Resident Evaluation**. This year Chief Residents will complete an end-of-the-month evaluation of residents' performance in Morning Report. Knowledge, Professionalism, Communication Skills, and practice based learning will be assessed.

5. **End-of-month examinations** are provided on ward rotations and subspecialty rotations. Data from these exams will be placed in a central data bank for review by Associate Program Directors. The data will be reviewed at the semi-annual review.

6. **Monthly board review examinations** will provide comparative data to PGY 2s and PGY 3s.

7. **Intern OSCE.** Interns participate in an OSCE during the Skills and Competency rotation. The results of the OSCE will be provided to each intern and reviewed with the Director of the rotation.

8. **Mini-CEX.** The Mini-CEX allows an opportunity for assessment of skills in history taking, physical examination, and communication (patient education, discussion of treatment plan, etc.). Data has shown that multiple observations are superior to limited observations. Interns must complete five Mini-CEX. PGY2 must complete three and PGY3s must complete two. The resident is responsible for ensuring the Attending documents this assessment utilizing the ABIM form. Copies of Mini-CEX must be provided to the Office of Medical Education.

9. **In-Training Exam.** All trainees will participate in the national standardized In-Training exam to assess clinical knowledge. This test provides normative data and is predictive in the PGY 2 year of ABIM passage.

10. **Procedure Skill Log.** Residents are required to perform and document procedures.

11. **Portfolios.** Residents are required to maintain a portfolio on a CD-Rom. This portfolio should include current curriculum vitae (to be updated annually), all presentations (short and long cases from morning report, journal clubs, presentations at scientific meetings, as well as copies of publications. The portfolio will be reviewed at each of the semi-annual review sessions. An updated copy of your CD-Rom portfolio must also be given to the Medical Education office and will be maintained in your Resident Binder.

12. **Semi-Annual, Annual & Exit Interviews**. Residents will meet with their Associate Program Director every six months to review performance identifying areas needing improvement and to monitor progress over the preceding six months. The semiannual review also offers an opportunity for resident to discuss long term goals and develop a mentoring relationship with the Associate Program Director. Residents will meet annually with the Program Director and at graduation for the exit interview.

13. **Hopkins' Modules.** Residents are required to complete the Hopkins' ambulatory modules during their residency. Performance will be tracked by the Associate Program Director.

14. **The Boards**. Performance on the ABIM certifying examination provides objective information about residents' acquisition of knowledge and ability to apply in a testing situation.

L. REVIEW AND MONITORING RESIDENT PERFORMANCE

1. Monitoring Resident Performance

Resident performance is monitored closely by the program to identify residents whose performance is "of concern".

The Associate Program Director will review each resident's monthly evaluations to identify residents receiving marginal (4) or unsatisfactory/failing (3, 2, 1) scores in any competency.

Chief Residents and faculty are encouraged to contact the Program Director for any resident whose performance is "of concern" even if the resident is not assigned to that faculty's service. In this way concerns identified by faculty (who will not have the opportunity to complete formal end-of-the-month evaluations) will be addressed. In such cases, the Program Director will request information outlining concerns be documented in writing. The Program Director will assess the situation and take appropriate action, including counseling, assigning a mentor for remediation, recommending professional counseling, or discussion with the Residency Operations Committee. (In extreme cases, due process is begun with the Graduate Medical Education office to resolve any issue(s).)

2. Referral to the Residency Operations Committee (ROC)

- Residents with marginal and/or failing performance will be discussed at the Residency Operations Committee (ROC).
- Residents whose performance is "of concern" as determined by the Program Director will be discussed and reviewed at the (ROC).
- Residents whose performance is declining (not necessarily marginal or unsatisfactory) will also be discussed.

The ROC meets monthly to evaluate and monitor trainees' performance as well as to determine intervention including altering schedules and assignments, development of remediation plans/programs, placement on probation, and/or initiation of corrective action. The meeting is attended by the Program Director, Associate Program Directors, Subspecialty Education Coordinators, Chief Residents, representatives from the Resident Council, and the Vice Chair for Education.

3. Residents with marginal or poor performance

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a. Residents with Marginal Performance or "Of Concern" Performance

- Residents' who performance is "of concern" will be identified as described above.
- The resident's file will be reviewed by the Program Director and who may solicit additional information.
- The Program Director will meet with residents with marginal or poor performance on their end-of-the-month evaluation to discuss the evaluation.
- The Program Director will present the information to the Residency Operations Committee (ROC).
- Options for remediation will be discussed at the ROC for residents who performance is marginal.
- A personalized remediation plan will be developed and documented.
- A mentor will be identified for the resident.
- The Program Director will complete an initial remediation summary.
- The Program Director will meet with the resident to review the plan. A written copy of the plan will be given to the resident and to the resident's mentor.
- The resident's mentor is responsible for meeting monthly with the resident to implement the remediation plan. The mentor will provide the Program Director with written monthly summaries of the resident's progress.
- Residents who have marginal evaluations in any training year will have their overall performance formally reviewed by the Residency Operations Committee to determine the following:
  - promotion to the next year of training
  - repeating the year of training
  - repeating a rotation
  - preparing a special series of rotations to meet specific individual needs
- The resident who **fails to improve and receives more than two marginal evaluations in a given year will be at high risk for repeating the academic year.**

b. Residents with Unsatisfactory Performance

- Residents with "unsatisfactory performance" will be monitored
- Residents will be monitored for six (6) months for unsatisfactory performance in any "core competency" will be monitored for 3 (3) months for unsatisfactory performance in a "non-core" competency. Residents who fail a rotation will be required to successfully repeat the rotation before they will be considered for:
  - Reappointment
  - Promotion
  - Certification to sit for the ABIM certifying examination
- The rotation will be repeated after completion of the current academic year and may result in the individual resident being "off track".
- **Residents may appeal** decisions made by the ROC. This appeal must be made to the Program Director in writing. A final recommendation regarding the consequences will be made by the ROC which may:
  - Overturn the failing grade
  - Retain the failing grade
  - Require repetition of the rotation
  - Initiate due process for resident dismissal

c. Problem Residents

- Residents who are identified as "problem residents" pose unique problems.
- Attempts will be made to Identify whether the issue is academic, disciplinary or personal. Such residents may be referred for psychiatric evaluation, counseling, etc.

M. PROBATION

a. Consideration for Initiation of Probation

Any of the following circumstance will trigger referral to the ROC for placement on probation

- One evaluation containing an overall competency score of ≤ 4
- One evaluation containing multiples scores of ≤ 4, particularly in the "core competencies"
- Two or more evaluations containing scores of ≤ 4 in any of the competencies
- Failure to log duty hours
- Deficient (i.e. < 60%) conference attendance
- Deficient attendance at Board Review (i.e. missing > conferences without cause.
- Failure to report to work without excuse
- Failure to return from vacation without excuse.
- Resident is suspected to be under the influence of recreational drugs or alcohol during working hours or dependent on recreational drugs or alcohol
- Occurrence of a "critical incident" such as failing to complete duties, negligence, or lack of professionalism or humanism
- Intentional and/or malicious abuse of patient confidentiality as per the HIPAA guidelines (e.g. accessing patient information for purposes unrelated to treatment, research, or chart review)

b. Institution of Probation

- The resident's possible pending probationary status should not be a surprise to him [e.g. Praise or Early Concern Cards should be on file]. Adequate and timely informing by the attending is necessary. Lack of notification of the resident at midmonth of the possibility of failure is grounds for possible dismissal of the evaluation. Good documentation by the Program Director of discussion of expectations before the process begins, as well as results after the process is underway, is essential
- The ROC will vote to determine if a resident will be placed on probation. Fifty percent of members must be present to initiate a vote. In addition, the vote must carry a two thirds majority.
- The probationary period will be individualized and may last from three months to one year.
- Residents will meet with the Program Director following the ROC's decision to place the resident on probation; the Program Director will discuss terms of the probation and plans for remediation.
- Residents have the right to appeal the decision for placement on probation. The resident may present his or her appeal in person or submit an appeal in writing to the ROC. If the appeal is not accepted the resident has the right to appeal to the GME office.
- Extension or termination of the probationary period will be determined by ROC.
- Attending faculty who work with the resident may be informed of concerns about the resident's performance but may not be notified regarding probationary status.

c. Terms of probation

- Residents on 6-month probation cannot receive more than one "4" (or a lesser score) in any competency without being reassessed at the ROC for possible educational leave-of-absence, extension/continuation of probation, or immediate termination. Receiving a score of ≤ 3 in any of the three core competencies during the probationary period is grounds for immediate termination from the program.
- Should the problem be deemed remediable by the ROC, a specific course of goals and objectives, as well as curricular materials should be set up for review by the resident and his/her mentor.
- A formal evaluation process must also be set up to assess progress in the areas of concern. Retroactive credit will be petitioned by the Program Director to the RRC for rotations successfully completed **after successful completion of the probationary period.**
- Residents who do not successfully complete probation will be referred to the ROC for possible recommendation for termination.

N. ANNAUAL REVIEW AND PROMOTION CRITERIA

1. Annual Evaluation of Residents

A resident's overall clinical competence, humanistic qualities and moral and ethical behavior be evaluated during each of the three years of training.

- Residents finishing their first and second years of training will be rated on an ABIM Annual Evaluation Summary Form. ***Note: ABIM will not give credit for any year rated as marginal (www.abim.org)***
- Residents rated as superior or satisfactory will receive credit for the year of training
- Residents rated as unsatisfactory in their R-1 or R-2 year will receive no credit by ABIM
- Residents rated marginal in the R-1 year may receive credit for that year of training if deemed appropriate by the Residency Operations Committee
- Residents receiving marginal ratings in both R-1 and R-2 years must take an additional year of training since the ABIM will not grant credit for the second marginal year
- In the R-3 year, all residents must be judged satisfactory in each component of competence listed above.

2. General Criteria for Promotion

- Receive passing evaluation scores in all six competencies for all rotations (not more than one rating of 4 and no ratings < 4 on any evaluation)
- Pass mini-CEX (each event)
- Attend **60%** of required conferences
- Log duty hours on a timely basis
- Present at least one research submission (case report required for interns, abstract paper)
- Perform required chart audits
- Recommended by ROC and approved by CCC committees to advance to the next year or graduate
- In academic good standing (i.e. resident cannot be on probation)
- Have 12 month rotation credit

3. Specific Criteria

a. The PG-1 year will emphasize acquisition of fundamental patient care skills. Under supervision the senior resident and attending physician, s/he is expected to accomplish the following:

- Demonstrate ability to perform a complete history, physical exam, appropriate patient work-up including: laboratory/radiographic studies, data assessment, differential diagnosis and management plan demonstrate effective communication skills (patients, patient families, peers and faculty) as well as with record keeping
- Demonstrate a professional commitment to patients (patient welfare is priority)
- Demonstrate appropriate compassion, integrity and respect for patients and their families
- Demonstrate appropriate medical judgment in the delivery of medical care in outpatient and inpatient settings
- Passed Mini-CEX exams for each ward month (total = 5)
- Demonstrate scholarly activity

b. The PG-2 year will emphasize expansion of knowledge, intellectual skills and psychomotor skills. Sub-specialty experience, supervising skills, and teaching skills. Under supervision of senior residents and attending physicians, s/he is expected to accomplish the following:

- Show continued improvement in clinical judgment and medical knowledge
- Demonstrate ability to supervise a general medicine ward team and subspecialty teams
- Demonstrate ability to teach medical students and interns
- Demonstrate ability to enter subspecialty rotations and master basic objectives for those rotations
- Develop skills required of a consultant in Internal Medicine

- Passed Mini- CEX (3)
- Attend required Board Review Conferences
- Successful passage of USMLE Step 3 prior to start of PG-3 year (required)
- Scholarly activity (by end of second year)
- Submission of board study by May 1st of Year 2. Must be approved by Associate Program Director.

c. The PG-3 resident is expected to accomplish the following:

- Demonstrate maturation of clinical judgment and medical knowledge
- Show mastery of all the procedural skills required by ABIM
- Demonstrate excellent ability as a teacher, evaluator, and team supervisor
- Demonstrate appropriate skill in providing medicine consultations
- Achieve at least a satisfactory score on each ABIM criterion
- Passed Mini-CEX (2)
- Complete scholarly project requirement
- Complete ambulatory practice improvement project

4. Final Recommendations for Promotion and Graduation

The Clinical Competency Committee (CCC) meets to review resident performance providing an overall performance score. The CCC makes recommendations to the ROC for promotion and graduation.

- **Outstanding (9):** Achieved 9 in all six core competencies; the "best resident" in his class this year.

- **Superior (8):** Achieved ≥ 8 or more in all three required areas core competencies areas and ≥ 5 in all other areas; performance places resident in the top 10% of his class

- Very good to superior (7): Achieved > 7 in all core competencies areas and > 5 in all other areas; equivalent to top 25%

- **Above Average (6):** Achieved ≥ 6 all core competencies areas and ≥ 5 in all other areas; equivalent to the top 30%.

- **Satisfactory (5)**: Achieved 5 in all core competencies areas and ≥ 5 in all other areas: Solidly at the center. Constitutes the average resident. Mid 30%

- **Marginal. Performance needs attention (4)**: Achieved 4 in any core competency. Lower 30%. At risk for further problems. Intervention should occur, starting with discussion at the ROC level. Remediation alternatives may include scheduled "one-on-one" with either a CMR or mentor, assignment to a specific individual with proficiency in that area, maintenance of a reading log, or shadowing with an "outstanding" or "superior+" resident for a month.

- **Unsatisfactory or Failing:** Only achieved **≤** 3 in any core competency. No reasonable expectation of ability to handle patient care unsupervised in the next six months.

O. GRADUATION CRITERIA

- Successful completion of each residency year
- 36 months of training
- Meet all ABIM criteria and standards for training and certification
- Passing score on each ABIM criterion (ABIM form)
- CCC recommendation and approval by ROC

P. BOARD ELIGIBILITY

The WSU residency has adopted guidelines provided by the ABIM for board eligibility.

1. ABIM Special Candidate Criteria

In the event that a resident has completed a full Internal Medicine residency in another country prior to entering our program, we are willing to present a resident to the ABIM as potentially board-eligible after 2 (rather than 3 years) of training if his/her performance has been superior during the PG-1 year (as determined by results of monthly inpatient and semi-annual outpatient evaluations).

2. Residents Obviously Unsuitable for Certification

Poor performance in all components of clinic competence which persists over time with no evidence of improvement (e.g. irreversible psychopathology, inability to develop a fundamental knowledge base, or dishonesty) will not be recommended to sit for the ABIM certifying examination.

Q. ABIM PREPARATION POLICIES

The Department of Medicine is committed to ensuring successful passage of the ABIM certifying examination by its entire residency. Efforts will be made by the program to identify residents who are "at risk" for failing ABIM in order to provide opportunities to increase the likelihood of success on the ABIM.

1. Board Review

Board review is mandatory for PGY 3's and strongly recommended for PGY 2's. Residents who miss one board review session without cause will receive a warning. Residents who miss a second board review session will incur an extra call. Residents who miss three sessions will be referred to the ROC for placement on probation.

2. Addressing "At-risk" Residents

- Residents who score below the 40th percentile on the PGY 2 In training Exam will not be allowed to do a research elective
- Residents who are deemed "at risk" will be required to maintain a reading log. This log must be updated weekly and will be reviewed by the Associate Program Director or Resident Mentor.
- PGY2 residents, who are at risk for ABIM failure, as determined by the program, will be required to take an external board review course. This course must be taken at the end of year two or the beginning of year three. PGY3 book money will be used to pay the fee for the board review course. The Department of Medicine will supplement book money to cover the entire cost of the course. NB: Travel expenses, lodging, etc. are the responsibility of the trainee and will NOT be reimbursed by the Department.

R. PROGRAM EVALUATION TOOLS

The Department of Medicine is committed to continuous improvement in the Internal Medicine training program. The following tools are used to evaluation the quality and effectiveness of the program

- Performance on ITE
- Rotation evaluations
- End of year program surveys
- Exit Interviews

- Post graduation surveys
- ABIM board passage rate
- Performance in fellowship
- Performance in Practice

S. MOONLIGHTING POLICY

1. Eligibility

Internal Medicine Residents are eligible to request moonlighting privileges upon the successful completion of 24 months of internal medicine training. Requirements for moonlighting are as follows:

- Residents must have an unrestricted medical license from the State of Michigan. (NB. Successful passage of Step 3 is required to attain an unrestricted medical license. A copy of the license must be submitted to the Program Director at the time of request to be placed in your file.
- Have overall satisfactory performance in the residency program
- Achieve 40 percentile on the In-Training Exam
- Comply with conference attendance guidelines
- Current ACLS certification

- Demonstrate experience and competence with the following procedures

Abdominal Paracentesis	3
Arterial puncture (ABG)	3
Arthrocentesis-Knee	3
Central venous line placement	3
Lumbar puncture	3
NG tube placement	3
Pap smear and endocervical cultures	3
Thoracentesis	3

2. Requests and Eligibility

Request for moonlighting privileges must be made to the Program Director at the end of the PGY2 academic year. Residents must have written approval of the Program Director.

3. Limitations and Restrictions

Moonlighting activity is

- Limited to Harper , DRH, and VA hospitals
- Permitted only during electives, ambulatory care, and vacation months
- Resident moonlighting activities **is prohibited** during rotations on the medicine inpatient wards, ICU, CCU, Emergency Room or other rotation months with night call.
- Residents are limited to four **(4) moonlighting sessions per month** (one session equals a 12-hour week night or weekend)**.**
- **Moonlighting hours worked are counted towards the 80-hr work week limit** and cannot be exceeded. If exceeded, this will result in immediate suspension of moonlighting privileges.
- Residents may not moonlight while on call. If done, this will result in immediate suspension of moonlighting privileges and initiation of corrective action.
- Note: Med-Peds residents may not moonlight at Children's Hospital while on Medicine call rotations and can not moonlight at DRH, HUH or VA while on Pediatric inpatient rotations.
- Moonlighting will not be allowed to negatively impact on the resident's education or performance.
- All moonlighters must abide by the Moonlighting Policies at each of the various DMC hospitals

- Residents on J1 and H1 visas (can only have one payer) may not participate in moonlighting activities due to restrictive INS policies.

4. Revocation of Moonlighting Privileges

Moonlighting privileges may be revoked by the Program Director and/or the Clinical Competency Committee if the resident violates any of the limitations and restriction defined in the previous section.

T. INSTITUTIONAL / DEPARTMENTAL POLICIES

Within the Residency Program, the Department of Internal Medicine and the Detroit Medical Center equal opportunity regardless of race, national origin, age or gender is guaranteed. The professionalism of a physician (both faculty and resident) encompasses respect and compassion towards each other as well as to patients, their families and other health professionals.

Gender bias and sexual harassment are often misinterpreted and so require special attention here:

What is Sexual Harassment?

Sexual harassment at work occurs whenever unwelcome conduct on the basis of gender affects a person's job. It is defined by the Equal Employment Opportunity Commission (EEOC) as "unwelcome sexual advances, requests for sexual favors, and other verbal or physical conduct of a sexual nature when:

- submission to such conduct is made either explicitly or implicitly a term or condition of an individual's employment, or
- submission to or rejection of such conduct by an individual is used as a basis for employment decisions affecting such individual, or
- such conduct has the purpose or effect of unreasonably interfering with an individual's work performance or creating an intimidating, hostile or offensive working environment"

A sexually hostile work environment can be created by:

- discussing sexual activities
- unnecessary touching
- commenting on physical attributes
- displaying sexually suggestive pictures
- using demeaning or inappropriate terms, such as "Babe"
- using unseemly gestures
- ostracizing workers of one gender by those of the other
- granting job favors to those who participate in consensual sexual activity
- using crude and offensive language

Residents are expected to display professional behavior in all activities. Instances of sexual harassment and/or other bias should be brought to the *immediate (same day)* attention of the Program Director and the Chief of Service at the institution the harassment occurs in.

CORRECTIVE ACTION PROCEDURES

This document describes the procedures to be followed when a resident ("Resident") is subject to corrective action, as provided by the Residency Agreement between Wayne State University/Detroit Medical Center Graduate Medical Education Program ("WSU/DMC") and the Resident.

As used in this document, "corrective action" includes the following actions:

1. **Suspension**. This action involves the temporary removal from the residency program ("Program") for a definite period of time. It does not include a summary suspension, as discussed in Paragraph 3, below.

2. **Reappointment without Advancement**. This action involves reappointment to the Program without advancement to the next training level.

3. **Decision Not to Reappoint**. This action involves a decision not to reappoint a Resident following the expiration of the term of his or her current contract.

4. **Termination**. This action involves immediate and permanent dismissal from the Program.

5 **Other.** Other corrective action includes, but is not limited to, the following:
   - Placing the Resident on probationary status.
   - Probation status shall not exceed one year. If the probation exceeds six months, the probation shall include at least one interim review at the approximate midpoint of the probation.
   - Probation is imposed in accordance with paragraph 13 and 14 of the Procedure section.
   - Issuing the Resident a letter of warning, admonition or reprimand that documents the cause for concern and becomes part of the Resident's permanent record.

Criteria for Initiation of Probation

Corrective action may be based upon the following criteria:

- Failure of the Resident to fulfill each and every obligation imposed by the Residency Agreement.
- Any action, conduct or health status of the Resident that is adverse to the best interests of patient care or the institutions to which the Resident is assigned.

The criteria described above include, but are not limited to, the following examples:

- Breach of professional ethic;
- Misrepresentation of research results
- Violation of the rules of the Program, of the institution to which the Resident is assigned or of the law
- Inadequate medical knowledge, deficient application of medical knowledge to patient care or research, deficient technical skills or any other deficiency that adversely affects the Resident's performance.

Parties Who May Initiate Corrective Action

- Any DMC Hospital or other hospital to which the Resident is or has been assigned, or in which duties under the Residency Agreement are otherwise performed
- WSU/DMC;
- The Department or Section Chief to which the Resident is assigned; **or**
- The Program Director

Separate Action by DMC Hospitals or Other Hospitals

In addition to the corrective actions described in this document, any DMC Hospital or other hospital to which the Resident is assigned may, in accordance with the policies of such hospital, limit, restrict or suspend, summarily or otherwise, the Resident's participation in the Program at such hospital. The Hospital shall first consult with the Dean, the Chair of the Dean's Council, the Dean's counsel or appropriate Program Director regarding such action. Such action by a Hospital shall not require the initiation of corrective action under this policy.

NB. Any notice required by this document shall be deemed sufficient if the notice provisions of the Residency

Agreement is satisfied.

Specific Procedure for Correction Action

1. All requests for the corrective actions described above shall be in writing, submitted to the Coordinator of WSU/DMC and supported by reference to the specific activity, conduct, deficiency or other basis constituting the grounds for the request. The procedures described in Paragraphs 2-12 below shall be followed for such corrective actions, and the procedure described below in Paragraph 13 and 14 shall be followed for all other corrective actions.

2. WSU/DMC shall investigate the request for corrective action in the manner and to the extent it deems appropriate. The investigative procedure may include consultation with the Resident and/or other parties, as determined in the sole discretion of WSU/DMC, and shall be completed no later than thirty days following receipt of the request.

3. The Chair of the WSU/DMC Graduate Medical Education Program ("Dean's Council") shall appoint a Committee of not less than three members of the Dean's Council. The Chair of the Dean's Council shall not serve as a member of the Committee, nor shall the Department or Section Chief of the Department to which the Resident is assigned or the individual initiating the corrective action.

4. Upon completion of the investigation, WSU/DMC shall forward the request and a written report of its investigation and recommendations to the members of the Committee. A copy of the request shall also be sent to the Resident, along with a copy of the Corrective Action Procedures then in effect, and a notice that he or she may request an appearance before the Committee.

5. The Resident shall have ten days following the date of the notice described in Paragraph 4 above to file a written request for an appearance before the Committee. This request may include the Resident's written response to the request for corrective action. The request is to be made to the Chair of the Dean's Council. The request for an appearance shall specify:

   The name of the single physician, if any, who will accompany and represent the Resident;

   - The Resident's request to be represented by an attorney (although such a request shall be denied in such circumstances as may be determined solely by the Committee). The Chair of the Dean's Council shall notify the Resident within ten days of the request for appearance if the request to be represented by an attorney will be granted; and
   - The names of any witnesses the Resident intends to call.
   - The rights to representation by a physician, to request representation by an attorney, and/or to call witnesses shall be deemed waived if the request for an appearance fails to specify the information described above.

6. If the Resident fails to request an appearance within the applicable time period:

   - He or she waives any right to such appearance and to any further appellate procedures to which he or she might otherwise have been entitled; and
   - He or she will be deemed to have accepted an adverse decision by the Committee, which decision shall thereupon become the final decision and shall be implemented.

7. The Committee shall consider and decide upon the request for corrective action at its next meeting or as soon thereafter as may be practicable. The following procedures shall be applicable if the Resident has requested an appearance in accordance with the provisions of Paragraph 5 above:

   - The Resident shall be provided fifteen days notice of the time, place and date of the meeting;
   - The Resident may present witnesses named pursuant in Paragraph 5;
   - WSU/DMC may present witnesses;

- Either party may cross-examine any witness appearing in person;
- Any party may present evidence of a type on which reasonable persons customarily rely in the conduct of serious affairs, regardless of the admissibility of such evidence in a court of law; and
- The Committee shall record its evidentiary proceedings. Deliberations of the Committee shall not be recorded.

8. The Resident shall be deemed to have waived his or her rights to appear as well as any appeal rights if, having requested an appearance, he or she fails without good cause to attend the meeting.

9. Following the appearance of the Resident and the presentation and examination of all witnesses and evidence, the committee shall deliberate to determine appropriate action. The Committee may take either the action sought in the initial request for corrective action or such other action that the Committee determines to be warranted.

10. The Committee shall notify the Resident and the Dean's Council of its findings and corrective action decision no later than fifteen days following the meeting.

11. The Resident may submit a written request for reconsideration by the Dean of the decision of the Committee within ten days of the date of notice of such decision. The Dean, in his or her sole discretion, may affirm, modify or reverse the decision of the Committee, or return the case for consideration by the full Dean's Council.

12. The Dean shall notify the Resident of his or her decision within fifteen days of the receipt of such request for consideration. The Dean's decision shall be final and binding except as described below in Paragraph 12.

13. To the extent there are procedures established by WSU for appeal of an adverse reconsideration decision by the Dean to the WSU Provost, the Resident may appeal to the WSU Provost in accordance with such procedures.

14. The procedures described in Paragraphs 1 through 12 above shall not apply to the other corrective action that is provided for above by Paragraph 1. The Resident shall have the opportunity, however, to informally discuss the pertinent circumstances with his or her Program Director in the event that the Resident is subjected to such other corrective action. The Resident shall be entitled to present such information or provide such explanation that may be relevant, but the Program Director's determination of the action to be taken, if any, shall be final and binding.

15. If the Program Director determines that the Resident should be placed on probation, the Program Director shall provide the Resident with the following information in writing:

    - The length of the probationary period, which shall not exceed one year
    - The academic or professional deficiency or conduct, or other basis giving rise to the probation
    - The criteria which the Resident must meet in order to satisfy the terms of probation
    - The approximate date or dates on which the Resident's probationary status will be reviewed

A copy of such written probation notice, including the information provided to the resident, shall be submitted to the Graduate Medical Education Office. If the Program Director fails to provide such information, the Resident may request review by the Committee as set forth in paragraphs 1 through 12 of this section.

SUMMARY SUSPENSION

1 Description.

The Resident may be summarily suspended from the Program, based on the criteria listed above under General Provisions, and such suspension shall become effective immediately upon imposition. In the event any corrective action described under the General Provisions section is also recommended, summary suspension shall continue pending completion of the corrective action proceedings under Correction Action

Procedure section above. If no such corrective action is recommended within ten days, or if any corrective action described in Paragraph 1.1-5 is taken, the summary suspension shall terminate upon expiration of the ten-day period or upon the taking of such corrective action.

2. Parties Who May Initiate.

Summary suspension, as described above in Paragraph 1, may be initiated by any of the parties described under the General Provision section above.

3. Action by DMC Hospitals or Other Hospitals.

As provided in the General Provisions section above, a DMC Hospital or other hospital to which the Resident is assigned may summarily suspend the Resident from participating in the Program at such hospital, in accordance with that hospital's procedures. Such action may be taken independent of and in addition to any action taken pursuant to Paragraph 1 of this section.

Corrective Action Procedures (see previous section)

U. TIME OFF POLICIES AND PROCEDURES

In order to meet the requirements set by the American Board of Internal Medicine (ABIM) for certification, the following policy is established to govern time off from training and is effective July 1, 1999.

- Time off will be calculated in terms of days
- A week shall consist of seven days – Sunday through Saturday
- The American Board of Internal Medicine (ABIM) allows a resident to be off a maximum of 91 days (13 weeks) during the 36 months of training to be eligible to take the board certification exam.
- The ABIM requires that vacation be used during each academic year and cannot be carried over to another academic year.

Completion/Non-completion of Rotation

The rounder will be responsible for notifying the Program Director or designee and noting on the evaluation form whether a resident has had an excessive number of days off from the rotation. These cases will be reviewed by the Program Director and Associate Program Director for a determination of whether or not the resident will receive credit for the rotation. In addition, the resident is responsible for notifying the Medical Education office of any unplanned days off during all rotations. Again, approval for such days off must be given by the Program Director and Associate Program Director prior to the unplanned days off.

1. Vacation

All residents are eligible for a **maximum of 21 days vacation per year** or a total of 63 days for the three-year residency (84 days for Med-Peds). The Department will allow up to one week per year for a prior approved conference. Vacations must be taken in 7 day blocks (one week). All time off is counted towards the maximum **91 days off permitted by ABIM**.

ABIM policy will not permit residents to forgo vacation in order to reduce the three-year training requirement.

Vacation requests must be submitted to the Medical Education Office February/March prior to the start of the next academic year. Vacations will not be granted for PGY 1,2s in June. Vacations will only be

approved during elective rotations and during the PGY 1 ER rotation. However, vacation requests are not guarantees of time off; do not make travel arrangements before your vacation is confirmed. The program will determine vacation assignments. Vacation dates are given on a first come first serve basis. Residents are advised to submit requests early. The vacation month may NOT be changed. You will be notified 3 months prior to each vacation request to confirm all vacation requests and submit specific dates if they were not already submitted. Failure to respond to the e-mail requesting confirmation will result in vacations being cancelled. There will be no exceptions.

It is the resident's responsibility to verify all time off, including vacation with the Continuity Practice supervisor and scheduler at least two month prior to time away.

While residents are free to travel during vacation, the program must insist that residents who travel out of the country be back in Detroit 48 hours prior to the start of the next rotation.

Residents traveling overseas should request a travel letter from the Medical Education Office. This will help prevent unnecessary delays in returning to Detroit. Travelers must return in time to begin the next rotation.

Residents who fail to report for work on time will be considered to be on unauthorized leave resulting in:

- Loss of pay for each day that the resident is late
- Loss of moonlighting privileges for the remainder of the residency
- Referral to the Residency Operations Committee for placement on probation or possible suspension and/or termination from program

2. Planned Personal Days

a. Shall include the following:
    - Job and fellowship interviews (note rotation limitations below)
    - USMLE and ACLS examinations
    - Special circumstances
b. Shall be taken during non-call rotations only
c. Requests for planned personal days should be made well in advance to accommodate patient care and coverage issues. Request must be submitted **no later than the 1st day of the month** previous to the requested day.
d. Planned personal days will not be granted on Continuity Practice Clinic day except under extenuating circumstances. Should the resident have a practice session scheduled on the planned personal day, the attending supervising physician **must** be notified at least 2 weeks in advance and **only** after the approval of the Program Director or designee.
e. Planned personal tie off for educational purposes (USMLE, ACLS) will not be counted against the 91 days off allowed by the ABIM.
f. Personal days can not be added to schedule vacation/holidays.

3. Unplanned Personal Days

a. Time off is given up to the maximum of 91 days allowed by the ABIM in three years of residency. Residents who exceed the 91 days maximum time off will not be eligible to graduate in accordance with ABIM guidelines.
b. All time off must have the approval of the Program Director or designee.
c. Resident must notify the Chief Medical Resident as soon as possible
d. Should the resident have clinic scheduled on the unplanned personal day, they must notify their supervising attending physician as soon as possible as well as the Ambulatory Chief Resident who will then notify the practice manager.

e. Emergency absence on a call-night puts the *Jeopardy* system to work. It is the responsibility of the scheduled resident to alert the Chief Medical Resident and arrange for a replacement by using the *Jeopardy* resident on call. Payback will be required.

4. Maternity Leave of Absence

Maternity leave of absence requests must be made as early as possible to appropriately adjust rotation schedules. Contact the Program Director and the Medical Education Office (Shirley Kmetz) as soon as possible.

Residents must use any available vacation time first. If time off exceeds vacation allowances residents may apply for a FMLA. Absences exceeding 91 days over the 3 years will extend training to cover excessive days off. This requirement is necessary in order for a resident to be eligible for board certification.

5. Paternity Leave of Absence

We will, whenever possible, arrange a five-day paternity leave immediately following the birth of a child. The resident must return to work by the infant's 10th day of life. Residents must notify the Chief Medical Resident and the Medical Education Office (Shirley Kmetz), as soon as possible, so rotation schedules can be adjusted. This leave will be counted towards the 91 maximum days off allowed by ABIM.

6. Family Medical Leave Act (FMLA)

Residents are eligible for the Family Medical Leave Act (FMLA) for 12 weeks in any calendar year. To qualify for a FMLA one must have a physician complete a standard FMLA form (available from Medical Education Office). FMLA protects your job and in this case your residency position. Leaves beyond the 12 weeks are at the sole discretion of the program. Leaves of absence although unpaid place enormous strain on the program and on the residency. Therefore, extended leaves will only be available under extenuating circumstances and are not guaranteed. Finally, the program has the right to terminate your residency if you do not return to work after a FMLA. Finally, vacation after a FMLA must be approved by the program director.

A resident will receive 100% of the stipend for the first 30 days of a leave, after which time they are eligible for long term disability (for which they will receive 60% of their stipend for the duration of their leave. (Contact the GME Office 2B-UHC for details regarding Long Term Disability. Payment of premiums for benefits will continue for 60 days.)

7. Personal Leave of Absence

Approval of personal leaves of absence may be granted at the discretion of the WSU/DMC Program Director for up to 30 calendar days. Personal leaves of absence shall be unpaid. The Detroit Medical Center will continue to provide insurance premium payment for 30 days; after 30 days, the postgraduate trainee will be provided the opportunity to continue insurance coverage in accordance with the provisions of current law (COBRA). A family leave of absence is a conditional privilege of postgraduate training. Such time off will be provided in accord with DMC policy in order to accommodate specific family care needs. Depending on the length of the leave and individual board requirements, training time may need to be extended as determined by your Program Director. Residents are required to use vacation time for personal leaves. Residents requiring leaves of absence beyond vacation time must complete a FMLA) request. Leaves beyond those allowed by FMLA will be at the discretion of the Program Director and are not guaranteed. Stipends and benefits will be discontinued until the resident returns to service.

8. Visa Issues

In the event an intern is late starting residency due to visa issues, this must be resolved by no later than 45 days from start date (i.e., August 15th) with intern ready to start rotation by September 1st. The intern is required to give a progress report via e-mail on the status of their visa every two weeks to the program director. No position will be held beyond the August 31st deadline.

If visa issues arise during your residency and you are not able to perform your duties, we expect the issue to be resolved within 90 days. If this does not occur, you may be terminated from the program

V. BENEFITS

Educational Reference Books
The Department of Internal Medicine has copies of the MKSAP (print and audio) as well as other reference materials available for your use. These materials can be loaned out at no charge. However, there will be a $25 late fee (funds will be taken from your book money) for any and all materials that are not returned by the specified due date. If the materials are not returned by the end of your residency you will not be allowed to graduate.

Educational Books and Conference Allowance (July-June)
The Department of Internal Medicine, Medical Education Office will provide support towards the purchase of books, attendance at an educational conference, palm pilots (no computers or printers) as follows:

PGY1	$300
PGY2	$500
PGY3/4	$600
CMRs	$700

Original receipts **must** be submitted for reimbursement of any expenditure. Travel must be approved in advance and original airline, lodging and food receipts for be submitted for reimbursement. Original receipts must be submitted to the Administrative Director or her designee in the Medical Education Office (2E-UHC).

NOTE: All reimbursement and payment requests must be submitted to the Medical Education Office **no later than May 31st of each academic year. This deadline is *firm*. Please note that these monies *will not* be carried over from one academic year to another (Jul-Jun).** Also, book money will be withheld for failure to complete professional responsibilities including; evaluations, procedure logs and duty hours.

Conferences: Residents wishing to use their educational monies to attend a conference must submit a request six weeks in advance to the Administrative Director which includes the name, location and date of the meeting, rotation at time of meeting, rotation coverage and a copy of the letter of acceptance for presentation at a national meeting or any other meeting approved by the Program Director.

Approval for time off for conferences may not exceed 7 days in any academic year. Attendance during ward or unit rotations are less likely to be approved, but will be considered if a plan for team coverage is also submitted.

The Department of Internal Medicine strongly encourages the submission of research and scholarly work by residents for presentation at various conferences and professional meetings. To that end, the Department, when possible, will financially support resident presentation of their work when book monies are not available. The following guidelines will be used in determining reimbursement.

- **Residents must submit an e-mail request to the Administrative Director for financial support and travel approval that includes the name, date and location of the meeting, rotation at time of the meeting and rotation coverage. A copy of the acceptance letter for poster or oral presentation must be provided as an attachment to the e-mail or as a hard copy to the Administrative Director at least 6 weeks prior to the date of presentation**.
- Reimbursement will be made based on availability of funds, and up to a maximum of $800 per year per resident, for presentations at conferences.
- The cost of presentation materials (slides, posters, etc.) will be the responsibility of the Medical Education office **based upon prior approval**. It is expected, however, that presentation materials will be prepared by the

resident on a diskette using power point software. The slides will need to be approved by the Director for Resident Research or identified mentor prior to finalization.

- Reimbursement for out of state travel to regional or national meetings will only be provided to residents who are first author. Oral presentations will receive priority over poster presentations.
- Time off for conferences cannot exceed 7days total per academic year. A coverage plan for both day and night call duty must be submitted with the e-mail request for presentation reimbursement at least six weeks prior to the conference.
- Residents are responsible for alerting appropriate faculty, Ambulatory Director, Practice Manager, Chief Medical Resident of conference attendance once it is approved.
- No more than one conference per year will be supported per resident.

All of the benefits listed below are provided to postgraduate trainees who are on the Detroit Medical Center payroll. WSU/DMC reserves the right to add, delete or otherwise change benefits without advance notice at WSU/DMC's discretion and as WSU/DMC deems appropriate.

Health Insurance

The Detroit Medical Center offers trainees the choice between two health insurance providers. (Coverage is effective on the date of your appointment)

Please note that you are responsible for reporting any change in your family's status (e.g. marriage, birth of a child, etc.) to the GME office in person within 30 days of the occurrence. If you do not report such changes within the required period of time, it will not be possible to obtain coverage for that individual until open enrollment which takes place during the month of November each year, with coverage taking effect January 1.

Sponsored Dependents (E.G. Parents) that are claimed as dependents on your income tax can be enrolled at premium participation cost as long as benefit requirements are met (see enclosed for requirements).

Dental Insurance

Dental insurance is provided to all trainees. **You are responsible for reporting any change in the status of you or your family to the GME office in person within 30 days of the occurrence.** Sponsored dependents are not eligible for coverage under dental insurance.

Life Insurance and Accidental Death & Dismemberment Coverage

Life insurance benefit is two times annual stipend. **After initial enrollment, any change in beneficiary must be reported to the GME office in person.**

Short-Term Illness

Trainees who started on or after 7/1/97 (including Sinai trainees who transferred to DMC payroll effective 5/11/97) will receive payment of stipend for verifiable illness for up to 180 days as follows: 1-90 days at 100%; 91-180 days at 75%. Trainees who started prior to 7/1/97 will receive full payment of stipend for verifiable illness for up to 90 days. Program Directors will notify the GME office when a trainee is out ill for more than 3 calendar days. For absences in excess of 3 calendar days, physician verification may be required. Illness time does not accumulate.
The WSU/DMC Graduate Medical Education Program does not have a separate policy for maternity leave; time off for pregnancy and delivery is provided for under Short Term Illness.

Depending on the length of the leave and individual board requirements training time may need to be extended as determined by your Program Director.

Long-Term Disability

A long-term disability plan underwritten by Provident Life & Accident Insurance Company is provided to all trainees on the DMC payroll. The plan provides 60% of salary to a maximum benefit of $2,000 per month. For trainees who started on or after 7/1/97 (including Sinai trainees who transferred to DMC payroll effective 5/11/97), long-term disability benefits are payable after 180 consecutive days of disability and are payable as long as the disability continues (maximum to age 65 benefit period). For trainees who started before 7/1/97, long-term disability benefits

are payable after 90 consecutive days of disability and are payable as long as the disability continues (maximum to age 65 benefit period).

An optional supplemental policy is available, at your own expense, up to a maximum of $2,000 per month. For a supplemental application contact a Provident representative at (810) 827-2570.

Depending on the length of the leave and individual board requirements training time may need to be extended as determined by your Program Director.

Employee Assistance Program

The Detroit Medical Center offers an Employee Assistance Program (EAP) to all Postgraduate Trainees. The EAP is designed to help you with personal problems or work situations that affect your work and home life such as anxiety or depression, alcohol or substance abuse, marital or family problems, legal or financial matters. To contact an EAP counselor, call 313-745-1900 or 877-789-3271.

Professional Liability Coverage

Your professional liability coverage is through the DMC Insurance Company, Limited. Your policy is a limited claims-made policy with extended reporting endorsement (tail coverage); coverage limit is $2.5 million per claim. This coverage does not extend outside of the training program.

Tax Sheltered Annuity (TSA) Program

This Program can help you reduce your current taxes and increase your retirement savings by saving pre-tax dollars. You have a choice of fixed annuity contracts, as well as variable annuity (mutual fund) investment options within an annuity contract(s).

The program Reserves the right to change policy mid-year. All policy changes must be approved by the ROC. Residents will be notified by email with in 2 weeks for any changes.

Appendix A

RESIDENCY OPERATIONS COMMITTEE
2007-2008

Committee Chair and Program Director	Dr. W. Wiese-Rometsch
Associate Program Directors	Dr. Neelima Thati, Dr. W. Krell
Vice Chair for Education	Dr. Diane Levine
Chief of Medicine, DRH/UHC	Dr. P. Brown
Chief of Medicine, Harper Medicine, VAMC	Dr. M. Edelstein/B. Dubaybo
MedPeds Program Director	Drs. E. Ayers/R. Roxas

Sub-specialty Education Coordinators

Cardiology	Dr. Deepak Thatai
Endocrinology	Dr. Abdul Samra
Gastroenterology	Dr. Murray Ehrinpreis
Geriatrics	Dr. Joel Steinberg
Hematology/Oncology	Dr. Charles Schiffer
Infectious Diseases	Dr. Jack Ebright,
Nephrology	Dr. Jose El Am
Pulmonary Medicine	Dr. James Rowley
Research	Dr. Anupam Goel
Rheumatology	Dr. Jose Granda

Chief Medical Residents

Dr. Khaled Awad	Ambulatory
Dr. Haroon Faraz	DRH
Dr. Mark Hakim	Med-Peds
Dr. Sarah Harley	DRH
Dr. Patricia Reyes	Ambulatory
Dr. Raul Torres	VAMC
Dr. Stacey Valley	HUH

Resident Representatives	**TBD**

CLINICAL COMPETENCY COMMITTEE