INTERNAL MEDICINE HOUSE STAFF

POLICY AND PROCEDURE MANUAL

BETH ISRAEL MEDICAL CENTER

DEPARTMENT OF MEDICINE

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This manual contains important policies and procedures related to many aspects of your training in the Department of Medicine. You are responsible for knowing and following them.

This manual may be revised. The **most updated version will reside** on the house staff page of the website www.bimcmedicine.org

HOW TO USE THIS MANUAL

1. You can locate a policy in the **table of contents**. You can click on a topic and you will be taken to that section.
2. You should also **type the term or subject you are searching for in the search bar of this PDF document**. It will be highlighted in all places it appears in this document. This an excellent way to be sure you find all mention of a particular topic.
3. This manual should be **used in conjunction with** the House Staff Survival Guide, which contains more clinically oriented information, guidelines, expectations and other information, with the information posted on the house staff page of the www.bimcmedicine.org website, and with the GME website.(www.bethisraelgme.org)

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PROFESSIONALISM: ESSENTIAL THINGS TO REMEMBER

The purpose of this document is to highlight the most common expectations in the program that some house officers occasionally lose sight of. When this happens, it can negatively impact their performance evaluations, their relationship amongst their peers or their standing in the training program. Our goal is to give you tools for success and professional development, and this reminder document is written in that spirit.

1. Follow the Departmental Dress Code (located in this manual—see table of contents.)

2. Check your chpnet.org email account at least every 36 hours. Many important communications, often time sensitive or related to the delivery of care, are sent via email and you must stay current with your email.

3. Never change your schedule without the approval of a chief medical resident. For example, you should never change, swap or trade call assignments, jeopardy assignments, ambulatory assignments, elective rotations, vacation or any other assignments without the approval of a chief medical resident.

4. Under no circumstances should a resident ever cancel scheduled ambulatory patients without permission from their preceptor. Do not ever call the front desk staff and re-arrange or otherwise cancel your schedule. If changes need to be made, your faculty preceptor needs to approve them and will direct the ambulatory staff to make them.

5. Always wear your hospital issued ID.

6. Do not take "days off" during electives. Electives are paid employment days and you cannot take long weekends or leave early for vacation when on elective as you are being paid for these days. If your elective faculty supervisor says it's ok for you not to be present on certain days—this still must be approved by a chief medical resident.

7. Carry your pager at all times on all rotations. This includes ambulatory, electives and research rotations.

8. Complete your peer and faculty evaluations on time. Evaluations are critical to your development and to that of your peers. Peer evaluations, and evaluations of faculty by trainees are kept anonymous.

9. Know your schedule. You must know when you are on jeopardy or have an ambulatory bridge session, and you must know when you are supposed to be at work and the scope of your duties at work.

10. Be reachable and available when on jeopardy/sick call. Not being reachable when on jeopardy or sick call is a very serious professionalism violation.

11. Write Resident Admission Notes. These are required of PGY-2/3 residents for all admissions and transfers. They need not be long, but they need be. Targeted, brief, reflective of thought, focused on the differential, assessment and plan, and in the chart.

DEPARTMENT OF MEDICINE

UNIVERSAL POLICY ON RESIDENT/FELLOW SUPERVISION

A core educational goal of the Department is to provide trainees with graded and progressive responsibility and independence, consistent with their individual abilities, and always under the guidance and supervision of attending physicians.

Consistent with ACGME regulations, the Department uses the following terms to describe levels of resident supervision:

A. Direct Supervision: The supervising physician is physically present with the resident and the patient

B. Indirect Supervision:

1. **With direct supervision immediately available** – the supervising physician is physically within the hospital or other site of patient care, and is immediately available to provide Direct Supervision.

2. **With direct supervision available –** the supervising physician is not physically present within the hospital or other site of patient care, but is immediately available by means of telephonic and/or electronic modalities, and is available to provide Direct Supervision.

C. Oversight: The supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered.

Policy on Resident/Fellow Supervision

1. In the inpatient setting, all residents (medical residents and subspecialty fellows) function at all times under the direct or indirect supervision, or the oversight of, an identifiable, appropriately credentialed and privileged attending physician, as defined above. The attending listed in PRISM is the attending of record for a patient.

2. Residents/fellows must follow the BIMC Institutional guideline that outlines for which circumstances and events the attending physician should be notified.

3. Procedures: Residents may only perform procedures for which they have **documented certification** on New Innovations and obtained appropriate consent. If certification has not been documented, residents may perform procedures only under direct supervision of either another resident or fellow with documented certification, or an attending physician with privileges to perform that procedure. All procedures that require patient consent (paracentesis, lumbar puncture, central line, etc) must have a Universal Protocol (aka "Time Out") completed before the procedure.

4. Supervision may be exercised through a variety of methods. Some activities require the physical presence of the supervising faculty member. For many aspects of patient care, the supervising physician may be a more advanced resident or fellow. Other portions of care provided by the resident can be adequately supervised by the immediate availability

of the supervising faculty member or resident physician, either in the institution, or by means of telephonic and/or electronic modalities. In some circumstances, supervision may include post-hoc review of resident delivered care with feedback as to the appropriateness of that care.

5. PGY-1 residents shall always be supervised either directly or indirectly with immediate supervision available. Supervision may be either by a senior resident, a fellow, or an attending, as appropriate.

6. Faculty members functioning as supervising physicians should delegate portions of care to residents, based on the needs of the patient and the skills of the residents.

7. Senior residents or fellows should serve in a supervisory role of junior residents in recognition of their progress toward independence, based on the needs of each patient and the skills of the individual resident or fellow.

8. Faculty supervision assignments should be of sufficient duration to assess the knowledge and skills of each resident and delegate to him/her the appropriate level of patient care authority and responsibility.

9. Residents and faculty members should inform patients and each other of their respective role in each patient's care.

10. Every inpatient on the inpatient medical service must have a daily progress note by the attending physician of record, or their designee, that is appropriately dated and timed, and reflects awareness and supervision of the care delivered by residents.

11. In the ambulatory setting, during the first six months of training, an attending physician must see every patient cared for by a resident at every visit. After this period, and if a resident has achieved the necessary milestones, as determined by their ambulatory preceptor and/or the IM training program, care may be delivered under indirect supervision or oversight by an attending physician.

12. In general there is a chain of command, but **any trainee or student at any level may seek direction or guidance directly from an attending physician at any time**. The **Chain of Command and Supervision** is as follows, in descending order:

    1. Attending Physician of Record or Consulting Attending, as applicable
    2. Attending Physician of Record or Consulting Attending designee (for example, a covering physician, or the hospitalist on call for hospitalist patients)
    3. Subspecialty fellow as applicable
    4. Resident team leader (either PGY-2 or PGY-3)
    5. PGY-1
    6. Medical students (both third and fourth year)

13. If any time, a resident or fellow is not able to obtain appropriate guidance or supervision from an attending physician, or seeks a different opinion, they should immediately contact the chief medical resident on call (pager 10026) or their senior/chief fellow, or one of their program directors. There is a chief medical resident on call at all times, and they always have direct access to a program director. The program directors always have direct access to the Chair of Medicine.

14. There is always a hospitalist attending physician on call, available at pager 10086. Private physicians must always have coverage arranged.

15. Only medical residents may write orders for patients under their care. In a medical emergency, any credentialed and appropriately trained physician may write an order, but this action must then be immediately communicated to the residents caring for the patient.

16. The privilege of progressive authority and responsibility, conditional independence and a supervisory role in patient care delegated to each resident must be assigned by the program director and faculty members.

17. The Institution, as represented by the Chief Medical Officer and the Chair of Medicine, share overall responsibility for the quality of care delivered to patients on the medical service. Either they, or their designee, or the IM Program Director or Fellowship Program Directors, may act to ensure quality of care, including the supporting, directing or altering of the supervision of residents and fellows, as appropriate.

18. Medical residents and fellows in the Department of Medicine operate under the general administrative and regulatory oversight of the IM Program Director. This is in conjunction with the Fellowship Program Directors, Division Chiefs and subspecialty Faculty, who are responsible for direct clinical, administrative and regulatory supervision of fellows.

19. Medical residents may not be released from any scheduled duty without direct approval of a chief medical resident and/or a program director, as appropriate. For example, residents on elective rotations must obtain permission from either a chief medical resident or a program director regarding changes in their schedule.

BIMC INSTITUTIONAL GUIDELINE FOR ATTENDING NOTIFICATION

The ACGME requires that "Programs must set guidelines for circumstances and events in which residents must communicate with appropriate supervising faculty members". Beth Israel Medical Center has approved this guideline, which applies to all residency programs.

The Attending Physician responsible for the management of a patient's hospital course must be kept apprised of a patient's condition. The following guidelines may be used to support your decision to call your attending; they do not replace your clinical judgment and are not meant to be exhaustive.

Examples of acute, unexpected changes in status, when the attending, supervising physician (or senior resident where appropriate), must be called as soon as possible, include:

GENERAL REQUESTS

- Any trainee feels a situation is more complicated then he or she can manage
- Nursing physician staff or the patient requests that the attending be contacted

CRITICAL CLINICAL STATUS

- Transfer to another level of care (i.e. MICU, SICU, CCU, ICU)
- RRT or Code
- Patient Death
- Unplanned intubation or ventilatory support
- Hemodynamic instability, including unanticipated arrhythmia
- Development of significant neurological or mental status changes

ADVERSE EVENTS OR UNEXPECTED INTERVENTIONS

- Patient fall or other injury
- Any medication or treatment errors
- Unplanned blood transfusion
- Significant post-procedure complications
- Emergent consult

TREATMENT/DISCHARGE ISSUES

- Any significant change in treatment plan
- Patient leaves AMA or elopes
- Unexpected discharge

DEPARTMENT OF MEDICINE

UNIVERSAL POLICY ON DUTY HOURS

All training programs within the Department of Medicine must follow the ACGME and New York State/IPRO duty hour regulations. The regulations below are based on the new ACGME Duty Hours effective July 1, 2011.

Duty hours are defined as "all clinical and academic activities related to the program; i.e., patient care (both inpatient and outpatient), administrative duties relative to patient care, the provision for transfer of patient care, time spent in-house during call activities, and scheduled activities, such as conferences. Duty hours do *not* include reading and preparation time spent away from the duty site."

Duty hour regulations for all residents (including fellows) in all training programs in the Department of Medicine are:

1. Maximum of 80 hours of duty per week, averaged over a 4 week period, inclusive of all in-house call activities and all moonlighting.

2. Maximum duty periods by PGY level:

    a. Duty periods of **PGY-1 residents** must not exceed 16 hours in duration, including all handoff and transition of care activities.
    b. Duty periods of **PGY-2 residents and above** may be scheduled to a maximum of 24 hours of continuous duty in the hospital. Unscheduled strategic napping, taken as needed, especially after 16 hours of continuous duty, and between the hours of 10pm and 8am, is strongly suggested.
        i. Residents may remain on-site for handoff and transitions of care up to an additional 3 hours after their duty period (ACGME rule is 4 hours, but New York State/IPRO rule is 3 hours; we abide by the strictest standard).
        ii. Residents must not be assigned additional clinical responsibilities after 24 hours of continuous in house duty.

3. Extensions of duty: In unusual circumstances, residents, on their own initiative, may remain beyond their scheduled period of duty to continue to provide care to a single patient. Acceptable justifications of such extensions of duty include caring for a severely ill or unstable patient, academic importance of the events transpiring, or humanistic attention to the needs of a patient or family.

    a. In this circumstance, residents must:
        i. Hand over the care of all other patients to others.
        ii. Document the reasons for remaining past duty hours to care for the patient in question and submit that documentation in every circumstance to the program director in writing (or in New Innovations).
    b. In this circumstance, the program director must:
        i. Review each submission of additional/extended service, and track both individual resident and program-wide episodes of additional duty.

4. Residents must be scheduled for a minimum of one day free of duty every week (when averaged over four weeks). At-home call cannot be assigned on these free days.

5. Residents cannot work more than 13 days in a row (New York State/IPRO rule.)

6. Residents must not be scheduled for more than six consecutive nights of night float.

7. PGY-2 residents and above must not be scheduled for in-house call more frequently that every third night, when averaged over a four week period.

8. Minimum Time Off between Scheduled Duty Periods:

    a. **PGY-1 residents:** Should have 10 hours off, and must have 8 hours off between scheduled duty periods.
    b. **PGY-2/3 residents:** Should have 10 hours off, must have 8 hours off between scheduled duty periods.
        i. After 24 hours of continuous in-house duty, these residents must have at least 14 hours free of duty.
        ii. "While it is desirable that residents in their final years of education have eight hours free of duty between scheduled duty periods, there may be circumstances when these residents must stay on duty to care for their patients or return to the hospital with fewer than 8 hours free of duty." (ACGME Common Program Requirements, July 1, 2011). Circumstances of return-to-hospital activities with fewer than eight hours away from the hospital by residents in their final years of education must be monitored by the program director.

9. At-Home Call

    a. Time spent in the hospital by residents on at-home call must towards the 80-hour maximum weekly hour limit. The frequency of at home call is not subject to the every-third-night limitation, but must meet the one-day-free-in-seven free of duty requirement, when averaged over four weeks.
    b. At home call must not be so frequent or taxing as to preclude rest or reasonable personal time for each resident.
    c. When residents taking home call are called in to work from home, the hours worked count towards the 80 hour weekly limit but do not initiate the need for a new "off-duty period".

10. Faculty and residents must be educated to recognize the signs of fatigue and sleep deprivation and must adopt policies to prevent and counteract its potential negative effects on patient care and learning.

Program Directors should consult the ACGME website (www.acgme.org) for further and subspecialty specific details, and for useful FAQ documents related to Duty Hours.

DEPARTMENT OF MEDICINE

POLICY ON SLEEP DEPRIVATION AND FATIGUE

1. What do I do if I am too tired or fatigued to work or get home safely, even if I have not violated duty hours?

Consider "alertness strategies", such as drinking caffeine (30 minutes or so before driving), taking a brief walk outside, or take a short nap in one of the call rooms on 11Baird.

2. What if the above approaches don't work or I am not comfortable they will work, or they are not possible at the time?

Tell someone immediately. Notify your immediate clinical supervisor (resident, fellow, attending) and page the Chief Medical Resident on call. Provisions will be made to remove you from duty immediately so that you can sleep.

If you feel you cannot get home safely, arrangements will be made to get you home. Arrangements will differ according to the individual circumstances and where a trainee lives, but may include escorting a person home, providing money for public transportation, having someone drive the trainee home, paying for a taxi home, or arranging for sleeping arrangements until a family member or friend can pick up the trainee from work.

3. What happens to me if I tell someone I am too fatigued to work or to get home safely? Do I get in trouble?

No!!! The Program's policy towards those who ask to be removed from duty due to sleep deprivation or fatigue is the following:

No fault, no blame, no questions asked--period.

Removing one's self from duty due to fatigue is considered a highly professional thing to do.

Of course, as appropriate the Residency leadership will assist and support house staff if there is a serious or ongoing issue of well being.

4. What are the signs and symptoms of sleep deprivation and fatigue?

American Academy of Sleep Medicine Signs and Symptoms of Sleep Deprivation and Fatigue

- Falling asleep in conferences or rounds (environment can unmask sleepiness but does not cause sleepiness)
- Feeling restless or irritable with people
- Having to check your work repeatedly
- Difficulty focusing on the care of your patients
- Feeling like you just don't care

There is a power presentation from the American Academy of Sleep Medicine on the www.bimcmedicine.org website for your review.

THE ACGME 8 TO10 HOUR BREAK RULE

The ACGME 8 to 10 Hour Break Rule

How many hours must I have off between daily duty assignments?

The ACGME mandates that there should be a 10 hour break, and must be an 8 hour break, between all assignments. While we want you to report duty hour violations, our real goal is to do our best to prevent them from happening in the first place!!

What do I do if I think I will have a break rule violation?

If you anticipate a break rule violation:

1. Notify your immediate supervisor (intern notifies resident, resident notifies chief on call) or you may directly notify your supervising fellow or attending physician, or the Chief Medical Resident on call (pager 10026), or contact a program director (whichever you are most comfortable with). Support and guidance will be brought in as needed to help you avoid a break rule violation through re-distribution of work, adjustment of schedules, or other means.
2. Work with your team to return to work slightly later the following day at a time that would allow for the proper break period. Involve a Chief Resident or program director as needed to help facilitate this.
3. Residents should be proactive and help interns be compliant, rather than leaving it "up to the intern."

Examples:

1. House officer leaves the hospital at 10:30pm and returns at 6:30am the next morning--- OK, 8 hour break.
2. House officer leaves the hospital at 11pm and returns at 7am the next morning --- OK, 8 hour break.

ACGME ADMISSION AND ONGOING CARE CAPS

ACGME Admission Caps

ACGME regulations state that:

A. Max number of new patients per admitting day for PGY2/PGY3 residents is 10 new admissions and 4 transfers.
B. Max number of new patients per admitting day for PGY-1 residents is 5 new admissions and 2 transfers.
C. First year residents must not be assigned more than 8 new admissions in a 48 hour period.
D. PGY-2/3 residents must not be assigned more than 16 new admissions in a 48 hour period.

1. **"New admissions" are: Patients for whom you personally write the admission H+P or the resident admit note**, and who are admitted to Medicine either directly, from the ED, or from a non-Medicine service (Surgery, Psychiatry, Detox, Rehab, etc).
2. **"Transfers" are: Night float patients** you pick up in the morning (remember—you didn't write an admission H+P or resident admit note on these patients, so they are transfers), patients from the MICU/CCU, or patients you receive from other Medicine floors.
3. **It is OK to take more than 2 (for PGY-1) or 4 (for PGY-2/3) transfers per admitting day.** However, any transfers that you take over these numbers then start to count as new admissions as you tally up towards the total caps outlined in points A and B, above.

Example:
At 7am on a long call day, a PGY-2 receives 6 night float patients, and then admits 6 more patients from the ED and gets 2 transfers out of the MICU over the rest of the long call. Did the resident violate any cap rules?

Answer:
No. The first 4 night float patients are transfers. The fifth and sixth night float patients are above the transfer cap of 4, so they are then counted as new admissions. So, heading into the rest of the long call day, the resident tally is 4 transfers and 2 admissions. Then, the 6 new ED admissions bring the new admissions total to 8. The two MICU transfers bring the new admissions total to 10 (because the cap of 4 transfers has been passed already). The total # of new patients is 14, all included.

"Quick Check" Method for Admission Cap Violations:

No cap violations have occurred for a house officer if, over an admitting day, **both** of the following are true:

1. **The total number of new patients to a resident's service, inclusive of all admissions and transfers, is 14 or less (7 or less for interns.)**

AND

2. **The total number of new admissions personally admitted by the resident is 10 or less (or by the intern is 5 or less.)**

If a PGY-2/3 has personally admitted 10 new patients, they are capped for new admissions but still can get transfers. If they have accepted only 4 transfers (for example, 4 night floats at the start of a call day) they can still take more transfers—these just must be counted as "new admissions" and towards the 14 patient overall total. Similar is true for interns, with numbers adjusted for their caps, following the same principles as described above.

What do I do if I anticipate I (or someone on my team) will incur an admission cap violation?

Interns should notify their resident. However, residents are responsible for keeping track of intern admission caps. Residents in danger of capping should first double check their calculations using the above guidelines, and then notify the Medical Admitting Resident and the Chief Medical Resident on call as necessary—they will assist in evaluation of the situation and re-distribution of work as appropriate.

I'm the Medical Admitting Resident and everyone is capped! What do I do!?

First, re-check your calculations, being sure to count night float patients as transfers, following the rules outlined above. If you feel that everyone available is capped, or you feel the teams are overwhelmed, page the Chief Medical Resident on call immediately at 10026.

ACGME Ongoing Care Caps

A first year resident must not be responsible for the ongoing care of more than 10 patients. Second or third year residents, when supervising more than one first year resident, must not be responsible for the ongoing care of more than 20 patients.

What does "ongoing care" mean?

Ongoing care is defined as spanning more than one work day. Transient (meaning for a few hours within a single work day) rises above cap are acceptable, and allow for the natural lack of synchrony between admissions and discharges. However, if transient rises above cap are occurring every day or at an unreasonable frequency, this would also be considered a violation of the ongoing care rule.

Some examples for PGY-1 residents (applicable in principle to PGY-2/3 residents):

1. If a first year resident starts the day with 8 patients, gets four admissions but also discharges two and finishes the day with ten patients, this is acceptable.
2. If an intern finishes the day with twelve patients, but two are discharged after the intern leaves work, and the intern returns the next morning to a census of 10, this is acceptable.
3. If an intern finishes a day with 11 patients and returns the next morning to a census of 11 patients—this is a violation of the ongoing care cap.
4. If scenario #1 occurs every day, this is a violation of the ongoing care cap.

DEPARTMENT OF MEDICINE

HOUSE STAFF DRESS CODE

This policy is consistent with and in addition to the Institutional Dress Code Policy.

1. The House Officer and his/her clothing must be neat and clean. Male House Staff must wear collared shirts and pants. Female House Staff must wear shirts, blouses, skirts, sweaters, pants or dresses.

2. Scrubs may be worn only on long call, on night float, or when working in the intensive care units.

3. The Department of Medicine and Residency Program leadership regard the wearing of ties by men, and the wearing of white coats at all times by both male and female house staff, as the most professional appearance. House staff who wish to meet the Department's and Residency Program's expectations for professionalism will dress in this manner.

4. Ties and collared shirts must be worn by men when in the ambulatory setting.

5. The following items of clothing are considered inappropriate apparel for a House Officer and must not be worn while on hospital premises:

    a. Jeans
    b. Shorts
    c. T-shirts or tank tops
    d. Open-toed shoes or sandals
    e. Backless dress and tops
    f. Midriffs and low-cut tops
    g. Stretch pants/ Leggings
    h. Mini-skirts
    i. Hoodies, sweatshirts and sweatpants

4. House Staff should have nails that are kept neat, clean and trimmed.

5. Identification badges must be visible and worn at chest height in the Medical Center at all times.

DEPARTMENT OF MEDICINE

RESIDENCY TRAINING PROGRAM

POLICY ON SCHEDULE REQUESTS

The Program Office will make every attempt to accommodate schedule requests that are reasonable and follow proper procedure. We cannot guarantee that all requests will be granted, but we will always do our best.

Highest priority is given to requests for fellowship/job interviews and requests to travel to present academic work. Schedule requests that are made or approached in an unprofessional way are much less likely to be approved. Demonstrating proper professionalism during your time the program will also increase the chance that your schedule request will be granted.

There are certain situations in which residents will be required to find their own coverage, and maintaining a professional reputation amongst your colleagues at all times in the program will usually greatly assist you in finding coverage.

Annual Vacation Requests

Selection forms are usually sent to all house staff, via e-mail, in early February for the next academic year. Vacation requests are given in 14 day intervals. Selections should be made with 2 weeks in the first half of the academic year (July-Dec) and 2 weeks in the second half of the academic year (Jan-Jun). Forms should be returned to Cynthia Dominguez. The American Board of Internal Medicine forbids residents from forfeiting their vacation time. (You MUST take your vacation!)

Block Requests

(Requests regarding sick call, taking USMLE/COMLEX 3, golden weekends, religious holidays, family functions, weddings, etc.)

For block requests regarding travel to present academic work, please refer to the "Policy on Conferences and Academic Travel."

No block requests, other than requests to travel to present academic work (see policy on this), or to attend a job or fellowship interview, will be accepted if you are scheduled for MICU, CCU or night float.

Due to the large number of residents in the program and the need to try to accommodate everyone, **only one request per block is allowed**.

Residents should submit two things to Residency Program Manager. 1) A block request received by the due date for the block (watch your email for due dates from the program office staff) and 2) a completed prerequisite form. Both forms are available on www.bimcmedicine.org

If you email the chief medical resident first with a request, you will be re-directed to the step above.

Unless there is an immediate emergency, e-mail requests to a chief medical resident without the above required documentation will not be accepted.

Fellowship or Job Interview Requests

Requests to attend fellowship or job interviews will be granted, regardless of rotation.

All residents requesting time off to attend a fellowship/job interview **MUST**:

- Advise the appropriate chief medical resident (CMR) **as soon as** the interview invitation is received
- Provide a copy of the invitation to the CMR.

The CMR will work with ambulatory site staff regarding rescheduling of ambulatory patients and missed resident sessions. Coverage for inpatient duties should be arranged by the resident but MUST THEN ALSO BE APPROVED BY THE CMR. If a resident cannot find coverage for a fellowship or job interview, the CMR will assist.

Jury Duty:

Provide copy of summons upon receipt to the CMR and program coordinator.

DEPARTMENT OF MEDICINE

RESIDENCY TRAINING PROGRAM

POLICY ON CONFERENCES AND ACADEMIC TRAVEL

The Department is extremely proud of the academic work produced by our house staff, and we encourage house staff to submit their work for presentation to local, regional and national conferences, in addition to submission for publication.

1. House officers must be in good academic and professional standing in the Residency Program.
2. A maximum of 3 calendar days may be taken for conference travel.
3. Requests for conference travel should be made first to Ms. Cynthia Dominguez in the Residency Program Office.
4. All efforts will be made to accommodate requests to travel to present academic work during MICU, CCU or night float rotations. However, due to the schedule disruption this may cause, and other factors, these requests cannot be guaranteed.
5. While there is no set "maximum" number of conferences a house officer may travel to, residents should exercise reasonable judgment in requesting conference travel.
6. Coverage should be arranged by the house officer for both ambulatory and inpatient rotations. Ambulatory patient sessions may not be canceled.
7. All requests for conference travel must be reviewed and approved by the appropriate Chief Medical Resident (PGY-1 or PGY-2/3 scheduling chief, and the ambulatory Chief. As much advance notice must be given to the chief residents as possible (i.e., as soon as a house officer knows they have had a project accepted and wish to request travel).
8. Documentation of project or academic work acceptance for presentation must be submitted for permission to travel to be granted.
9. Travel to international conferences is restricted and is not usually granted.
10. The Department will reimburse medical house officers for up to $800 of travel/academic related expenses. For reimbursement, the following conditions must be met:

    a. House officers must be either first or second author on the academic work that is being presented, or be an author on the project and be the primary person presenting the work at the conference.
    b. Pre-approval paperwork must be completed by the house officer and submitted to Cynthia Dominguez in the Program Office.
    c. Expenses must be directly related to travel to and from the conference site, meals during the conference, expenses incurred for poster or abstract production, and similar.
    d. Receipts must be submitted for all expenses.
    e. Reasonable judgment must be exercised; inappropriately expensive meals or travel expenses not related to the conference will not be reimbursed.

DEPARTMENT OF MEDICINE

INTERNAL MEDICINE RESIDENCY PROGRAM

POLICY ON ELECTIVES

1. Categorical residents are allowed up to 6.5 months of total elective time over the course of their three year categorical residency.

    a. Two months of the 6.5 elective months MUST be taken as ambulatory electives (i.e., not inpatient consult based, but rather outpatient office based).
    b. During each of the other 4.5 elective months, residents must arrange to attend one half day subspecialty ambulatory/clinic session per week. This must be documented on the "Request Prerequisite Form" (see below).
    c. Compliance with the above two rules is essential to ensure the training program remains compliant with the ACGME requirement that 33% of your internal medicine residency occur in the ambulatory setting.

2. Preliminary PGY-1 residents are allowed 1 month of elective.

3. Duties and Professionalism during elective time:

    a. Although efforts will be made to protect elective time, especially electives that are important for securing fellowship or jobs, house officers should expect some jeopardy or other weekday/weekend assignments during their elective time (except during away electives outside of New York City). House officers that want to ensure they have a free weekend during elective MUST submit this in advance as a request to the appropriate scheduling chief resident.
    b. While on electives, house officers may not change their schedule without the permission of a chief medical resident or a program director. For example, if you are on a subspecialty elective and your subspecialty faculty supervisor says you "don't have to come in on Monday or Tuesday", this has to be approved by a chief medical resident or program director. Employees cannot take "days off" from paid employment. Vacation days should be used for such instances.

4. Residents MUST be reachable by pager at all times when on <u>any elective</u> (other than away electives outside of New York City).

5. To arrange an elective within a Division of the Department of Medicine, residents should:

    a. Decide what elective you want to do (feel free to speak with the chiefs, a faculty member or a program director for advice/assistance).
    b. Speak to Cynthia Dominguez or Joan Neufeld about scheduling it.
    c. Fill out and have signed the "Request Prerequisite Form"

6. To arrange an elective outside the Department of Medicine at Beth Israel Medical Center, residents should:

a. Fill out the "Out Rotation" forms and other paperwork for these electives (see Joan Neufeld or Cynthia Dominguez).

7. AWAY Electives (Electives outside of Beth Israel Medical Center) are a limited resource for all training programs at the institution. The IM Residency has established guidelines for use of this limited resource:

    a. To participate in an away elective, a resident must be in satisfactory academic and professional standing in the program.
    b. All away electives must be approved by a resident's program director buddy.
    c. Generally speaking these are offered on a first come, first serve basis, consistent with the guidelines herein and the total number of away electives available to the IM training program overall.
    d. No away electives may be taken in the PGY-1 year.
    e. The experience sought must be something not available at Beth Israel Medical Center.
    f. The experience must be in the area of internal medicine or in a subspecialty of internal medicine or a related area (such as public health). Away electives in areas outside medicine (radiology, pathology, anesthesiology, etc) are not allowed.
    g. The away elective should be directly related to an upcoming fellowship or job application.
    h. Away electives may not be taken after a resident has matched for fellowship or has secured a job for after training.
    i. Residents may not request or sign up for an away elective without a specific experience, rotation and location already determined.
    j. Residents must have all completed documentation submitted to the IM Program Office at least 90 days before the start of the elective. Away electives require special agreements between institutions that can take months to establish (legal review and GME review are needed)—so following this timeline is critical to setting up an away elective. Residents should speak with Cynthia Dominguez for guidance on paperwork.

8. Research Electives

    a. Fill out the "Out Rotation" forms and other paperwork for these electives (see Joan Neufeld or Cynthia Dominguez).
    b. The Centers for Medicare and Medicaid Services has ruled that residents may only engage in research that is directly related to the diagnosis or treatment of an individual patient. To satisfy this requirement, all residents on research elective must link their research to a specific patient. This requires two things:

        i. The identification of an individual patient or patients, including MR#. This can be a patient you are seeing currently or had seen in the past, either in the inpatient or outpatient setting.
        ii. A short presentation of your research to your colleagues, as scheduled by the chief residents.

DEPARTMENT OF MEDICINE

UNIVERSAL POLICY ON MOONLIGHTING

The institutional policy and procedure for moonlighting is on the GME website: www.bethisraelgme.org, "Forms/Requests", "Moonlighting + House physician & Attestation Form".

- Internal Medicine house staff are not permitted to moonlight.
- Fellows may not moonlight at their level of training. For example, a cardiology fellow may not moonlight in a CCU or as a cardiologist. A pulmonary fellow who has completed training in internal medicine who is Board Eligible or Board Certified in internal medicine can moonlight as an internist.
- Fellows cannot be paid for moonlighting until the Departmental "Moonlighting Certification Form" has been signed by the trainee and the Fellowship program director and submitted to the IM Program Office. This form is available from the Fellowship administrators or the IM Program Office.
- To moonlight, a trainee must be credentialed by the Department of Medicine.
- Learn and Earn Medical Residents may only moonlight during the "Earn" portion of their residency program.
- Moonlighting of fellows is approved at the discretion and with the approval of the Fellowship program director and/or the IM program director.
- Residents or fellows requesting permission to moonlight must be in good standing.
- Moonlighting activities must not interfere with trainees' ability to achieve the goals and objectives of the educational program.
- All duty hours regulations must be followed for all types of moonlighting.

The Department or Division will monitor the resident or fellow for fatigue and any decline in performance. It is the policy of the Department of Medicine that all moonlighting (internal and external), when combined with the house officer's scheduled hours, must fall within all duty hour regulations – maximum 80 hours per week; minimum 24 continuous hours off every seven days; no more than 24 hours continuous patient care responsibilities; no more than 3 hours sign over following 24 hour shifts; no more than 12 hour shifts in the emergency room; all assignments separated by 8 to 10 hours of off-duty time.

Prior to submitting packets to either the GME office or the Office of Credentialing Services at Beth Israel or other institutions, the house officer is responsible for determining all of the requirements and the assembly of the supporting letters and documentation.

UNIVERSAL DEPARTMENTAL POLICY ON EVALUATION, RESIDENT/FELLOW PERFORMANCE ASSESSMENT, PROMOTION AND ADVERSE ACTION

BETH ISRAEL MEDICAL CENTER

DEPARTMENT OF MEDICINE

The Beth Israel Department of Medicine and Subspecialty Divisions follow Institutional, American Board of Internal Medicine, ACGME and Departmental guidelines.

EVALUATION

The faculty must evaluate resident performance in a timely manner during each rotation or similar educational assignment, and document this evaluation at completion of the assignment in New Innovations.

Faculty evaluations of residents and fellows submitted via New Innovations are open and may not be kept confidential or anonymous from residents/fellows.

Residents must evaluate their peers, faculty supervisors and students on every rotation, as applicable.

Residents and fellows must be evaluated by faculty, by peers, by non physician staff, by patients and by themselves (self evaluation/reflective exercises).

Peer to peer evaluations are kept anonymous between parties. All programs must distribute peer to peer feedback in a way that **ensures peer to peer anonymity**. This should include appropriate spacing of provision of feedback and removal of identifying comments (without alteration of the essential content of the evaluation), and other methods as appropriate.

Resident/Fellow evaluations of faculty must always be kept anonymous to faculty.

Residents and faculty must each be provided the opportunity to evaluate the program or fellowship anonymously each year. All programs must evaluate this feedback and document an action plan for improvement for selected areas.

Individual faculty performance as it relates to the teaching program must be reviewed at least annually and this evaluation must be documented. This is done by the appropriate Division Chief, and must include anonymous evaluations from the medical residents/fellows as appropriate.

PERFORMANCE ASSESSMENT AND PROMOTION

<u>Sources Used for Performance Assessment</u>

Performance assessment is structured around the six ACGME Core Competencies. Performance assessment comes from faculty, peer, program director, nurse manager and program office staff evaluations (narrative and/or numerical) and from less formal sources, including but not limited to: discussion and input with/from peers, chief residents, supervising physicians, other program or hospital staff, as well as e-mail communications. This informal information is critical to understanding trainee performance, complements written evaluations and is considered in

promotion, retention, awarding of credit and decisions to initiate remediation or other adverse action.

How the 1 to 9 Evaluation Scale is Used

The 1 to 9 numerical scale is used in a comparative manner, with performance relative to ones' peers being an important aspect of performance evaluation. Numerical evaluations and numerically anchored descriptors (for example, "unsatisfactory", "satisfactory", "excellent") do not necessarily outweigh or negate performance that is poor relative to one's peers, or inability to meet the necessary performance milestones (see below section on milestones). In addition, comments from evaluations or other forms of communication (as described above) may be weighed at least as heavily.

The American Board of Internal Medicine Committee on Clinical Competence

The IM Residency Training Program convenes the American Board of Internal Medicine Committee for the Evaluation of Clinical Competence four times a year. At this meeting, the proceedings of which are confidential, faculty from different Divisions in the Department of Medicine and chief residents review each and every trainee in the program, and discussion ensues regarding performance as appropriate. Recommendations are made by the Committee to the Program Director, and feedback from these meetings can be an important component of a trainee's performance evaluation. In order to maintain objectivity, the Program Director does not attend these meetings.

Milestones

Trainees must meet the all the milestones for performance for each PGY year in their training program to be considered for credit or promotion (Internal Medicine Residents--see the "Milestones for Credit and Promotion" document, Fellows—refer to appropriate milestones document in your program). Failure to meet certain milestones can be grounds for withholding credit or promotion or other action, at the discretion of the program director. Trainees should be aware that different milestones may exist for credit and promotion (for example, credit for a PGY-1 year in Medicine may be obtained, but a trainee may still not meet the stricter milestones and standards required for promotion to the PGY-2 year.)

FEEDBACK

Residents/Fellows are provided verbal feedback during every major rotation by supervising faculty (and peers as appropriate), and verbal and written evaluation at the end of each rotation. As appropriate, a program director provides the trainee anonymous feedback submitted by their peers, nurse managers and program office staff. Program Directors, Associate Program Directors or their designee provide semi-annual feedback to trainees, which incorporates evaluations by core faculty, peers (peer evaluations are kept anonymous to the trainee), non physician staff and other sources. Trainees are given feedback on strengths and suggestions to improve performance. Peer feedback is distributed at intervals and in a manner that ensures preservation of anonymity.

PROFESSIONALISM EXPECTATIONS

All trainees are required to always demonstrate satisfactory interpersonal and communication skills and satisfactory professionalism (the individual physician's commitment to the patient that ensures patient safety, and respectful behavior to all other members of the medical center, including but not limited to other trainees, faculty, program support staff, nurses, social workers, patient care assistants and other support staff), and ethical behavior in all situations.

Variable performance in professionalism is considered unsatisfactory, and may result in a "marginal" rating or a determination of unsatisfactory performance submitted to the American Board of Internal Medicine.

Key aspects of demonstrating satisfactory professionalism are the timely completion of evaluations, medical records, duty hours and other required paperwork or tasks required of trainees (for example, participating in interviews with IPRO, or other departmental, programmatic or institutional initiatives that comply with ACGME regulations.) In addition, regular checking of a trainee's institutional e-mail account (every 36 hours at a minimum, unless on vacation or leave), and timely and appropriate responses to e-mail communications are considered essential aspects of professionalism and must be met consistently for performance to be considered satisfactory. In addition, adherence to dress codes and maintaining a professional appearance consistently is required for satisfactory performance.
Trainees may not make any changes to their annual, inpatient, ambulatory, elective, call or other schedules without the direct approval of a chief resident (for medicine house officers) or a program director, unless another process is specified locally (by a fellowship program director, for example). Acting in violation of this policy is grounds for disciplinary action including but not limited to remediation, probation or other adverse action.

In addition to clinical competence and professionalism, the trainee must demonstrate participation and competence in research as required by the training program and at the discretion of the program director.

Performance evaluations that are less than fully satisfactory in any of the ACGME Core Competencies are grounds for remediation, warning, probation, repeating part or all of the curriculum, a decision to withhold promotion, a decision to not grant credit, to withhold contract for the subsequent year, or for termination.

REMEDIATION

If the Training Program receives feedback or notices that a trainee's performance is not satisfactory, the trainee may be placed into remediation. Remediation may be initiated if performance improvement and coaching is required in one or more of the ACGME core competencies or milestones. The goal of remediation is always to improve the trainee's performance, and is viewed as a developmental (not punitive) measure.

1. The trainee meets with the Program Director or their designee (for example, an Associate Program Director/Chair/Division Chief)

2. The Program Director may request an Employee Health Services evaluation of the trainee.

3. The PD provides the trainee with a written letter or e-mail communication describing deficiencies and outlining a plan to remedy the deficiencies.

4. The plan outline is organized by the ACGME core competencies and includes:
    a. the action steps that the trainee must follow;
    b. the timeline for the steps to be completed;
    c. the reporting/monitoring to occur while the plan is being followed;
    d. the time of next meeting and feedback with the PD.

5. The action steps are individualized and may include (but are not restricted to):
    a. Enhanced supervision;

b. Modified assignments;
c. Adjusted workload;
d. Special reading/reporting;
e. Suggested/required consultation outside of the division/department.

6. A letter is signed by the program director and house officer, acknowledging that his/her performance and the remediation plan have been discussed. (E-mail communications between both parties can suffice.)

7. The faculty or Chief Medical Resident(s)/Chief Fellow responsible for the remediation will report periodically to the Program Director.

8. Successful remediation will not result in an adverse decision.

Failure to accomplish the goals of remediation may be cause for an adverse decision such as probation or termination. Failure to participate in remediation may also be cause for probation or termination.

DETERMINATION OF ADVERSE DECISIONS

(PROBATION, TERMINATION, NON-PROMOTION, NON-RENEWAL, NON-CREDIT)

- The Program Director will receive the remediation report.
- **Medical Residents:** The Program Director, Associate Program Directors, Chairman of the Department of Medicine and Vice Chair of Clinical Affairs constitute a Committee that will convene and make a determination regarding adverse decision based on the results of the remediation.
- **Fellows**: The Division Chief and Program Director with or without the Internal Medicine Residency Program Director will make a determination based on the results of the remediation.

Probation may be a period of heightened supervision with or without restriction of certain duties, strict and/or frequent re-evaluation or other approaches at the discretion of the Program Director and in consultation with the Graduate Medical Education Office as necessary.

DEPARTMENTAL DUE PROCESS

Trainees are informed of adverse decisions in as timely a manner as possible. In most circumstances the trainee is given a period of heightened supervision and remediation (and sometimes probation) to correct areas of deficiency.

Following re-evaluation, if the trainee has not demonstrated satisfactory improvement in the areas outlined (failure to remediate), the trainee may be subject to non-renewal, a decision of non-credit, repeat of training activities, or termination of employment. Should termination or non-renewal be necessary, every attempt is made to give the house officer 4 months notice prior to the end of the academic year.

When potentially serious problems occur, action will be taken immediately. For example, if there is evidence of egregious behavior in the areas of professionalism or patient care, or potential direct risk to patient care, there need not be a period of remediation or probation. Nevertheless, every attempt is made to support the trainee and provide remediation.

REPORTING AND RELEASE OF INFORMATION

Unsatisfactory professionalism, professional misconduct, termination of participation in the program, non-renewal, non-credit, involuntary withdrawal, withdrawal in lieu of adverse action, suspension, probation and other formal adverse action must be reported to the Beth Israel Office of Graduate Medical Education; to state boards and state agencies as required by individual boards; and to future employers or program directors when verification of training is requested.

It is the policy of the Department of Medicine to never release only partial information about a trainee's performance to a state medical board, potential/future employer or other any entity. This applies not only to written requests but also to verbal communications. Requests that a program director restrict their conversation with future employers or any other entity regarding trainee performance will not be granted.

GME GRIEVANCE PROCESS

Following probation, termination, non-promotion or non-renewal of contract, the trainee has the right to file a grievance with the hospital as outlined in the BIMC Policies and Procedures for House Staff. (http://www.bethisraelgme.org/)

PROCESS FOR ADDRESSING COMPLAINTS BY HOUSE OFFICERS

It is the policy of the Department of Medicine, and of all training programs within the Department, that no retribution or retaliation shall be taken or permitted against any house officer who submits complaints or grievances.

House Officers with complaints or grievances, not pertaining to disciplinary action or professional sanctions, should consider initially bring such grievances to their Program Director or Department Chair. However they may report concerns through any number of venues, and choose the one they are most comfortable with. These include speaking directly with the GME director/office, the Institutional House Staff Committee, the GME appointed ombudsmen, calling Continuum Corporate Compliance Hotline (1-800-692-2353), using the Residency Program's anonymous "suggestion" box off the house staff website, or submitting a concern to the GME office via New Innovations.
If the House Officer's concern remains unresolved, the House Officer may seek assistance through another of the above listed venues.

For IM House Staff, an anonymous online "suggestion box" exists, and submissions to this are review weekly by the program directors and chief residents for appropriate response. Reports of imminent harm or danger to a trainee or any other person should not be reported through this venue, as it is checked only weekly.

Should the House Officer's complaint remain unresolved after taking these measures, the House Officer is entitled to a hearing. The House Officer must request such hearing in a letter to the Chief of GME, describing the grievance and the attempts made to resolve it. The Chief of GME will inform the Chair and Program Director of the House Officer's Department/Program that a hearing has been requested. The Chief of GME will appoint an ad hoc Committee within two weeks, consisting of: 1) a Program Director or Chair who will serve as the Committee Chair; 2) a Senior Faculty member; and 3) a House Officer, none of whom shall be from the House Officer's Department/Program, to review the issue. Within two weeks, the Committee shall interview the House Officer, the Program Director, and other persons as deemed necessary, and present a written recommendation to the Chief of GME within two (2) weeks of the hearing. The report and recommendations of the Committee will be presented at the next GMEC meeting and a final decision and/or recommendation shall be made by the GMEC. The GMEC will monitor implementation of all such decisions.

Please see (http://www.bethisraelgme.org) for updated Institutional Policy.

DEPARTMENT OF MEDICINE

POLICY ON LEAVE AND ABSENCE FROM THE PROGRAM

It is the resident's/fellow's responsibility to refer to the BIMC Institutional Policies and Procedure Manual found at www.bethisraelgme.org [1]for updated policies, to their Program Manager or Coordinator &/or GME Office and subsequently to Human Resources, and the Benefits Office to ensure that they comply with all institutional contractual obligations.

ADMINISTRATIVE SUPERVISION OF HOUSE STAFF AND FELLOWS

Medical house staff operate under the administrative supervision of the Residency Program Office and may not be released from any duty without the approval of a chief resident or a program director. House officers rotating in a Division within the Department or in another Department must clear all schedule changes with the Residency Program Office. Division or other Departmental faculty are not authorized to release internal medicine house officers from paid work days, duty or educational activities at BIMC. During certain times (hospital holidays, for example), the duties of a medicine house officer rotating within a Division can be set by and aligned with the duties of those in the Division, but in general, permission for any schedule changes should be cleared by the house officer with Residency Program Office.

It is the medicine house officer's responsibility to be aware of the above policy and act accordingly.

Fellows operate under the administrative supervision of their program director, Division Chief, and/or Divisional administrative staff. The Internal Medicine Residency Program Office is always available for guidance and advice on all matters relating to Fellows.

AMERICAN BOARD OF INTERNAL MEDICINE REQUIREMENTS

All trainees must comply with the American Board of Internal Medicine requirements. The American Board of Internal Medicine allows only one month of absence per academic year, inclusive of vacation, sick time and any other time out of the program (for example, jury duty).

Further, the ABIM does not allow vacation to be "forfeited" for any reason.

The ABIM states: "Up to one month per academic year is permitted for time away from training, which includes vacation, illness, parental or family leave, or pregnancy-related disabilities. Training must be extended to make up any absences exceeding one month per year of training. Vacation leave is essential and should not be forfeited or postponed in any year of training and cannot be used to reduce the total required training period. ABIM recognizes that leave policies vary from institution to institution and expects the program director to apply his/her local requirements within these guidelines to ensure trainees have completed the requisite period of training."

The Departmental vacation/leave policy below is designed to allow the resident/fellow maximum flexibility.

VACATION / LEAVE

The Department of Medicine House Officer policies are constructed to comply with ABIM policies. Therefore, we provide **2 weeks of vacation** and **2 weeks of additional leave** per

[1] Username and password may be obtained from the program Coordinator.

academic year which may be taken as vacation or for other reasons. Scheduling for vacation or leave must occur with the approval of the department/division. In emergency situations and for prolonged illness, the Department and its Divisions will provide support for coverage arrangements.

PAID SICK LEAVE

Paid sick leave is 1 day per month (12 per year). Unused sick days are not rolled over to the next year. The Department of Medicine Policy is that all 12 days are available at the beginning of the year. House officers absent in excess of one (1) calendar week to a medical condition or to give birth must initiate a "Leave of Absence" claim (please see http://intranet.chpnet.org/ click "Human Resources", click "**Leaves of Absence**", "**Policies and Procedures", BI/SLR)**. To return to duty, house officers must obtain a "fit for duty" clearance from Employee Health Services.

PARENTAL LEAVE, FAMILY MEDICAL LEAVE ACT (FMLA), NON-FMLA

Leave under FMLA, like all other leave, must comply with the time allowed by the respective Residency Review Committee and Specialty Board, or the House Officer may be unable to graduate as originally scheduled.

House Officers should consult Human Resources for further requirements for taking leave under the FMLA, including application forms and documentation requirements. House Officers are subject to the Medical Center's FMLA policy, and non-FMLA policy, except to the extent it is inconsistent with anything in this section. Please refer to the Beth Israel GME website at www.bethisraelgme.org

PAID DAYS FOR BIRTH OR ADOPTION OF A CHILD

Three (3) days parental leave (either sex) is provided for birth/adoption, however trainees must keep in mind the ABIM requirements that limit time away from the program (see above).

COMPASSIONATE LEAVE FOR NEW HOUSE OFFICERS

First year trainees (including categorical and preliminary interns and first year fellows) are not covered by the FMLA (Family and Medical Leave Act). However, the institution's Compassionate Leave Policy is in recognition that new trainees may need leave in certain instances that would have been available under the FMLA. Refer to Policy and Procedure for House Staff Section HS 44 www.bethisraelgme.org

SICK TIME

Provision is made for sick time during training. There is no official "payback" policy in any training program within the Department. However, under certain circumstances, program directors (or their designees) may redistribute duties at a later point to ensure professionalism and to ensure the equitable distribution of duty among residents and fellows at a given level of training and adequate exposure of the individual house officer to training areas, including emergency medicine and continuity patient care experience. It also ensures that each house officer understands the systems-based practice aspects of physician coverage and the professionalism required in a collegial relationship with covering physicians.

NEEDLE-STICK INJURIES

House officers who sustain needle-stick injuries deal with a considerable psychological impact as well as the practical matter of getting tested, initiating medications, etc (see BIMC Institutional Policies and Procedure Manual www.bethisraelgme.org . Residents and Fellows in the Department of Medicine are excused from their duties for that day.

SICK LEAVE/ABSENCE PROCEDURE

In the event you can not report to work, contact your program[2] immediately so that coverage can be arranged. In certain circumstances, the program may require a note from your physician or Employee Health Service to be brought to the Residency Program Office before you are excused from duty. Failure to notify the training program of the need for leave late in pregnancy, planned medical leave or other pre-planned leave is unprofessional as it does not enable proper patient coverage and will disrupt the schedule of your colleagues unnecessarily. In certain cases such behavior could be grounds for disciplinary action or dismissal from a training program.

PROLONGED ILLNESS

The issues arising from prolonged absence secondary to illness will be dealt with on an individual basis regarding ABIM and other educational requirements. Every consideration will be given to making the house officer's transition back to work comfortable.

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[2] Internal Medicine Residents: consult the current policy on sick call procedures posted on the website, distributed to you by email or in the house staff manual. **It is your responsibility to know what the current policies are. Changes made to your ambulatory care sessions or inpatient schedule without approval of a chief resident (and in certain cases a program director) could be grounds for disciplinary action or even dismissal from the training program.**

DEPARTMENT OF MEDICINE

POLICY ON SELECTION OF RESIDENTS/FELLOWS

The Department of Medicine at Beth Israel Medical Center offers Internal Medicine residency training as well as several different fellowship training programs. Applications are requested through ERAS (Electronic Residency Application System) or via phone, fax, mail or E-mail to the respective Program Director. The evaluation criteria described below are applied to all applicants, whether through or outside of the NRMP. All applicants selected for interview are provided with access to the terms and conditions of employment.

All applicants to the Internal Medicine Residency Training Program must submit their application through ERAS. Applications not submitted through ERAS will not be considered.
The selection process, whether through or outside of the NRMP, seeks to attract individuals of high quality. All applicants must be graduates of an LCME (Licensing Committee for Medical Education), AOA (American Osteopathic Association), or ECFMG (Education Committee for Foreign Medical Graduates) approved program. None of the BIMC programs discriminate with regard to sex, race, age, religion, color, national origin, disability, sexual preference or any other applicable legally protected status.

We seek highly motivated house officers with strong academic performance, technical performance and communication skills who practice medicine with an open, inquisitive and cooperative spirit. The selection process does not rely solely on scores from standardized examinations or transcripts. Examinations, transcripts, curriculum vitae, letters of recommendation, research background, research potential and personal qualities and interactions are all considered. Our programs offer flexibility to accommodate physicians with a range of potential career interests including clinical practice, clinical research, and bench (molecular or physiological) research. The Program Director or his designee reviews the submitted applications. One or more of the key faculty members of the program interviews selected applicants. Key faculty members, Program Director and Division Chief rank the applicants using information from their interview assessments before the rank order list is submitted to the NRMP (if applicable) or prior to offering positions directly to eligible individuals for those programs that do not participate in the NRMP.

All applicants for fellowship positions must be specialty certified by the American Board of Internal Medicine (ABIM), or have obtained all of the qualifications to sit for the ABIM examination (including evidence of satisfactory completion of residency training), or present equivalent credentials acceptable to the RRC, GME, the Department of Medicine and the respective Division.
Fellowship applicants must demonstrate passage of the USMLE Step 3 or COMLEX 3 in order to start as a fellow at Beth Israel Medical Center. Having taken the exam before starting fellowship is not sufficient; documentation of passing the exam is required to begin training.

Any trainee transferring into a Department of Medicine training program, from any other program (a separate institution, separate discipline within Beth Israel, or from the Internal Medicine Training Program into any Fellowship Training Program), must provide written documentation from their Program Director or Chair of proficiency in each of the six ACGME core competencies. In addition, a list of completed rotations and evaluations must be provided to the receiving program (this does not apply to incoming fellows who have just completed residency training).

In addition to the above, all applicants must be compliant with the GME requirements stated in the Institutional House Staff Policies and Procedures Manual http://www.bethisraelgme.org/ login prior

to appointment. Note that this includes a requirement that all residents must pass Step 2 CK and Step 2 CS or COMLEX 2 in order to have promotion to, and contract offer for, the PGY-2 year in any Beth Israel Residency Training Program**.**

All applicants selected for residency (or a fellowship position) for the 2010—2011 academic year and beyond must take and pass USMLE Part 3 and/or COMLEX 3 prior to beginning the PGY-3 year in order for a contract to be offered. Residents and Fellows must seek and complete Board Certification, where available, upon completion of their training program.

FELLOWS:

To be offered a contract and train as a Fellow in any Division in the Department of Medicine, documentation of PASSAGE of either USMLE Step 3 and/or COMLEX 3 must be submitted prior to the beginning of training.

No exceptions are made to this institutional policy.

MILESTONES FOR CREDIT AND PROMOTION

DEPARTMENT OF MEDICINE

INTERNAL MEDICINE RESIDENCY TRAINING PROGRAM

This document outlines the overall educational goals of the training program, (referred to as "milestones") for trainees in the Internal Medicine Residency Training Program. They are intended to serve as a "road map" that lets residents know what overall educational and performance goals exist for each level of training. They are organized by the six ACGME Core Competencies, and center around the Program's goal of training residents to be well rounded internists through the provision of graded, progressive responsibility. They are based on ACGME and ABIM requirements and recommendations, in addition to those of the Department of Medicine, Beth Israel Medical Center, Continuum Health Partners, and the Internal Medicine Residency Training Program.

This document complements the individual goals and objectives outlined in the educational curriculum for each rotation/assignment, and the House Staff Manual of Policies and Procedures.

Please note that for the PGY-1 year, there are two sets of milestones — one set for obtaining credit, and a stricter set for achieving promotion to the PGY-2 year.

MILESTONES FOR "SATISFACTORY" PERFORMANCE TO OBTAIN CREDIT FOR THE PGY-1 YEAR:

Consistency of performance must be present throughout the year for the milestones in the areas of Interpersonal and Communication Skills and Professionalism. For milestones in the other Core Competencies, a pattern of appropriate, progressive competence and development must exist.

Patient Care:

1. Provide ongoing primary care, under resident and faculty supervision, for six-10 inpatients, including order writing, test ordering and accurate and complete documentation of daily events, events while on call and procedures.
2. Take a systematic, clear and logical history on patients.
3. Perform an accurate, complete and appropriately thorough physical examination.
4. Demonstrate clear, accurate and complete admission, daily progress and transfer notes, and discharge summaries. Notes must be original (not copied) and well-organized. Admission and transfer notes must reflect thorough chart review.
5. Demonstrate thorough review of laboratory and test results, with clear documentation.
6. Demonstrate consistent knowledge of patient status, physical findings, tests performed and results of consultations on rounds.
7. Demonstrate consistent careful and thorough handoffs to peers.
8. Demonstrate consistent completion of handoff tasks from peers.
9. Provide care for three to four patients in one afternoon session in the ambulatory setting.
10. Perform and facilitate accurate and timely medication reconciliation both upon admission and upon discharge.
11. Explain the purpose of any new medications given to patients during a hospital stay, and explain the possible side effects of medications a patient is receiving in a way that they can understand.
12. Perform and the Universal Protocol (aka "time out") for all procedures that require consent (including but not limited to lumbar puncture, paracentesis, central line placement, etc).

Medical Knowledge:

13. Demonstrate the ability to construct a pertinent, focused differential diagnosis.
14. Demonstrate choice of appropriate diagnostic tests for common medical problems.
15. Demonstrate knowledge of pathophysiology of one's own patients.
16. Demonstrate practical clinical knowledge necessary to care for hospitalized and ambulatory patients under resident direction.

Practice-Based Learning and Improvement:

17. Demonstrate the ability to identify strengths, limits and deficiencies in one's knowledge and expertise.
18. Participate in the education of patients, families, medical students, other house staff and other health professionals as appropriate.

19. Systematically analyze one's personal practice using quality improvement methods, and implement changes with the goal of practice improvement.
20. Use information technology to optimize learning and patient care.
21. Attend the required departmental conferences unless excused for valid reasons by chief medical residents or program directors.
22. Demonstrate awareness of and use of the educational curricula for each rotation.
23. Complete all evaluations at the conclusion of each rotation, including providing constructive comments and formative feedback for peers and faculty.
24. Demonstrate ability to receive, respond appropriately to, and incorporate formative feedback into one's daily practice. Such feedback may come from faculty, program directors, chief medical residents, but also from other house staff, medical students, nurses, social workers, physical therapists, patient care assistants, patients or families, other hospital staff and administrators, members of other departments, and the staff in the IM Program Office.

Interpersonal and Communication Skills:

25. Communicate effectively and appropriately with patients, families and the public, as appropriate, across a broad range of socioeconomic backgrounds.
26. Communicate effectively and respectfully with other physicians, other health professionals and health related agencies, including but not limited to nurses, social workers, patient care assistants, members of other departments, attending physicians, peers and the staff of the IM Program Office.
27. Maintain comprehensive, timely and legible medical records, including but not limited to admission history and physicals, daily progress notes, on-call follow up or incident/event notes, and ambulatory notes.
28. Demonstrate fluency in English.
29. Treat patients with courtesy and respect.
30. Listen carefully to patients.
31. Explain things to patients in ways that they can understand.
32. Answer patient and family questions with patience and concern.
33. Demonstrate ability to maintain open and appropriate lines of communication and notification with the supervising resident and attending physician, as appropriate for a situation.

Professionalism:

34. Wear your hospital issued ID Badge on your outermost garment at chest height at all times while on hospital premises, including in non clinical areas of the institution.
35. Dress appropriately, maintain a neat and clean appearance at all times while on hospital premises and abide by the Institutional and Departmental dress codes.
36. Demonstrate compassion, integrity and respect for others.
37. Demonstrate a responsiveness to patients' needs that supersedes self interest.
38. Demonstrate respect for patient privacy and autonomy.
39. Demonstrate accountability to patients, families, society, and the Profession.
40. Demonstrate a sensitivity and responsiveness to a diverse patient population, including but not limited to gender, age, culture, race, religion, disabilities and sexual orientation.

41. Arrive on time to all required assignments and rotations and depart at appropriate times.
42. Inform the chief medical residents and the residency manager of all absences according to protocol.
43. Demonstrate consistent professional communication with nurses, social workers, patient care assistants, members of other departments, attending physicians, peers and the staff of the IM Program Office.
44. Complete all evaluations at the conclusion of each rotation, including providing constructive comments and formative feedback.
45. Comply with all aspects of the Continuum Health Partners Code of Conduct (available on the CHP website.)
46. Comply with all Continuum Health Partners Policies and Guidelines (available on the CHP website.)
47. Be familiar with and complete the required paperwork for elective and research requests, and for travel to conferences, and understand that if paperwork is not submitted on time, requests will not be honored.
48. Report ACGME duty hours and patient cap violations to the chief medical residents or program directors.
49. Log duty hours on New Innovations truthfully and in a timely way for every rotation.
50. Complete the confidential annual ACGME survey of the program.
51. Be aware that changes to one's continuity clinic or schedule must be made only according to current protocol. A resident may not change their continuity clinic schedule without the permission of a chief resident or a program director (permission from the ambulatory preceptor is not sufficient).
52. Interact professionally with team members and ancillary personnel in the care of patients, with thorough attention to "coverage" and handoff issues.
53. Perform unsupervised only those procedures for which certification of competence has been documented, except in the case of a medical emergency.
54. Check hospital issued e-mail account at least every 36 hours unless on vacation or leave of absence, and respond promptly, especially to e-mail from the chief medical residents, the program directors, and the IM Program Office staff.
55. Follow through on commitments (for example, attending committee meetings, timely completion of remediation exercises.)
56. Be available for jeopardy call as assigned.
57. Do not "cut and paste" information in progress notes, discharge notes, or handoff databases. Information that is "cut and pasted" and is inaccurate, or is plagiarized, is considered a serious professionalism violation and one that can compromise patient safety, confidentiality and quality of care.
58. Schedule vacation responsibly and professionally.
59. Failure to complete all end of year duties (including but not limited to: sick call, clinic sessions, call, clinical assignments, end of program documentation including leaving accurate forwarding/contact information and following appropriate "check out" procedures) without written approval from a program director constitutes a serious professionalism violation and will result in this being noted on verification of training requests from all employers, hospitals, fellowship programs, secondary programs (for preliminary house staff) and state licensing agencies and all other requesting organizations for the duration of the trainee's career. In addition, addenda to

previously issued paperwork or verification of training (for example, for preliminary house staff) will be issued to include such professionalism violations.

Systems-Based Practice:

60. Work in interprofessional and multidisciplinary teams to enhance patient safety and improve patient care quality.
61. Participate in identifying systems errors and implementing potential systems solutions.
62. Promote and facilitate continuity of patient care between inpatient and outpatient settings.
63. Appropriately notify attending physicians of patient admission, transfer, change of status, and discharge.
64. Document performed procedures, and ensure sign-off by the physician who supervised the procedure.
65. Log duty hours on New Innovations truthfully and in a timely way for every rotation.
66. Complete medical records in a timely way.
67. Complete all evaluations at the conclusion of each rotation, including providing constructive comments and formative feedback as appropriate.
68. Participate in ambulatory quality improvement projects under the direction of the ambulatory faculty mentor.

Clinical Judgment:

69. Recognize the patient in trouble.
70. Know when to call for help.
71. Be able to appropriately prioritize patient needs.

MILESTONES FOR PROMOTION TO THE PGY-2 YEAR

The PGY-2 must be a role model and a leader for the team. The PGY-2 establishes the standard for patient care within the team. The PGY-2 must be able to step in and support the intern, sub intern or medical student. The PGY-2 must have demonstrated the responsibility to stay with the sick patient until continuity of care is established. The milestones and criteria for promotion are thus in addition to and more rigorous than the milestones required for credit as a PGY-1 and take into account the acuity of the patients on the inpatient medical service at Beth Israel Medical Center and the patient volume and workload at this large New York City Hospital in both the inpatient and outpatient settings. Consistency of performance is even more critical for the supervising resident, as lapses in care and lapses in judgment can result in severely adverse patient outcomes. Thus ability and capacity alone do not satisfy the requirements for promotion —consistency of performance is required for promotion. The trainee should be aware that special importance is placed on professionalism and interpersonal and communication skills. The Joint Commission supports the view that poor interpersonal and communication skills are not only unprofessional but threaten patient safety. Serious or repeated lapses, or failure to implement feedback, in professionalism or interpersonal and communications skills are grounds for non-promotion or other adverse action. Failure to respond to remediation could be grounds for probation or dismissal.

Examination Requirements: (NOTE: These are BIMC Institutional requirements for all training programs)

For graduates of medical schools in the US or Canada that are accredited by the LCME:

The USMLE Step 2 must be passed before the beginning of the PGY-2 year. Failure to have results of passage of the USMLE Step 2 exam available before the beginning of the PGY-2 year will result in termination from the medicine residency training program at the end of the PGY-1 academic year.

Starting July 1, 2009 house staff are required to take the USMLE Step 3 exam in the PGY 2 or 3 year. House staff are not required to pass.

For house staff entering training July 1, 2010 and beyond, all house staff are required to pass the USMLE Step 3 exam before the beginning of their PGY-3 year. Failure to have results of the passage of the Step 3 exam available before the start of the PGY-3 year will result in termination from the training program.

For graduates of Colleges of Osteopathic Medicine in the United States accredited by the American Osteopathic Association (AOA):

All graduates of osteopathic colleges are required to successfully pass COMLEX Part 2 or USMLE Step 2 prior to beginning the PGY-2 year. Failure to have results of passage available before the beginning of the PGY-2 year will result in termination from the medicine residency training program at the end of the PGY-1 year.

Starting July 1, 2009 house staff are required to take the COMLEX 3 or the USMLE Step 3 exam in the PGY 2 or 3 year. House staff are not required to pass.
For house staff entering training July 1, 2010 and beyond, all house staff are required to pass the COMLEX 3 or the USMLE Step 3 exam before the beginning of their PGY-3 year. Failure to

have **results of passage** of either of these exams available before the start of the PGY-3 year will result in termination from the training program.

Patient Care:

72. Demonstrate consistent thoroughness and attention to detail.
73. Demonstrate efficiency and organization necessary to lead a team, direct interns and guide students in the care of patients.
74. Demonstrate the ability to set the standard for the team.
75. Demonstrate, throughout internship, consistent review of all labs, ensuring that all patient care issues are settled and that patients will be cared for until transfer if necessary.
76. Demonstrate an accurate and thorough history and physical examination.
77. Demonstrate an independent thought process to form a coherent preliminary analysis and plan.
78. Demonstrate consistent ability to admit up to 5 new admissions and 2 transfers in a 24 hour period.
79. Demonstrate consistent ability to provide ongoing care for up to 10 inpatients.
80. Demonstrate consistent ability to see four or more ambulatory patients in one afternoon continuity session at the General Medical Associates' outpatient practice.

Medical Knowledge:

81. Demonstrate a differential diagnosis appropriate for the patient presentation
82. Demonstrate sufficient knowledge to handle medical emergencies and urgencies, to initiate therapy independently, to know the limits of knowledge, to follow basic protocols and guidelines and to recognize and provide care for the "sick" patient.

Practice-Based Learning and Improvement:

83. Attend, participate and contribute to conference on a regular basis or as requested by the chief medical residents or program directors.
84. Demonstrate knowledge of personal limitations.
85. Demonstrate the ability to provide formative feedback to peers and medical students.
86. Show a willingness and ability to participate in evaluation of performance, self evaluation or other developmental exercises as prescribed by the chief medical residents or program directors.

Interpersonal and Communication Skills:

87. Demonstrate the ability to request consultation and take information and instruction on the telephone.
88. Understand culturally sensitive issues.
89. Demonstrate consistent counseling of patients.

Professionalism:

90. Demonstrate the attitudes of commitment, support and willingness to consistently ensure that patient care is the prime responsibility of the individual and of the team.
91. Establish an acceptably low "no-show" rate in your ambulatory practice.
92. Establish trust with patients, families, peers and staff.
93. Be willing to provide help to colleagues when asked.

94. Ensure patient coverage.
95. Be free of substance abuse or be satisfactorily undergoing rehabilitation or treatment.

Systems-Based Practice:

96. Demonstrate the ability to efficiently supervise a team in the care of patients by establishing progressive independence in planning and coordinating care of patients, understanding the proper use of consultants, demonstrating the awareness of when to call for consultation and what questions to ask.
97. Demonstrate commitment to upholding the standards and goals of The Joint Commission through clinical practice, adequate documentation and participation in audit exercises/chart reviews and other related QI activities of the Department of Medicine and the Institution.
98. Demonstrate ability to provide and adequately document care that satisfies the Center for Medicare and Medicaid Services Core Measures or other key measures of quality of care as identified by the Department of Medicine or the Institution.
99. Consistently document a "Time Out" for all procedures that require consent.

MILESTONES FOR PROMOTION TO THE PGY-3 YEAR

The PGY-3 is a role model and a team leader. The PGY-3 establishes the standard for patient care within the team. Consistency of performance is even more critical for the supervising resident, as lapses in care, judgment or professionalism can result in severely adverse patient outcomes. As with promotion to PGY-2, ability and capacity alone do not satisfy the requirements for promotion to the PGY-3 year. The milestones listed below are in addition to the milestones required for credit for the PGY-1 year and the milestones required for promotion to the PGY-2 year, all of which still apply.

Examination Requirements: (NOTE: These are BIMC Institutional requirements for all training programs)

For graduates of medical schools in the US or Canada that are accredited by the LCME:

Starting July 1, 2009 house staff are required to take the USMLE Step 3 exam in the PGY 2 or 3 year. House staff are not required to pass.

For house staff entering training July 1, 2010 and beyond, all house staff are required to pass the USMLE Step 3 exam before the beginning of their PGY-3 year. Failure to have **the results** of the Step 3 exam demonstrating passage available before the start of the PGY-3 year will result in termination from the training program.

For graduates of Colleges of Osteopathic Medicine in the United States accredited by the American Osteopathic Association (AOA):

Starting July 1, 2009 house staff are required to take the COMLEX 3 or the USMLE Step 3 exam in the PGY 2 or 3 year. House staff are not required to pass.

For house staff entering training July 1, 2010 and beyond, all house staff are required to pass the COMLEX 3 or the USMLE Step 3 exam before the beginning of their PGY-3 year. Failure to have **the results** of the Step 3 exam demonstrating passage available before the start of the PGY-3 year will result in termination from the training program.

Patient Care:

100. Direct a team in safe patient care with appropriate consultation.
101. Master the organizational skills necessary to manage an inpatient team or a consult service.
102. Consistently be able and willing to support the intern, sub-intern or medical student in completion of all patient care responsibilities.
103. Ensure that all labs, results, consultations and clinical status are known and acted on prior to leaving the hospital each day (action may be direct or ensuring handoff of duties appropriately and appropriate for the situation).
104. Personally review radiographic studies when possible.
105. Ensure that continuity of care is established.
106. Demonstrate consistent ability to admit up to 10 new patients and 4 transfers in a 24 hour period.
107. Demonstrate consistent ability to be capably and effectively responsible for the ongoing care of up to 20 inpatients.

108. Exercise accurate clinical judgment in identifying and addressing patient problems.
109. Demonstrate appropriate choice of diagnostic tests.
110. Competently perform procedures.
111. Consistently write resident admission notes that summarize the pertinent positives and negatives of a new admission in an appropriately concise manner, and present a well thought out assessment, differential diagnosis and plan.

Medical Knowledge:

112. Demonstrate knowledge of pathophysiology of a broad range of disease.
113. Demonstrate practical clinical knowledge necessary to care for hospitalized and ambulatory patients.
114. Demonstrate the ability to interpret basic and common tests and data and incorporate these into clinical practice appropriately (for example, a comprehensive metabolic panel, a complete blood count, electrocardiograms and chest x-rays.)
115. Demonstrate ability to formulate and then tailor differential diagnoses for a wide variety of common complaints, conditions and situations.

Practice Based Learning and Improvement:

116. Demonstrate knowledge of personal limitations.
117. Engage in scholarly activity including presentation of resident grand rounds ("journal club"), resident EBM presentation and presentation at resident report. Show appropriate responsiveness to the guidance and timeline requests of the chief medical residents for these activities.
118. Facilitates the learning of students, peers and other health care professionals as appropriate through both direct teaching (for example, on rounds) and collaborative efforts (for example, working with the chief residents on case presentations.)
119. Provide team leadership and establish objectives for the educational content of resident teaching and attending rounds, including the liberal use of literature for the practice of evidence based medicine and preparation of short talks for interns and students apart from attending rounds.
120. Demonstrate commitment to teaching in all activities including work rounds.
121. Mentor junior trainees including review and guidance of history, physical, and case and topic presentations.
122. Demonstrate the ability to construct focused clinical questions in the P-I-C-O (Population, Intervention, Comparison, Outcome) format.

Interpersonal and Communication Skills:

123. Act in a consultative role to other physicians in a timely and appropriate manner.
124. Demonstrate the firmness to establish and uphold team standards.
125. Communicate to all others persons in the medical center with the utmost professionalism, courtesy and respect at all times.
126. Demonstrate the ability to listen to, counsel and educate patients.
127. Create and sustain therapeutically and ethically sound relationships with both patients and families.

Professionalism:

128. Demonstrate consistency in performance of all responsibilities.
129. Demonstrate that one is a “team player” and responds to requests to provide help to other colleagues.
130. Ensure care, handoff and appropriate discharge planning of patients prior to leaving the hospital.
131. Demonstrate consistent commitment to upholding the ethical principles of patient confidentiality and informed consent.
132. Failure to complete all end of year duties (sick call, clinic sessions, call, clinical assignments, documentation, among others) without written approval from a program director constitutes a serious professionalism violation and will result in this being noted on verification of training requests from all employers, hospitals, fellowship programs and state agencies for the duration of the trainee’s career.

Systems Based Practice:

133. Demonstrate knowledge and appropriate usage of follow-up, referral and consultation services in the ambulatory setting.
134. Demonstrate familiarity with practice guidelines.
135. Consider home and family environment from the time of admission.
136. Advocate for quality patient care and assist patients in dealing with health system complexities (such as discharge planning and obtaining follow up.)
137. Execute the duties of the Medical Book Resident and MICU Evaluating Resident with skill and professionalism.

MILESTONES FOR GRADUATION FROM THE RESIDENCY TRAINING PROGRAM

Below are listed the milestones that must be achieved in order for the residency training program to be able to verify that the resident has demonstrated sufficient competence to enter practice without direct supervision. These milestones must be consistently met throughout the PGY-3 year in order to graduate from the program.

NOTE: These milestones are in addition to all previous milestones listed.

Patient Care:

138. Lead a patient care team with minimal requirement for change in management.
139. Demonstrate absence of harmful clinical management.
140. Demonstrate ability to function independently in decision-making.
141. Demonstrate the ability to supervise a team in the intensive care units.
142. Demonstrate the ability to lead a "rapid-response" team at the bedside of critically ill patients.
143. Demonstrate knowledge of medical-surgical issues on the consult service.
144. **Demonstrating and documenting competence in the performance of procedures mandated by the American Board of Internal Medicine. These are:**
    a. **Advanced Cardiac Life Support**
    b. **Drawing venous blood**
    c. **Drawing arterial blood**
    d. **Performing a Pap smear and endocervical culture**
    e. **Placing a peripheral venous line**
145. **Know, understand and be able to explain aspects of the other procedures as specified by the ABIM at: http://www.abim.org/certification/policies/imss/im.aspx**

Medical Knowledge:

146. Demonstrate competence in executing accurate clinical judgment.
147. Demonstrate knowledge of a broad range of common diseases in internal medicine and subspecialties, and knowledge of less common diseases that can cause high morbidity or mortality for patients.

Practice Based Learning and Improvement:

148. Develop a comprehensive approach to learning based on ones own perceptions of gaps in fund of knowledge as well as the results of objective assessments, including the In-training Exam and summative evaluations.
149. Engage in scholarly activity including presentation at national conferences or submission of case reports or another form of scholarly work.
150. Be able to perform primary searches of the literature using commonly available databases (for example, Pub Med or OVID) to answer focused clinical questions.
151. Be able to evaluate the medical literature for validity, results and applicability and incorporate the results of common types of studies (randomized controlled trials,

diagnostic trials, systematic reviews prognostic studies and clinical decision rules) into clinical practice.

Interpersonal and Communication Skills:

152. Demonstrate the ability to resolve conflicts and respond to difficult or demanding patient or family situations with sensitivity, courtesy and respect.
153. Demonstrate the ability to instruct junior trainees in communication and conflict resolution.

Professionalism:

154. Function as a role model and mentor for younger trainees.
155. Provide support and guidance to junior trainees.

Systems Based Practice:

156. Demonstrate the ability to appropriately triage and assign acutely ill patients to a medical service, working cooperatively with other services as necessary.
157. Detect and avoid medical errors in decision making, and be able to analyze and reflect back on “near misses”.
158. Demonstrate knowledge of and use appropriate judgment in clinical settings that a PGY-3 works in.