



**Internal Medicine Residency Program  
Policies and Procedures**

**Academic Year  
2016-2017**

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## *Legends*

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### **Legends**

<b>Acronym/ Indicator</b>	<b>Title or Signifier</b>
ACGME	Accreditation Council for Graduate Medical Education
C.P.R.	Common Program Requirements
GME	MSM Graduate Medical Education Department
PGY-1	Post Graduate Year one also known as “intern,” first year resident, or R1
PGY-2	Post Graduate Year two, second year resident, or R2
PGY-3	Post Graduate Year three, third year resident, or R3

	<b>MOREHOUSE SCHOOL OF MEDICINE</b> INTERNAL MEDICINE RESIDENCY PROGRAM POLICIES AND PROCEDURES	POLICY NUMBER	IM-01
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	<b>SUBJECT: ELIGIBILITY, SELECTION, AND APPOINTMENT OF RESIDENTS AND TRANSFERS POLICY</b>	SUPERSEDES	

## Eligibility, Selection, and Appointment of Residents and Transfers Policy

### I. BACKGROUND

Resident recruitment, selection, and appointment are an essential component of the MSM Internal Medicine (IM) Program and must follow all applicable Morehouse School of Medicine, GME, and ACGME regulations.

### II. PURPOSE

The purpose of this policy is to establish a program policy regarding the selection and appointment of residents.

### III. POLICY

#### 3.1. Resident Eligibility

The following information is extracted from the Accreditation Council of Graduate Medical Education (ACGME) “Institutional Requirements” of the “Essentials of Accredited Residencies in Graduate Medical Education.”

Applicants with one of the following qualifications are eligible for appointment to accredited residency programs:

- 3.1.1. Graduates of medical schools in the United States accredited by either the Liaison Committee on Medical Education (LCME) or the American Osteopathic Association (AOA); graduates of Canadian medical schools approved by the Licentiate of the Medical Council of Canada (LMCC)
- 3.1.2. Graduates of medical schools outside the United States and Canada who have a current and valid certificate from the Educational Commission for Foreign Medical Graduates (ECFMG) prior to appointment or who have a full and unrestricted license to practice medicine in a United States licensing jurisdiction in their current ACGME specialty/subspecialty program
- 3.1.3. United States citizen graduates from medical schools outside the United States and Canada who have successfully completed the licensure examination (USMLE Step 3) in a United States jurisdiction in which the law or regulations provide that a full and unrestricted license to practice will be granted without further examination after successful completion of a specified period of Graduate Medical Education

- 3.1.4.** Graduates of medical schools in the United States and its territories not accredited by the LCME but recognized by the educational and licensure authorities in a medical licensing jurisdiction who have completed the procedures described in the paragraph above
- 3.1.5.** Those who have completed the fifth pathway, a period of supervised clinical training for students who obtained their premedical education in the United States, received medical undergraduate abroad, and passed Step 1 of the United States Medical Licensing Examination
  - 3.1.5.1.** After these students successfully complete a year of clinical training sponsored by an LCME-accredited United States medical school and pass USMLE Step 2 components, they become eligible for an ACGME-accredited residency as an international medical graduate.
  - 3.1.5.2.** The Fifth Pathway program is not supported by the American Medical Association after December 2009.
- 3.1.6.** Applicants who have passed United States Medical Licensing Examination (USMLE) Steps 1 and 2—Clinical Knowledge (CK) and Clinical Skills (CS), or have a full, unrestricted license to practice medicine issued by a United States State licensing jurisdiction.
  - 3.1.6.1.** Selectees cannot begin MSM residency programs prior to passage of the Step 2 Clinical Skills (CS) examination.
  - 3.1.6.2.** This expectation must be met by the time of the MSM-GME Incoming Resident orientation.
- 3.1.7.** Each resident in our programs must be a United States citizen, a lawful permanent resident, a refugee, an asylee, or must possess the appropriate documentation to allow the resident to legally train at Morehouse School of Medicine.
- 3.2.** The program director (PD) is responsible for verification of the applicants' credentials. Applicants who do not meet the criteria above cannot be considered for the MSM IM Residency Program.
- 3.3.** Residency Program Selection Committee
  - 3.3.1.** The IM Residency Program Selection Committee consists of, at a minimum, the program director, associate program directors (APDs), faculty members, and the chief residents. Additional members are included at the discretion of the program director.
  - 3.3.2.** The PD and APDs review applicants and are responsible for selection of applicants for interview.

- 3.3.3.** The Residency Selection Committee members participate in the interview process and, with the program director, determine the final choice of applicants to be ranked in the NRMP match.
- 3.3.4.** The selection committee members review all eligible applicants to the program.
- 3.4.** Resident Selection
  - 3.4.1.** Applicants are selected on the basis of preparedness, ability, aptitude, academic credentials, communications skills, and personal qualities such as motivation and integrity.
  - 3.4.2.** Academic credentials include medical school grades and performance as reflected in documentation received directly from the medical school, and United States Medical Licensing Examination (USMLE) scores.
  - 3.4.3.** Prior graduate medical education training, where applicable, will also be considered.
  - 3.4.4.** Formal educational and/or testing results submitted by the applicant may also be considered. Letters of reference from supervisors, educators, and peers, when appropriate, serve to provide additional information on personal characteristics, and are required and evaluated as well.
  - 3.4.5.** The selection committee then invites selected candidates for an individual interview which is conducted in person. The interview allows in-person confirmation of information provided in the written application as well as an opportunity to assess communication and other non-cognitive skills.
  - 3.4.6.** Confidential evaluations by each applicant interviewer will be collected and reviewed by the selection committee and become part of the application file.
  - 3.4.7.** The committee and the PD are responsible for the final ranking of candidates in the National Resident Matching Program. All current fourth year medical students from United States medical schools are required to apply through the NRMP process or other appropriate match processes. MSM participates in the NRMP All In Policy and programs will only review applications through ERAS.
  - 3.4.8.** NRMP Match:
    - 3.4.8.1.** The NRMP All In Policy requires any program participating in the Main Residency Match to register and attempt to fill all positions through the Main Residency Match or another national matching plan.
    - 3.4.8.2.** This includes all positions that may begin at the PGY-1 or PGY-2 level.
    - 3.4.8.3.** The NRMP will only consider certain exceptions.

- 3.4.8.4.** Program directors and administrators are required to review the terms and conditions of the applicable Match Participation Agreement for their specialty each year and comply with applicable match policies and the Match Commitment, which addresses violations of NRMP Policy.
- 3.4.8.5.** As noted in the Match Participation Agreement, program directors are prohibited from offering positions to ineligible applicants and must use the Applicant Match History in the Registration, Ranking, and Results (R3SM) System to determine an applicant's eligibility for appointment.
- 3.4.8.6.** As per the Match Participation Agreement, the following actions constitute a breach of the applicable Match Participation Agreement:
  - 3.4.8.6.1.** A program requesting applicants to reveal ranking preferences;
  - 3.4.8.6.2.** An applicant suggesting or informing a program that placement on a rank order list or acceptance of an offer during the Supplemental Offer and Acceptance Program (SOAP) is contingent upon submission of a verbal or written statement indicating the program's preferences;
  - 3.4.8.6.3.** A program suggesting or informing an applicant that placement on a rank order list or a SOAP preference list is contingent upon submission of a verbal or written statement indicating the applicant's preference;
  - 3.4.8.6.4.** A program requiring applicants to reveal the names or identities of programs to which they have or may apply; or
  - 3.4.8.6.5.** A program and an applicant in the Matching Program making any verbal or written contract for appointment to a concurrent-year residency or fellowship position prior to the release of the List of Unfilled Programs.
- 3.4.9.** All candidates who are interviewed shall be given a copy of the MSM agreement of appointment and a copy of this policy. Programs will document that the candidate has received a copy of the agreement of appointment by obtaining their signature at the time of interview.



**3.5. Transfers**

**3.5.1.** Before accepting a resident who is transferring from another program, the program director must obtain written or electronic verification of previous educational experiences and a summative competency-based performance evaluation of the transferring resident.

**3.5.2.** Residents are considered as transfer residents under conditions including:

**3.5.2.1.** Moving from one program to another within the same or different sponsoring institution;

**3.5.2.2.** When entering a PGY-2 program requiring a preliminary year even if the resident was simultaneously accepted into the preliminary PGY-1 program and the PGY-2 program as part of the match (e.g., accepted to both programs right out of medical school).

**3.5.3.** The term “transfer resident” and the responsibilities of the two Program Directors do not apply to any resident who has successfully completed a residency and then is accepted into a subsequent residency or fellowship program.

**IV. PURPOSE OF THE PROCESS**

**4.1.** The following components of the resident selection process have several general purposes:

**4.1.1.** First, a specific selection committee reviews all eligible applicants to ensure that all eligible candidates’ applications are given careful, fair, and consistent review.

**4.1.2.** Second, documentation of eligibility and successful performance at the medical school and on required licensure examinations is required to ensure that applicants possess proper academic credentials and are sufficiently prepared to benefit from graduate medical education.

**4.1.3.** Third, letters of reference are required and reviewed to gain insight into the applicant’s personal characteristics such as motivation, integrity, attitude, and ability to work with others, as viewed by a group of educators, mentors, or peers.

**4.2.** Appointment: The following procedure is required before any resident can officially be appointed as a resident:


**4.2.1.** Primary verification of all credentials is required.

**4.2.1.1.** The Residency Program in conjunction with the Office of GME and the Human Resources office will conduct this verification.

**4.2.1.2.** It is the responsibility of the resident to provide sufficient information to allow these verifications to be conducted.

- 4.2.2.** At a minimum, the MSM IM Residency Program must be able to obtain primary source verification of the following elements:
  - 4.2.2.1.** Certification of graduation from any accredited medical school or ECFMG-certified medical institution. This documentation must be submitted directly from the academic institution granting the degree or from ECFMG directly to the residency program.
  - 4.2.2.2.** ECFMG Certification must be current—certification stamped *indefinite* must be submitted with ERAs documents.
  - 4.2.2.3.** Letters of recommendation.
  - 4.2.2.4.** Documentation accounting for any lapses between the end of medical school and the present. Large gaps of time exceeding one month that are not verifiable will disqualify candidates for consideration for a GME program.
  - 4.2.2.5.** Proper documentation of employment and/or work performed since graduation from medical school. The standard for proper documentation will be imposed by the GME program.
  - 4.2.2.6.** Passing a criminal background check.
  - 4.2.2.7.** Passing of all six competencies in a summative evaluation from the program director for any resident or fellow completing training or transferring from preliminary training or another institution.
- 4.2.3.** Applicants who do not meet the criteria stated above cannot be appointed to any graduate medical educational program at the Morehouse School of Medicine.
- 4.2.4.** Completion of primary source verifications renders an applicant eligible for appointment but does not in and of itself result in automatic appointment. Residents are eligible to proceed through the appointment process.
- 4.2.5.** After all information is completed and reviewed, the applicant will be sent a letter of appointment. The official start date is contingent upon the resident completing all required paperwork (demographic/tax form, etc.) clearance by employee health service (resident must submit a complete history and physical form), and appropriate visa, if applicable.

- 4.3.** Monitoring: This process has been reviewed by members of the Graduate Medical Educational (GME) Committee, and agreed upon as a uniform approach to evaluation and selection of residency applicants.
- 4.4.** Ensuring compliance with the eligibility and selection criteria as described above is the responsibility of each program director. Oversight for GME is the responsibility of the designated institutional official (DIO) who monitors program compliance through regular annual program accreditation review and the GMEC who reviews policies and procedures on a regular basis.

	<b>MOREHOUSE SCHOOL OF MEDICINE</b> INTERNAL MEDICINE RESIDENCY PROGRAM POLICIES AND PROCEDURES	POLICY NUMBER	IM-02
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	<b>SUBJECT: TECHNICAL STANDARDS AND ESSENTIAL FUNCTIONS FOR APPOINTMENT AND PROMOTION POLICY</b>		SUPERSEDES

## Technical Standards and Essential Functions for Appointment and Promotion Policy

### I. BACKGROUND

- 1.1. Medicine is an intellectually, physically, and psychologically demanding profession. All phases of medical education require knowledge, attitudes, skills, and behaviors necessary for the practice of medicine throughout a professional career.
- 1.2. Those abilities that residents must possess to practice safely are reflected in the technical standards that follow.
- 1.3. These technical standards and essential functions are to be understood as requirements for training in all Morehouse School of Medicine residencies and are not to be construed as competencies for practice in any given specialty. Individual programs may require more stringent standards or more extensive abilities as appropriate to the requirements for training in that specialty.
- 1.4. Residents in Graduate Medical Education programs must be able to meet these minimum standards, with or without reasonable accommodation.

### II. STANDARDS

- 2.1. Observation
  - 2.1.1. Observation requires the functional use of vision, hearing, and somatic sensations.
  - 2.1.2. Residents must be able to observe demonstrations and participate in procedures as required.
  - 2.1.3. Residents must be able to observe a patient accurately and completely, at a distance as well as closely.
  - 2.1.4. They must be able to obtain a medical history directly from a patient, while observing the patient's medical condition.
- 2.2. Communication
  - 2.2.1. Communication includes: speech, language, reading, writing, and computer literacy.
  - 2.2.2. Residents must be able to communicate effectively and sensitively in oral and written form with patients to elicit information, as well as to perceive non-verbal communications.

**2.3. Motor Functioning**

**2.3.1.** Residents must possess sufficient motor function to elicit information from the patient examination by palpation, auscultation, tapping, and other diagnostic maneuvers.

**2.3.2.** Residents must also be able to execute motor movements reasonably required for routine and emergency care and treatment of patients.

**2.4. Intellectual—Conceptual, Integrative, and Quantitative Abilities**

**2.4.1.** Residents must be able to measure, calculate, reason, analyze, integrate, and synthesize technically detailed and complex information in a timely fashion to effectively solve problems and make decisions, which are critical skills demanded of physicians.

**2.4.2.** In addition, residents must be able to comprehend three-dimensional relationships and to understand spatial relationships of structures.

**2.5. Behavioral and Social Attributes**

**2.5.1.** Residents must possess the psychological ability required for the full utilization of their intellectual abilities, for the exercise of good judgment, for the prompt completion of all responsibilities inherent to diagnosis and care of patients, and for the development of mature, sensitive, and effective relationships with patients, colleagues, and other healthcare providers.

**2.5.2.** Residents must be able to tolerate physically and mentally taxing workloads and function effectively under stress.

**2.5.3.** Residents must be able to adapt to a changing environment, display flexibility, and learn to function in the face of uncertainties inherent in the clinical problems of patients.

**2.5.4.** Residents must also be able work effectively and collaboratively as team members. As a component of their education and training, residents must demonstrate ethical behavior consistent with professional values and standards.

**2.6. Accommodations**

**2.6.1.** MSM will make a reasonable accommodation available to any qualified individual with a disability who requests an accommodation.


**2.6.2.** A reasonable accommodation is designed to assist an employee or applicant in the performance of the essential functions of his or her job or MSM's application requirements.

**2.6.3.** Accommodations are made on a case-by-case basis. MSM will work with eligible employees and applicants to identify an appropriate, reasonable accommodation in a given situation. An accommodation need not be the most expensive or ideal accommodation, or the specific accommodation requested by the individual, so long as it is reasonable and effective.

*Technical Standards and Essential Functions for Appointment and Promotion Policy*

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- 2.6.4.** MSM will not provide a reasonable accommodation if the accommodation would result in undue hardship to MSM or if the employee, even with reasonable accommodation, poses a direct threat to the health or safety of the employee or other persons.
- 2.6.5.** Any decision to deny a reasonable accommodation on the basis of cost will be reviewed and approved by the Chief Financial Officer and Senior Vice President for Administration of MSM.
- 2.6.6.** In most cases, it is an employee's or applicant's responsibility to begin the accommodation process by making MSM aware of his or her need for a reasonable accommodation. See the full MSM Accommodation of Disabilities Policy for information on how to request a reasonable accommodation.
- 2.6.7.** NOTE: It is important to note that the MSM enrollment of non-eligible residents may be cause for withdrawal of residency program accreditation.

	<b>MOREHOUSE SCHOOL OF MEDICINE</b> INTERNAL MEDICINE RESIDENCY PROGRAM POLICIES AND PROCEDURES	POLICY NUMBER	IM-03
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	<b><u>SUBJECT: EVALUATION POLICY</u></b>	SUPERSEDES	

## Evaluation Policy

### **I. BACKGROUND**

- 1.1. Evaluation and feedback are crucial elements of the assessment of learners during their residency training.
- 1.2. The Morehouse School of Medicine Internal Medicine (IM) Program has numerous evaluations in place to help assess the acquisition of the knowledge, skills, and abilities needed to independently practice clinical medicine.
  - 1.2.1. Monthly written evaluations are the main tool used to assess our residents.
  - 1.2.2. Other tools include:
    - Multi-source evaluations (nurses, patients, peers, self)
    - OSCEs
    - Clinical skills exam
    - Mini-CEX
    - Direct observation
    - Continuity clinic evaluations
    - QI project participation and performance
    - Milestone assessments (which generally reflect a composite of the modalities noted above)

### **II. PURPOSE**

The purpose of this policy is to outline the procedures and processes for evaluation of residents, faculty, and the program per ACGME evaluation requirements.

### **III. RESIDENT EVALUATION**

- 3.1. The Clinical Competency Committee (CCC) and the PD are responsible for using all evaluation tools to develop a formative milestone-based evaluation for all residents every six months.

**3.2. Clinical Competency Committee (CCC)**

**3.2.1.** The IM Clinical Competency Committee is expected to monitor resident performance in accordance with ACGME Common and Specialty Program Requirements and the Morehouse School of Medicine (MSM) Graduate Medical Education (GME) policies and procedures regarding promotion and dismissal.

**3.2.2.** The purpose of the CCC is to review resident performance and to make recommendations to the program director for advancement to the next PGY level.

**3.2.3. CCC Composition**

**3.2.3.1.** The program director identifies and appoints 6 to 10 faculty members.

**3.2.3.2.** The members are appointed to the committee for a period of two (2) years as long as they remain active participants.

**3.2.3.3.** The PD, chairperson, and APDs are all members of the committee.

**3.2.4. Committee Responsibilities: The IM Residency Clinical Competency Committee will:**

**3.2.4.1.** Review all resident evaluations by all evaluators quarterly.

**3.2.4.2.** Prepare and ensure the reporting of milestone evaluations for each resident semi-annually.

**3.2.4.3.** Make recommendations to the program director for resident progress including promotion, remediation, and dismissal, following all GME policies as outlined in the MSM GME Policy Manual.

**3.2.5. Meeting Frequency**

**3.2.5.1.** The IM Residency CCC will meet once a month. Generally, meetings will be held on the third Thursday of each month.

**3.2.5.2.** In addition, the IM Residency CCC will agree to meet as necessary, to discuss any urgent issues regarding resident performance or other important program matters.

**3.2.5.3.** The residency program manager or designee will document each CCC meeting with meeting minutes. Minutes will be reviewed for accuracy at subsequent meetings.

**3.2.5.4.** In addition, the CCC's review and recommendation of each resident will be documented in the online residency management system, New Innovations.



**3.2.6. Procedure**

**3.2.6.1.** The CCC shall evaluate all of the residents on a biannual basis and provide consensus recommendations to the Residency Program.

**3.2.6.2.** In addition, if any resident is having academic problems or issues, he or she will be reviewed in discussion at the meeting.

**3.2.6.3.** Assessment tools and evaluation measures include:

- Rotation evaluations (to include input from faculty/ Attendings, other providers, colleagues, and nursing staff (360 evaluations)
- Peer review evaluations
- Didactic evaluations
- Resident portfolios
- In-Training Exam scores
- Conference participation and attendance records
- OSCEs
- Clinical competency exams
- Direct observation activities

**3.2.6.4.** The CCC can set thresholds for remediation, probation, and dismissal.

**3.2.6.4.1.** The CCC will complete a “Notice of Deficiency Form” for all residents who receive an adverse recommendation that will be sent to the PD and designated APD.

**3.2.6.4.2.** The PD or designated APD will meet with each resident and communicate the recommendation and design a remediation or improvement plan.

**3.2.7. Recommendations—**Upon review of each resident’s record, the CCC shall assess resident performance and make the following recommendations to the PD in accordance with MSM’s “Residency Promotion Policy” and “Adverse Academic Decisions”:

**3.2.7.1.** Progression—Resident is performing appropriately at current level of training with no need of remediation.

**3.2.7.2.** Promotion—Resident has demonstrated performance appropriate to move to the next level of training.

- 3.2.7.3.** Notice of Deficiency—Resident has demonstrated challenges in a specific competency or area but does not require remediation.
  - 3.2.7.4.** Notice of Deficiency with Remediation—Resident has demonstrated challenges in a specific competency or area and requires remediation.
  - 3.2.7.5.** Immediate Suspension—Serious misconduct or threat to colleagues, faculty, staff, or patients. Suspension time shall not exceed 30 days in an academic year. Action remains in the resident’s permanent record.
  - 3.2.7.6.** Probation—Resident has demonstrated challenges in a specific competency or area that are disruptive to the program. Probation time shall not exceed six months in an academic year. Action remains in the resident’s permanent record.
  - 3.2.7.7.** Non-Promotion—Resident will not be promoted to the next year of training due to repeated performance or academic deficiencies. Resident’s current level of training will be extended. Action remains in the resident’s permanent record.
  - 3.2.7.8.** Non-Renewal—Resident will not be promoted to the next year of training due to repeated performance or academic deficiencies. Resident’s current level of training will not be extended. Action remains in the resident’s permanent record.
  - 3.2.7.9.** Dismissal—Resident will not be promoted to the next year of training due to repeated performance or academic deficiencies. The resident will be dismissed from the program. Action remains in the resident’s permanent record.
- 3.3.** Inpatient Wards, MICU, and Subspecialties
- 3.3.1.** Interns and residents are evaluated twice a month by faculty during their inpatient and subspecialty rotations at Grady, the VA, and DeKalb Medical Center.
    - 3.3.1.1.** The first evaluation completed is the “Mid-month Evaluation” which is a competency-informed skills checklist that is meant to identify any problem areas and to guide mid-month feedback.
    - 3.3.1.2.** The mid-month evaluation is due by the end of the 18<sup>th</sup> day of the month.
    - 3.3.1.3.** The evaluation is completed in New Innovations by the assigned faculty member and residents can review this after it is signed by the evaluator.



- 3.6.1.** Residents are provided documented semiannual evaluation with feedback. The record of evaluation includes a logbook or an equivalent method to demonstrate that each resident has achieved competence in the performance of invasive procedures.
- 3.6.2.** Every six (6) months the residents meet with the program director or his or her designee (assigned associate program director) to review their performance and progression in the program.
  - 3.6.2.1.** Residents complete a self-assessment prior to their semi-annual evaluation.
  - 3.6.2.2.** During the semiannual meetings, areas of positive performance as well as deficiencies will be identified with a plan for improvement in those areas outlined.
  - 3.6.2.3.** Residents must log their procedure/case logs at least monthly in New Innovations and must ensure that their logs are current before each semiannual evaluation.
- 3.6.3.** At the final summative semi-annual evaluation prior to graduation (May or June of graduation year), the resident's complete performance will be reviewed and the residency director will verify whether the resident has demonstrated sufficient competence to enter practice without direct supervision. This evaluation becomes part of the resident's permanent record maintained by the institution, and is accessible for review by the resident in accordance with institutional policy.
- 3.6.4.** In addition to the monthly evaluation by faculty and other assessments specifically mentioned above, additional methods include:
  - Annual Clinical Competency Exam for interns during their first quarter of residency
  - Narrative evaluations by faculty and non-faculty evaluators (e.g., letters of commendation or concern)
  - Completion of patient safety online modules
  - OSCEs for first and second year residents
  - Patient Satisfaction Surveys
  - Medical records review and Chart Stimulated Recall
  - Oral case presentations during educational conferences
  - Mini-CEX
  - Milestone assessments
  - Self-assessment

**3.7. Faculty Evaluations**

- 3.7.1.** Faculty evaluations are performed annually by the chair of the Department of Medicine, in accordance with the faculty bylaws.
- 3.7.2.** Annually, the Program also evaluates faculty performance as it relates to the educational program. This evaluation includes a review of the faculty's clinical teaching abilities, commitment to the educational program, clinical knowledge, professionalism, and scholarly activities.
- 3.7.3.** Faculty evaluation includes written confidential and anonymous resident evaluation of each faculty after each clinical assignment.
  - 3.7.3.1.** In order for the resident evaluators to remain anonymous, the faculty members are given a composite evaluation every six months.
  - 3.7.3.2.** The program director monitors faculty evaluation on a monthly basis and automatically receives a notice from NI if a faculty member receives a rating of "marginal" or less on any section of the evaluation. If issues with faculty members are identified on the faculty evaluation or otherwise brought to the attention of the program director, that faculty member is given timely feedback and an opportunity to correct his or her deficiencies.

**3.8. Program Director Evaluations**

- 3.8.1.** The program director reports directly to the chair of the Department of Internal Medicine and indirectly to the associate dean for Graduate Medical Education.
- 3.8.2.** The program director is evaluated by the residents through the annual Institutional GME survey and by the chair of the DOM.

**3.9. Program Evaluations**

- 3.9.1.** All MSM programs are evaluated confidentially and anonymously by the residents and the faculty on an annual basis under the oversight and direction of the GME Office.
- 3.9.2.** The results of this annual evaluation are used by the Program to monitor the progress of the program improvement plans with the input from the Program Evaluation Committee (see PEC description and responsibilities).
- 3.9.3.** The PEC meets at least twice a year to monitor all aspects of the Program. The PEC and the PD are responsible for generating the Annual Program Evaluation Improvement Report which documents the Program's extensive review of resident performance, faculty development, graduate performance, and program quality.

**3.10. MSM IM Residency Program Evaluation Committee**

**3.10.1.** The purpose of the MSM IM Residency (PEC) for the Morehouse School of Medicine (MSM) IM Residency Program is to oversee and participate actively in all aspects of Program quality and improvement.

**3.10.2.** At all times, the procedures and policies of the PEC will comply with those of the ACGME common and specialty Program requirements and the Graduate Medical Education Committee as outlined in the GME Policy and Procedure Manual.

**3.10.3. Membership**

**3.10.3.1.** The program director shall appoint all members of the PEC. Members will include key clinical faculty who have experience in medical education and who work directly with the residents.

**3.10.3.2.** Class representatives for each PGY level serve on the committee.

**3.10.3.3.** The program director will appoint the chair of the committee.

**3.10.4. Responsibility of Members**

**3.10.4.1.** Members must commit to attend at least 70% of all meetings (monthly, faculty development, and ad hoc meetings as needed to address urgent program issues).

**3.10.4.2.** Committee members are expected to actively participate in the following activities per the ACGME Internal Medicine program requirements (V.C.):

**3.10.4.2.1.** Planning, developing, implementing, and evaluating educational activities of the program;

**3.10.4.2.2.** Reviewing and making recommendations for revision of competency-based curriculum goals and objectives;

**3.10.4.2.3.** Addressing areas of non-compliance with ACGME standards; and

**3.10.4.2.4.** Reviewing the Program annually using evaluations of faculty, residents, and others, as specified below:

- Resident performance;
- Faculty development;

- Graduate performance, including performance of program graduates on the certification examination;
  - At least 80% of those who completed their training in the program for the most recently defined three-year period must have taken the certifying examination.
  - A program's graduates must achieve a pass rate on the certifying examination of the ABIM of at least 80% for first-time takers of the examination in the most recently defined three-year period.
  - Committee members are expected to check for, identify, and follow any new program requirements.
- Program quality; and,
- Progress on the previous year's action plan(s).

**3.10.5.** The Program, through the PEC must:

**3.10.5.1.** Document formal, systematic evaluation of the curriculum at least annually, and take responsibility for rendering a written and Annual Program Evaluation (APE).

**3.10.5.2.** Prepare a written plan of action to document initiatives to improve performance in one or more of the areas listed in section V.C.2., of the Program requirements as well as delineate how they will be measured and monitored.

**3.10.6.** Scheduled Meetings

**3.10.6.1.** The PEC will meet a minimum of twice per year.

**3.10.6.2.** The PEC in its entirety or subcommittees will meet at least annually to document systematic and formal evaluation of the curriculum and render a written APE.


**3.10.7.** PEC Procedures

**3.10.7.1.** The PEC shall evaluate the Program on an ongoing basis and make recommendations to the Program.

**3.10.7.2.** All PEC meetings shall be documented with a sign-in sheet and agendas, PowerPoint slides, and meeting minutes as appropriate.

- 3.10.7.3.** When conducting the formal program evaluation meeting, the PEC may choose to break out into four subcommittees:
- Resident and graduate performance
  - Faculty development
  - Program quality
  - Curriculum review
- 3.10.7.4.** The PEC aggregates and summarizes all relevant data. These completed summaries will be the “minutes” for the PEC meetings.
- 3.10.7.5.** The PEC reviews and approves the final APE report.
- 3.10.7.6.** The PEC monitors completion of the annual program evaluation improvement plan.



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	<b><u>SUBJECT: LEAVE POLICY</u></b>	SUPERSEDES	

## Leave Policy

### I. **BACKGROUND**

- 1.1. The amount of time a resident can be away from residency duties and still meet Board requirements vary among the specialties. For Internal Medicine, the ABIM (American Board of Internal Medicine) Policy on leaves of absence or vacation states:

“Trainees may take up to one month per year of training for vacation, parental or family leave, or illness (including pregnancy-related disabilities). Training must be extended to make up any absences exceeding one month per year of training. Vacation leave is essential and cannot be forfeited to make up for a late start to training.”

- 1.2. Morehouse SOM IM Residency recognizes that a resident may need to be away from work due to medical or certain family reasons. Leaves of absence are defined as approved time away from residency duties, other than regularly scheduled days off as reflected in a rotation schedule.
- 1.3. All leaves will be scheduled with prior approval by the chief medical residents and the program director, with the exception of emergencies or unexpected illnesses. In unexpected/emergency situations, the resident should contact the chief medical residents and program director at the earliest possible time.

### II. **PURPOSE**

The purpose of this policy is to outline the leave time that residents are eligible for and highlight the processes and procedures that need to be undertaken with various leave types.

### III. **POLICIES**

#### 3.1. Holidays

- 3.1.1. All time off, including holidays, is scheduled at the discretion of the program director.
- 3.1.2. Official MSM IM Residency holidays are not automatically observed as time off for house staff.

**3.2. Vacation**

- 3.2.1.** Vacation is scheduled by the chief medical residents and approved by the program director.
- 3.2.2.** MSM IM interns or residents may take fifteen (15) days of paid vacation.
- 3.2.2.1.** A vacation is considered five (5) working days.
- 3.2.2.2.** Generally, the five days are taken as Monday through Friday. Consequently, the surrounding weekends may be granted at the discretion of the program director.
- 3.2.3.** Vacation time must be used in the appointment year in which it is accrued. Any unused time does not carry over and is not paid out at the appointment year-end.
- 3.2.4.** Residents are not allowed to take their vacations on the following rotations:
- Ward rotations
  - ICU rotations
  - ECC rotations
- 3.2.5.** No vacation greater than three (3) weeks in duration will be granted, including those that entail international travel.
- 3.2.6.** Vacations of two (2) or more weeks' duration must be taken during back-to-back elective/ambulatory months, with part of the vacation occurring at the end of one elective rotation and the remainder at the start of the next elective/ambulatory rotation. Any other arrangements must be approved by the program director.
- 3.2.7.** If international travel is anticipated, it is the resident's responsibility to have complied with all visa restrictions and rules.
- 3.2.7.1.** Questions concerning international travel by residents with a J-1 visa must be resolved and answered prior to leaving the country.
- 3.2.7.2.** Residents with a J-1 visas who are considering international travel must contact Ms. Tammy Samuels, the Director of Graduate Medical Education, prior to making travel plans at [tsamuels@msm.edu](mailto:tsamuels@msm.edu).
- 3.2.8.** Residents who must renew their visa status should do so during planned vacations. Additional time off or educational leave will not be granted to accomplish visa renewal.

**3.3. Sick Time**

- 3.3.1.** Time off due to illness must be reported to the chief medical residents, the supervising Attending, the program director, and program manager.
- 3.3.2.** Residents are provided fifteen (15) paid sick days.
- 3.3.3.** Residents are not paid for unused sick time and sick time does not carry over to the next appointment year, if applicable.
- 3.3.4.** Sick time can only be used for time off due to the resident's illness or the illness of the resident's spouse, parent, or child.
- 3.3.5.** Sick time must be used prior to going into unpaid status, if available.
- 3.3.6.** The Program generally requires a letter from a physician or other clinical provider for time off work beyond two days (48 hours).
- 3.3.7.** MSM provides job-protected family and medical leave to eligible residents for up to 12 workweeks of unpaid leave during a 12-month period based on the following qualifying events:
  - 3.3.7.1.** For incapacity due to pregnancy, prenatal medical care, or child birth;
  - 3.3.7.2.** To care for the employee's child after birth, or placement for adoption or foster care;
  - 3.3.7.3.** To care for the employee's spouse, son, daughter, or parent who has a serious health condition; or
  - 3.3.7.4.** For a serious health condition that makes the employee unable to perform the employee's job.
- 3.3.8.** Eligible residents who care for covered service members may also be eligible for up to 26 workweeks of unpaid leave in a single 12-month period.
- 3.3.9.** Residents are eligible for FMLA leave if they have:
  - Worked for MSM for at least one year,
  - Worked 1,250 hours over the previous 12 months, and
  - A qualifying event occurs as outlined above.
- 3.3.10.** Direct all questions to and inquire about the most current FMLA leave information with the MSM Human Resources Department.

**3.4. Return to Duty**

- 3.4.1.** For leave due to parental or serious health conditions of the resident or a family member, a physician's written "Release to Return to Duty" or equivalent is required with the date the resident is expected to return to resume his or her residency. This information is submitted to the Human Resources Department (HRD).
- 3.4.2.** When applicable, the residency program director will record in writing the adjusted date required for completion of the PGY or the program because of Extended Resident Leave. One copy is placed in the resident's educational file and a copy is submitted to the Office of Graduate Medical Education (GME) to process the appropriate Personnel Action.

**3.5. Educational Leave**

- 3.5.1.** In order to encourage scholarship, up to five (5) days of educational leave per year is available to all interns and residents to be utilized if accepted to present scholarly work and research.
- 3.5.2.** This leave must be approved by the program director and is generally limited to elective months.
- 3.5.3.** For unapproved requests or requests that extend beyond the allowable days, the resident may use vacation days, but this must have PD approval.
- 3.5.4.** The Program encourages resident presentations at state, regional, and national meetings. Days spent at such a conference do not count as leave, but travel days count as days off.
- 3.5.5.** Residents will be allowed to also use Educational Leave for essential examinations, such as Step III of the USMLE.
  - 3.5.5.1.** Exam Leave requests can only be requested to take exams, not to prepare for exams.
  - 3.5.5.2.** In addition, residents must submit requests for all exams so that they are not inadvertently scheduled for call.
- 3.5.6.** Residents may present information at professional meetings regardless of their current clinical responsibility provided they notify the chiefs to identify adequate coverage and the activity is approved by the program director.
  - 3.5.6.1.** It is the resident's responsibility to find coverage for his or her clinical duties if chiefs are unable to assign coverage.
  - 3.5.6.2.** The resident should limit his or her absence from his or her clinical responsibility to the shortest time necessary to travel to the meeting, make the presentation, and return to assigned rotation.

**3.5.7.** Residents in the PGY-3 year applying for fellowship positions may have five (5) days of Educational Leave for both professional meetings and fellowship interviews.

**3.5.7.1.** Although it is recognized that days off for interviewing for fellowship training or securing employment after your residency may be necessary, these should be kept to a minimum.

**3.5.7.2.** All requests for days off for interviewing must be approved by the program director.

**3.5.7.3.** Interview days should not be scheduled during ward or intensive care months.

**3.5.7.4.** If the resident applying for fellowship does not request elective rotations during interview season, THE LEAVE CAN BE DENIED.

**3.5.7.5.** Time required beyond five (5) days will be taken from vacation.

**3.5.7.6.** Also, it is recommended that residents pay close attention to using vacation time if planning on taking vacation at year end. Residents must manage their educational days effectively. It is expected that residents will be responsible and make sure they have planned well.

**3.5.8.** NOTE: Leave requests for professional meetings must be submitted to the program director using the Scholarly Activity Leave Form.

**3.6.** Military Leave/Jury Duty


**3.6.1.** Residents will be granted military leave or leave for jury duty as required by applicable law.

**3.6.2.** Please contact the MSM Human Resources for specific questions about such leave.

**3.7.** Personal Leave

**3.7.1.** Personal leave may be provided at the discretion of the program director in 30-day intervals according to the policies established by the individual residency programs.

**3.7.2.** Residents will be required to exhaust other forms of leave for which they may qualify prior to being eligible for personal leave.

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	<b>SUBJECT: RESIDENCY LEARNING AND WORK ENVIRONMENT POLICY</b>	SUPERSEDES	

## Residency Learning and Work Environment Policy

### **I. BACKGROUND**

The MSM IM Residency Program addresses learning and working environment requirements in addition to incorporating a program policy for duty hours in the learning and working environment policy.

### **II. PURPOSE**

- 2.1. The purpose of this policy is to comply with ACGME duty hour requirements and maintain patient safety and resident and fellow wellbeing.
- 2.2. The Morehouse School of Medicine Internal Medicine Residency Program follows the ACGME Common Program Requirements (effective 7/1/13) for duty hours in the learning and working environment as stated below.
- 2.3. All MSM IM residency house staff must report duty hours into the New Innovations system.

### **III. PROFESSIONALISM, PERSONAL RESPONSIBILITY, AND PATIENT SAFETY**

- 3.1. The MSM IM Residency Programs educate residents and faculty members concerning the professional responsibilities of physicians to appear for duty appropriately rested and fit to provide the services required by their patients. MSM IM residency is committed to and responsible for promoting patient safety and resident wellbeing in a supportive educational environment.
- 3.2. The program director ensures that residents are integrated and actively participate in interdisciplinary clinical quality improvement and patient safety programs.
- 3.3. As such, the learning objectives of the program are:
  - 3.3.1. Accomplished through an appropriate blend of supervised patient care responsibilities, clinical teaching, and didactic educational events; and,
  - 3.3.2. Not compromised by excessive reliance on residents to fulfill non-physician service obligations.
- 3.4. MSM GME and the program director ensure a culture of professionalism that supports patient safety and personal responsibility.
- 3.5. Residents and faculty members must demonstrate:
  - 3.5.1. Assurance of the safety and welfare of patients entrusted to their care;
  - 3.5.2. Provision of patient- and family-centered care;

- 3.5.3. Assurance of their fitness for duty;
  - 3.5.4. Management of their time before, during, and after clinical assignments;
  - 3.5.5. Recognition of impairment, including illness and fatigue, in themselves and in their peers;
  - 3.5.6. Attention to lifelong learning;
  - 3.5.7. Monitoring of their patient care performance improvement indicators; and
  - 3.5.8. Honest and accurate reporting of duty hours, patient outcomes, and clinical experience data.
- 3.6. All residents and faculty members must demonstrate responsiveness to patient needs that supersedes self-interest. Physicians must recognize that under certain circumstances, the best interests of the patient may be served by transitioning that patient's care to another qualified and rested provider.

#### **IV. TRANSITION OF CARE**

The IM Residency Program must facilitate professional development for faculty and residents regarding effective transitions of care, and ensure that sites engage in standardized transitions of care consistent with the setting and type of patient care (see the IM Residency Transition of Care Policy).

#### **V. FATIGUE MANAGEMENT AND MITIGATION**

- 5.1. The IM Residency Program educates faculty and residents in fatigue mitigation processes, in recognition of the signs of fatigue and sleep deprivation.
- 5.2. The Program has a fatigue mitigation plan that includes strategic napping, adjusting schedules or back-up support, including a process to ensure continuity of patient care should faculty or resident be unable to perform his or her duties (see the IM Residency Fatigue Management and Mitigation Policy).

#### **VI. SUPERVISION AND CLINICAL RESPONSIBILITIES**

The program director and faculty members will assign the appropriate level of authority, responsibility, conditional independence, and supervisory role for each resident based on PGY-level, patient safety, resident education, severity and complexity of patient illness/condition, and available support services (see the IM Residency Supervision Policy).


#### **VII. TEAMWORK**

- 7.1. Residents must care for patients in an environment that maximizes effective communication.
- 7.2. This must include the opportunity to work as a member of effective inter-professional teams that are appropriate to the delivery of care in the specialty.

**VIII. DUTY HOURS**

- 8.1.** The IM Residency Program complies with resident duty hours and definitions as set forth by the ACGME.
- 8.2.** The program director and the program manager will monitor duty hours with a frequency to ensure compliance with ACGME requirements (see the IM Residency Program Duty Hour Policy).



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	<b><u>SUBJECT: CALL POLICY</u></b>	SUPERSEDES	

## Call Policy

### I. **BACKGROUND**

In general, “call” or “being on call” is a period of continuous work activity by residents that generally occurs within the hospital.

### II. **PURPOSE**

The purpose of this policy is to define the different types of call activity as well as the frequency and the duty hour roles relevant to call.

### III. **DEFINITIONS**

#### 3.1. Short Call

3.1.1. This designation is used to describe the team assigned to take overnight admissions that have been admitted by the Night Float resident.

3.1.2. Short Call is not defined by any specific time parameters.

3.1.3. Short Call occurs on the Grady Wards and VA Wards.

#### 3.2. Long Call

3.2.1. This designation is not overnight call but a 12-hour period from 7 a.m. to 7 p.m. when the admitting team admits new patients and transfers.

3.2.2. On the Grady Inpatient ward, service call is every fifth day (q5).

3.2.3. On the VA ward, service call is every third day (q3).

3.2.4. Long Call occurs on the Grady Wards and VA Wards.

#### 3.3. 24-Hour Call

3.3.1. Residents taking 24-hour call have regular access to a call room and are encouraged to take “strategic naps” as a form of fatigue mitigation.


3.3.2. Twenty-four-hour call can be no more frequent than every third night.

3.3.3. In the Grady ICU, 24-hour call is every third night.

3.3.4. In the VA ICU, 24-hour call is every fifth night.

3.3.5. On Grady Ward service, 24-hour call is periodic and would generally occur twice during the month.

- 3.3.6.** The maximum in-house on-call frequency for PGY-2 residents and above must be no more than every third night.
- 3.3.7.** 24-Hour Call occurs on the Grady Wards (weekend coverage), in the Grady ICU, and in the VA ICU.
- 3.4.** Post Call
  - 3.4.1.** This designation refers to the four hours at the end of the 24-hour call period that can be used for transitional activities, but where the resident is not admitting or assuming care for additional patients.
  - 3.4.2.** Residents are not allowed to work more than four (4) hours “post call.”
- 3.5.** At Home Call
  - 3.5.1.** At Home Call occurs on Grady Medicine Subspecialty rotations. Residents only take at home calls until 10 p.m.
  - 3.5.2.** Second- and third-year residents do “at home” or pager call.
  - 3.5.3.** The Attending physician on the subspecialty service supervises the resident taking “at home call.” This call is monitored to ensure that it does not become excessive.
  - 3.5.4.** At-home call must not be so frequent or taxing as to preclude rest or reasonable personal time for each resident.
  - 3.5.5.** Interns do not do “at home call.”
  - 3.5.6.** MSM IM residents are not called into the hospital during their at-home call period.
- 3.6.** Call Rooms
  - 3.6.1.** Call rooms are accessible to residents 24 hours a day at both Grady and the VA hospitals.
    - 3.6.1.1.** At Grady, the call rooms are on the 14th floor and must be opened by Grady Public Safety (404) 616-4025).
    - 3.6.1.2.** At the VA, the call room for MSM residents is 8C-164 (next to nursing station on 8C); the door code is 8273#.
  - 3.6.2.** In addition to access to call rooms, residents have 24-hour access to food and beverages while in the hospital.

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	<b><u>SUBJECT: DUTY HOUR POLICY</u></b>	SUPERSEDES	

## Duty Hour Policy

### I. BACKGROUND

MSM IM Residency Program seeks to be in full compliance with the Duty Hour Policies set forth by the ACGME for all residents.


### II. PURPOSE

- 2.1. The purpose of this process is to outline the program’s monitoring and oversight of duty hours and document how duty hour logging issues and/or violations are addressed by the Program.
- 2.2. All residents must log in daily to New Innovations in order to report (or log) their duty hours for that day.
- 2.3. At intern orientation and throughout the year residents receive education about logging in duty hours and about ACGME duty hour rules. They receive updates in regularly scheduled monthly meetings and program emails.
- 2.4. Each resident class has a chief resident and a “Duty Hour Champion” who work collaboratively with program administration to stress the importance of timely and accurate duty hour logging.
- 2.5. The Program adheres to the following ACGME Duty Hour rules:
  - 2.5.1. 80 Hour—80 hours per week averaged over four weeks.
  - 2.5.2. 24+4—24 consecutive hours with four hours for transitional activities.  
NOTE: Log in by selecting **24+4**—do not log in 28.
  - 2.5.3. 16 hours only (PGY-1)—PGY-1/Interns may not be scheduled or work more than 16-hour shifts.
  - 2.5.4. In-House Call—Call no more than once every third night. Remember: ECC and ICU are *SHIFTS*, not calls.
  - 2.5.5. Time off between scheduled duty periods (Short Break)—All residents should have 10 hours off (and **must** have eight hours off) between shifts.
  - 2.5.6. Day Off—One 24-hour period off per week averaged over four (4) weeks. No at-home call assigned.
  - 2.5.7. Night Float—Residents may not be scheduled for more than six (6) consecutive Night Float duties.

- 2.5.8.** At-Home Call—At-home call is not subject to the every-third-night limitation, but must satisfy the requirement for one-day-in-seven free of duty, when averaged over four (4) weeks (see Call Policy for additional details).
- 2.5.9.** Residents in the final years of education (PGY-2 and PGY-3) must be prepared to enter the unsupervised practice of medicine and care for patients over irregular or extended periods. While it is desirable that residents in their final years of education have eight (8) 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 eight (8) hours free of duty (C.P.R. VI.G.5c).(1)).
- 2.5.10.** Per the ACGME C.P.R.s, 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.
- 2.5.10.1.** *Justifications for such extensions are limited to reasons of required continuity of care for a severely ill or unstable patient, academic importance of the events transpiring, or humanistic attention to the needs of a patient or family.*
- 2.5.10.2.** Documentation of such extensions must be submitted to the program director for review and feedback.
- 2.5.10.3.** In the MSM IM Residency Program, circumstances such as those above would be rare.
- 2.5.10.3.1.** Possible instances could include weather-related emergencies or a wide-scale medical emergency.
- 2.5.10.3.2.** Residents are required to report these instances when they must return to hospital activity with fewer than eight (8) hours away from the hospital and they are monitored by the program director via New Innovations.
- 2.5.10.3.3.** Each submission of additional service is reviewed and tracked by the program director for both individual residents and program-wide episodes.

- 2.6.** Duty hours are defined as all clinical and academic activities related to the program:
- 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
  - Scheduled activities, such as conferences
- 2.7.** Duty hours do not include reading and preparation time spent away from the duty site.
- 2.8.** Duty Hour Logging Compliance Process
- 2.8.1.** Logging compliance will be checked weekly.
- 2.8.2.** Each Monday morning (or the first day of the week if Monday is a holiday), the PM reviews duty logging compliance for the prior week using the New Innovations Dashboard.
- 2.8.3.** An email reminder is then sent to each noncompliant intern or resident reminding him or her to complete the logging requirements ASAP but no later than 24 hours from the notification time.
- 2.8.4.** The dashboard is checked again on Wednesday morning. At that time residents who are still not in compliance with logging will get a call and/or email from the Residency Office staff stressing duty hour compliance.
- 2.8.5.** On Friday, the PM compares the Monday list with those still pending completion. A list of noncompliant interns or residents is then forwarded to the PD.
- 2.8.6.** If logging is not completed by the following Monday, the PD will contact the resident and set up a specific time for the resident to complete duty hours.
- 2.8.7.** If logging is still not completed within 48 to 72 hours, the PD will generate a “Notice of Deficiency” for the resident who will then be in jeopardy of losing “good standing” in the Program.
- 2.9.** Duty Hour Violations
- 2.9.1.** On a daily basis, duty hour violations are reviewed by the PM.
- 2.9.2.** Initially, the PM informs the resident if there is an error in documentation (if the documentation is unclear, then the PD informs the resident) and then provides guidance on the proper logging process.

- 2.9.3.** On a weekly basis, the PD reviews each violation and then either approves the cause or reason (“justification”) submitted, declines the justification, or, if a justification is not given, asks for more information or a justification.
- 2.9.4.** For recurrent “true violations,” the PD/PM initiates direct or systemic changes to minimize violations. These include:
- Directly contacting Attending of record for further education
  - Involving chief residents and duty hour champions in resident support/education
  - Changing resident hours/rotations
- 2.10.** The Duty Hour Compliance Report is generated in New Innovations on a monthly basis. A monthly action plan to address new or recurrent violations will be generated.

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	<b><u>SUBJECT: MOONLIGHTING POLICY</u></b>	SUPERSEDES	

## **Moonlighting Policy**

### **I. BACKGROUND**


The MSM Internal Medicine Residency Program recognizes that senior residents have an interest in expanding their financial and clinical opportunities through pursuing other work activities in medicine outside of their residency program. Per ACGME program requirements, PGY-1 residents are not permitted to moonlight.

### **II. PURPOSE**

The purpose of this policy is to clarify the moonlighting policy of the MSM IM residency program.

### **III. POLICY**

- 3.1.** Morehouse School of Medicine Internal Medicine residents are currently not allowed to “moonlight” (practice clinical medicine) outside of the parameters of their residency training under any circumstances.
- 3.2.** This policy reflects concern for preserving reasonable duty hours and allowing residents to have appropriate study time to prepare for their ABIM Certification Exam.
- 3.3.** Any questions about this policy should be directed to the MSM IM program director.

	<p align="center"><b>MOREHOUSE SCHOOL OF MEDICINE</b> INTERNAL MEDICINE RESIDENCY PROGRAM POLICIES AND PROCEDURES</p>	POLICY NUMBER	IM-09
		EFFECTIVE DATE	01/21/2015
		PAGE(S)	02
	<b>SUBJECT: FATIGUE MANAGEMENT AND MITIGATION POLICY</b>	SUPERSEDES	

## Fatigue Management and Mitigation Policy

### **I. BACKGROUND**

Morehouse School of Medicine Internal Medicine Residency Program is committed to promoting patient safety and resident wellbeing in a supportive educational environment.

### **II. PURPOSE**

In compliance with the ACGME requirement to ensure that faculty and residents appear for duty appropriately rested and fit for duty (C.P.R.VI.A.1), this policy provides guidance on the methods used to educate faculty members and residents regarding:

- 2.1. Recognizing the signs of fatigue and sleep deprivation
- 2.2. Alertness management and fatigue mitigation processes
- 2.3. Adopting fatigue mitigation processes to manage the potential negative effects of fatigue on patient care and learning


### **III. DEFINITIONS**

- 3.1. Fatigue management—Recognition by either a resident or supervisor of a level of resident fatigue that may adversely affect patient safety and enactment of a solution to mitigate the fatigue.
- 3.2. Fitness for duty—Mentally and physically able to effectively perform required duties and promote patient safety.
- 3.3. Resident—Any physician in an accredited graduate medical education program, including interns, residents, and fellows.
- 3.4. Scheduled duty periods—Assigned duty within the institution encompassing hours, which may be within the normal work day, beyond the normal work day, or a combination of both.



**IV. PROCEDURE**

- 4.1.** MSM will provide all faculty members and residents information and instruction on recognizing the signs of fatigue and sleep deprivation, and information on alertness management and fatigue mitigation processes, and on how to adopt these processes to avoid potential negative effects on patient care and learning.
  - 4.1.1.** This is accomplished by orientation sessions sponsored by GME and a department-specific boot camp early in the academic year.
  - 4.1.2.** This information is then posted on Blackboard for easy reference.
- 4.2.** To ensure that patient care is not compromised if a resident or faculty member must apply fatigue mitigation techniques while on scheduled duty, residents should contact the chief medical resident or their faculty supervisor so that appropriate coverage can be obtained to ensure continuity of patient care.
- 4.3.** MSM IM and its hospital affiliates ensure that adequate sleep facilities are available to residents and/or provide safe transportation options for residents requesting assistance due to fatigue because of time spent on duty.

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	<b><u>SUBJECT: TRANSITIONS OF CARE POLICY</u></b>	SUPERSEDES	

## Transitions of Care Policy


### I. **BACKGROUND**

MSM IM Residency Program works to design schedules and clinical assignments that maximize the learning experience for residents, as well as to ensure quality care and patient safety, and to adhere to general institutional policies concerning transitions of patient care.

### II. **PURPOSE**

- 2.1. To establish protocol and standards to ensure the quality and safety of patient care when transfer of responsibility occurs during duty hour shift changes and other scheduled or unexpected circumstances.
- 2.2. Transitions of care are necessary in the hospital setting for various reasons.
- 2.3. The transition/hand-off process is an interactive communication process of passing specific, essential patient information from one caregiver to another.
- 2.4. Transition of care occurs regularly under the following conditions:
  - 2.4.1. Change in level of patient care, including inpatient admission from an outpatient procedure or diagnostic area or ER and transfer to or from a critical care unit;
  - 2.4.2. Temporary transfer of care to other healthcare professionals within procedure or diagnostic areas;
  - 2.4.3. Discharge, including discharge to home or another facility such as skilled nursing care;
  - 2.4.4. Change in provider or service change, including change of shift for nurses, resident sign-out, and rotation changes for residents.
- 2.5. The transition/hand-off process must involve face-to-face interaction with both verbal and written communication. At a minimum, the transition process should include the following information in a standardized format that is universal across all services:
  - 2.5.1. Identification of patient, including name, medical record number, and date of birth;
  - 2.5.2. Identification of admitting/primary physician;
  - 2.5.3. Diagnosis and current status/condition of patient;

- 2.5.4.** Recent events, including changes in condition or treatment, current medication status, recent lab tests, allergies, anticipated procedures and actions to be taken;
- 2.5.5.** Changes in patient condition that may occur requiring interventions or contingency plans.
- 2.6.** The MSM IM Residency Program requires all interns and residents to undergo training in patient handoffs. The preferred method of standardizing handoffs in our Program is to use the “SBAR?” method where:
- S signifies “Situation”
  - B signifies “Background”
  - A signifies “Assessment”
  - R signifies “Recommendation”
  - Then there is time for questions.
- 2.7.** AM sign out rounds are between 7:30 and 7:55 a.m. prior to Morning Report. These rounds are supervised by the chief residents.
- 2.8.** Afternoon sign out rounds are at 4 p.m. in the 7<sup>th</sup> Floor Medicine Conference Room. Afternoon sign out rounds are supervised by the chief medical residents or a senior (third year) resident.
- 2.9.** Evening sign out rounds are at 7 p.m. in the 7<sup>th</sup> floor conference room or other designated area. The NF 3 resident supervises evening sign out.
- 2.10.** Off Service Notes—Residents are required to write appropriately detailed off-service notes when leaving the service. A verbal hand off should also be given. Off-service notes should include presenting complaints, all pertinent diagnoses, hospital course, and plan of care.
- 2.11.** Transfers—Transfer notes should be written on all patients transferring to and from the ICU and patients who are transferred to and from non-medicine services (e.g., Surgery or OB/GYN). Receiving interns and residents will then write a “transfer accept note” which has the same components as a SOAP (Subjective, Objective, Assessment, and Plan) note, but includes “hospital course.”
- 2.12.** Admissions—The resident on the inpatient ward service should notify the PCP of the admitted patient within 24 hours. This can be done by phone or electronically.
- 2.13.** Discharge Summaries—To facilitate transition of care at discharge, Discharge Summaries should be done on the day of discharge, but must be done within seven (7) days. Patients being discharged to other facilities should have the Discharge Summary sent to the provider of record at the accepting facility. Note that whenever possible, a verbal sign out should be provided.

	<b>MOREHOUSE SCHOOL OF MEDICINE</b> INTERNAL MEDICINE RESIDENCY PROGRAM POLICIES AND PROCEDURES	POLICY NUMBER	IM-011
		EFFECTIVE DATE	01/21/2015
		PAGE(S)	05
	<b><u>SUBJECT: RESIDENT PROMOTION POLICY</u></b>		SUPERSEDES

## Resident Promotion Policy

### I. BACKGROUND

- 1.1. Residency is an essential dimension of the transformation of the medical student to the independent practitioner along the continuum of medical education (Int. A. ACGME C.P.R.).
- 1.2. A resident is expected to progressively increase his or her level of proficiency in order to advance within a residency program.

### II. PURPOSE

- 2.1. The purpose of this policy is to ensure that residents progress through each year of residency with the appropriate knowledge, skills, and attitudes needed to assume progressive responsibility for patient care.
- 2.2. This policy is also provided so residents are able to track their progression with a full understanding of what is required to move to the next level of training.

### III. PROMOTION REQUIREMENTS

- 3.1. In order for a resident to complete an MSM residency education program, he or she must successfully meet the following standards in addition to any program-specific requirements:
  - 3.1.1. The resident must exhibit clinical and academic performance and competence consistent with the curricular standards and the level of training undergone.
  - 3.1.2. The resident must satisfactorily complete all assigned rotations as supported by evaluation documentation in each Post Graduate Year (PGY).

**Promotion Criteria**

The following promotion criteria apply to PGY-1 to PGY-2 levels:
<input type="checkbox"/> The resident must pass a complete clinical skills exam (direct observation by faculty) with a score of 80 or above.
<input type="checkbox"/> The resident must receive an overall “Satisfactory” evaluation in all of his or her required rotations (five or more on monthly evaluation).
<input type="checkbox"/> The resident must successfully complete an OSCE exam.
<input type="checkbox"/> The resident must not have any professionalism or ethical issues that preclude him or her from being moved to the next level of residency in the opinion of the Clinical Competency Committee.
<input type="checkbox"/> The resident must be continually eligible to practice medicine on a limited license in Georgia.
<input type="checkbox"/> The resident must complete the GME returning resident orientation.
<input type="checkbox"/> The resident must be compliant with all MSM IM Residency Program policies including, but not limited to, being up to date with his or her duty hour log.

Final decisions on promotion to the next level of residency are made by the Clinical Competency Committee and the program director.

**Promotion Criteria (continued)**

The following promotion criteria apply to PGY-2 to PGY-3 levels:
<input type="checkbox"/> The resident must successfully complete an OSCE exam.
<input type="checkbox"/> The resident must receive an overall grade of “Satisfactory” or above on all required rotations.
<input type="checkbox"/> The resident must pass USMLE Step 3 by 24 months of residency.
<input type="checkbox"/> The resident must not have any professionalism or ethical issues that preclude him or her from being moved to the next level of residency in the opinion of the Clinical Competency Committee.
<input type="checkbox"/> The resident must be continually eligible to practice medicine on a limited license in Georgia.
<input type="checkbox"/> The resident must complete the GME returning resident orientation.
<input type="checkbox"/> The resident must be compliant with all MSM IM Residency Program policies including, but not limited to, being up to date with his or her duty hour log.
<input type="checkbox"/> The resident must have up-to-date ACLS certification.
<input type="checkbox"/> The resident must complete a board study plan and have it approved by the resident’s APD.

Final decisions on promotion to the next level of residency are made by the Clinical Competency Committee and the program director.


**PGY-3 Graduation Criteria**

<b>The following graduation criteria apply to the PGY-3 level:</b>
<input type="checkbox"/> The resident must receive an overall grade of “Satisfactory” or above on all required rotations.
<input type="checkbox"/> The resident must not have any professionalism or ethical issues that preclude him or her from being moved to the next level of residency in the opinion of the Clinical Competency Committee.
<input type="checkbox"/> The resident must be continually eligible to practice medicine on a limited license in Georgia.
<input type="checkbox"/> The resident must be compliant with all MSM IM Residency Program policies including, but not limited to, being up to date with his or her duty hour log.
<input type="checkbox"/> The resident must have completed an approved scholarly activity.
<input type="checkbox"/> The resident must have completed and logged all required ABIM procedures.
<input type="checkbox"/> The resident must present an approved Senior Talk.
<input type="checkbox"/> The resident must complete the GME, HR, and MSM IM exit procedures.
<input type="checkbox"/> The resident must be performing as “Satisfactory” or above in all six ACGME competencies.
<input type="checkbox"/> The program director must determine that the resident has had sufficient training to practice medicine independently as evidenced by meeting the goals above and within a final summative assessment.

- 3.2. The program director must certify that the resident has fulfilled all criteria, including the program-specific criteria, to move to the next level in the Program.
- 3.3. The resident must demonstrate professionalism, including the possession of a positive attitude and behavior, along with moral and ethical qualities that can be objectively measured in an academic and/or clinical environment.

- 3.4.** The resident must achieve a satisfactory score on program-specific criteria required in order to advance. ACGME-RRC Program Requirements provide the outline of standards for advancement.
- 3.5.** Upon a resident's successful completion of the criteria listed above, the residency program director will certify by placing the semi-annual evaluations and the promotion documentation into the resident's portfolio indicating that the resident has successfully met the specialty requirements for promotion to the next educational level. If this is a graduating resident, the program director should place the Final Summative Assessment in the resident's portfolio.
- 3.6.** Process and Timeline for Promotional Decisions
  - 3.6.1.** Normal promotion decisions are made no later than the fourth month of the appointment. Reappointment agreements are prepared based on the residency program director's recommendation for promotion.
  - 3.6.2.** When a resident will not be promoted to the next level of training, the Program will provide the resident with a written notice of intent no later than four (4) months prior to the end of the resident's current appointment agreement. If the primary reason for non-promotion occurs within the last four (4) months of the appointment agreement period, the program will give as much written notice as circumstances reasonably allow.
  - 3.6.3.** If a resident's appointment agreement is not going to be renewed, the residency Program must notify the resident in writing no later than four (4) months prior to the end of the resident's current contract. If the decision for non-renewal is made during the last four (4) months of the contract period, the residency Program must give the resident as much written notice as possible prior to the end of the appointment agreement expiration.
  - 3.6.4.** For more information concerning adverse events, refer to the GME Adverse Academic Decisions and Due Process Policy.



	<b>MOREHOUSE SCHOOL OF MEDICINE</b> INTERNAL MEDICINE RESIDENCY PROGRAM POLICIES AND PROCEDURES	POLICY NUMBER	IM-012
		EFFECTIVE DATE	01/21/2015
		PAGE(S)	09
	<b><u>SUBJECT: SUPERVISION POLICY</u></b>	SUPERSEDES	

## Supervision Policy

### I. BACKGROUND

- 1.1. Internal Medicine Residency is clinical training in a supervised environment where the trainee is given graded responsibility to manage patients based on the attainment of the knowledge, skills, and abilities needed to safely manage patient care and other clinical responsibilities.
- 1.2. As such, supervision of residents and ongoing assessment of their clinical skills is of prime importance during residency training.

### II. PURPOSE

- 2.1. The purpose of this supervision policy is to ensure that residents are provided adequate and appropriate levels of supervision during the course of the educational training experience, and to ensure that patient care continues to be delivered in a safe manner.
- 2.2. The privilege of progressive authority and responsibility, conditional independence, and a supervisory role in patient care delegated to each resident is assigned by the program director and faculty members to ensure effective oversight of resident supervision.
- 2.3. The program follows the ACGME classification of supervision:
  - 2.3.1. Direct Supervision—The supervising physician is physically present with the resident and patient.
  - 2.3.2. Indirect Supervision 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.
  - 2.3.3. 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.
  - 2.3.4. Oversight—The supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered.

- 2.4. The Program maintains current call schedules with accurate information enabling residents to obtain timely support from a supervising faculty member.
- 2.5. The program director will ensure that all Program policies relating to supervision are distributed to residents and faculty who supervise residents. A copy of the program policy on supervision is included in the official Program Manual/Handbook and made available to each resident upon matriculation into the Program.

### **III. PROGRAM SUPERVISION POLICY**

- 3.1. All program faculty members supervising residents must have a faculty or clinical faculty appointment at the Morehouse School of Medicine or be specifically approved as supervisor by the program director.
- 3.2. Faculty schedules will be structured to provide residents with continuous supervision and consultation.
- 3.3. Residents must be supervised by faculty members in a manner promoting progressively increasing responsibility for each resident according to his or her level of education, ability, and experience. Residents will be provided information addressing the method(s) to access a supervisor in a timely and efficient manner at all times while on duty.
- 3.4. Residents and faculty members should inform patients of their respective roles in each patient's care.
- 3.5. All team admissions are discussed with the Attending of record on the day of admission. The Attending of record (admitting physician) must then see and examine that patient within 24 hours from the time of admission.
- 3.6. When not providing direct supervision, a designated Attending will be available for immediate consultation by pager/phone 24 hours a day.
- 3.7. In the setting where an intern is being supervised by a PGY-2 or PGY-3 resident, it is expected that the supervising resident evaluates the patient at least daily. Attending supervision should be adequate to provide quality patient care.
- 3.8. Interns and residents perform procedures on their patients under the supervision of Attending physicians.
  - 3.8.1. Competence in performing procedures should be documented in the ABIM procedure log that each resident is given.
  - 3.8.2. Procedures are to be done in accordance with hospital policy at all times.

**IV. SUPERVISION OF AT-HOME CALL**

- 4.1. Residents may decide to check on clinic patient tasks while at home, but this is not required by the residency program.
  - 4.1.1. If residents choose to do this, they are to have all work supervised and cannot act independently.
  - 4.1.2. Residents may enter orders to be authorized by Attendings (pending) and may contact patients as they normally would during clinic (with documentation of all calls which are to be copied to Attendings) knowing that Attendings are immediately available by phone, providing indirect supervision with direct supervision available.
- 4.2. Residents taking pager call at home for the Renal and Cardiology services must notify their Attending of all calls within eight (8) hours. All questions on patients in the ICU or other urgent consultations should be discussed with the consult Attending or record overnight.

**V. PROGRESSIVE AUTHORITY AND RESPONSIBILITY, CONDITIONAL INDEPENDENCE, SUPERVISORY ROLE IN PATIENT CARE**

- 5.1. PGY-1 residents are supervised either directly or indirectly with direct supervision immediately available.
- 5.2. The Program provides additional information addressing the type and level of supervision for each post-graduate year in the program that is consistent with ACGME program requirements and, specifically, for supervision of residents engaged in performing invasive procedures (see rotation-specific information in the Handbook and the House Staff Procedure Supervision document).

**VI. GUIDELINES FOR WHEN RESIDENTS MUST COMMUNICATE WITH THE ATTENDING**

- 6.1. Any time a patient is transferred to a higher level of care, being discharged (including discharged against medical advice), or when end-of-life decisions are made, the supervising Attending must be notified as soon as possible, but within 24 hours by the team caring for the patient.
- 6.2. Supervising Attendings should be explicit in directing residents when to notify them if they differ from the 24-hour policy (cannot be longer than 24 hours).

**VII. SUPERVISION AND NIGHT FLOAT**

- 7.1. At Grady Hospital, the Night Float admissions are supervised by the Chief Medical Residents (CMR) and the Team H attending on Monday through Thursday.
- 7.2. On Friday through Sunday, the NF Float admissions will be supervised by the CMRs as well as the Attendings taking short call admissions over the weekend (see specific rotations for further details).

- 7.3. This information (short call and on call Attendings) is readily available to residents via the monthly call schedule.
- 7.4. The overnight supervisor for cross cover issues for patients already admitted to the Medicine service is the team Attending of record for that patient. This Attending should be immediately available by phone to supervise the NF 1 and NF 3 residents and advise regarding patient care issues.

**VIII. SUPERVISION IN THE AMUBLATORY SETTING**

- 8.1. Each patient evaluated by a resident in the MSM IM program in the ambulatory setting has a member of the medical staff as the designated Attending physician who is physically present and readily available during the patient encounter.
- 8.2. Residents will perform a history and physical examination on each patient and review the findings with the supervising Attending physician.
- 8.3. The resident will develop an assessment and plan and will discuss this plan with the supervising Attending. Subsequently, a plan of care will be agreed upon and then presented to the patient.
- 8.4. The resident will generate a problem-based note in the EMR summarizing the contents above. Each note will be reviewed and signed by the supervising Attending.
- 8.5. Residents will provide continuity of care for patients under the supervision of a team of supervising physicians.

## Morehouse School of Medicine Internal Medicine Residency House Staff Procedure Supervision Table

### Levels of Supervision

<b>Direct Supervision</b>	The supervising physician is physically present with the resident and patient.
<b>Indirect Supervision</b>	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.
<b>With Direct Supervision Available</b>	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.
<b>Oversight</b>	The supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered.

### Procedure Supervision

The trainee will not be performing the procedure	Attending present (Direct)	Attending in hospital and available for consultation (Indirect)	Attending out of hospital but available by phone (Indirect)	Supervising resident present (Direct)	Supervising resident in hospital and available for consultation (Indirect)	Supervising resident out of hospital but available by phone (Indirect)	The trainee may perform the procedure with supervising Attending/resident oversight
NA	1	2	3	4	5	6	Oversight
<b>CORE PROCEDURES</b>					R1	R2	R3
Admit patients to service					5	3	3
Complete H&P					5	3	3
Treat and manage common medical conditions					5	3	3
Make referrals and request consultations					5	3	3
Provide consultations within the scope of his/her privileges					4	3	3
Use all skills normally learned during medical school or residency					3	3	3
Render any care in a life-threatening emergency					4,5	6	3
<b>SEDATION</b>					R1	R2	R3
Local anesthesia					4	3	3
Moderate sedation					1	1	1
<b>GENERAL INTERNAL MEDICINE</b>					R1	R2	R3
Abscess drainage					4	3	3
Anoscopy					3	3	3
Arterial blood gas					5	3	3
Arterial line placement					4	3	3
Arthrocentesis					4	3	3
Aspirations and injections, joint or bursa					4	3	3
Bladder catheterization					5	3	3
Bone marrow aspiration					1	1	1
Bone marrow needle biopsy					1	1	1
Cardioversion, emergent					4	3	3

## Supervision Policy

The trainee will not be performing the procedure	Attending present (Direct)	Attending in hospital and available for consultation (Indirect)	Attending out of hospital but available by phone (Indirect)	Supervising resident present (Direct)	Supervising resident in hospital and available for consultation (Indirect)	Supervising resident out of hospital but available by phone (Indirect)	The trainee may perform the procedure with supervising Attending/resident oversight
NA	1	2	3	4	5	6	Oversight
Cardioversion, elective					1	1	1
Central venous catheterization					4	3	3
ECG interpretation panel, emergent					5	3	3
ECG interpretation panel, elective					3	3	3
Excisions of skin tags/other					1	1	1
Feeding tube placement (nasal or oral)					5	3	3
Flexible sigmoidoscopy					1	1	1
Lumbar puncture					4	3	3
Lymphangiography—NA					NA	NA	NA
Pap smear					1,4	3	3
Paracentesis					4	3	3
Pericardiocentesis (emergent)					2	2	2
Right heart catheterization (SG)					1	1	1
Suturing					5	3	3
Tendon/joint injections					4	3	3
Thoracentesis					4	3	3
Tracheal intubation, emergent					1,4	3	3
Tube thoracostomy					1	1	1
Venipuncture					Oversight	Oversight	Oversight
Peripheral IV placement					Oversight	Oversight	Oversight

- All procedures are discussed with the Attending physician prior to proceeding.
- Attending physician (or designated Attending) is to be available by phone at all times.
- NA = procedure not performed by IM residents.

**Morehouse School of Medicine  
Department of Internal Medicine  
Resident Position Descriptions**


<b>TITLE</b>	<b>Post Graduate Year–1 Resident (Intern)</b>
<b>REPORTS TO</b>	Program Director, Chief Medical Resident, Senior Level Resident
<b>POSITION SUMMARY</b>	An intern (or PGY-1) is a highly supervised medical school graduate who serves as the immediate manager of hospitalized patients and individuals in the outpatient settings. The intern also assists in teaching assigned medical students on the general floors and makes daily rounds with the medical students.
<b>COMPETENCIES AND ESSENTIAL FUNCTIONS</b>	
<b>Inpatient Responsibilities</b>	<ul style="list-style-type: none"> <li>• The intern performs a comprehensive admission history and physical examination on all patients admitted to the service. These are recorded in a written or computerized medical record.</li> <li>• The intern develops an assessment and plan, and reviews these with the Attending physician and supervising resident.</li> <li>• The intern writes admission and subsequent orders that are approved by the supervising resident.</li> <li>• The intern writes prescriptions for hospital pharmacy filling for post-hospital care with approval from the supervising resident and Attending physician.</li> <li>• The intern assists with arranging appropriate follow-up care of patients.</li> </ul>
<b>Outpatient Responsibilities</b>	<ul style="list-style-type: none"> <li>• The intern performs history and physical exams on all ambulatory patients.</li> <li>• Develops assessments and plans.</li> <li>• Writes prescriptions as appropriate with review by an Attending physician.</li> <li>• Performs outpatient procedures and schedules follow-up under the direction of an Attending physician.</li> </ul>
<b>KNOWLEDGE, SKILLS, AND ABILITY</b>	<p>The intern independently may perform the following procedures after observation and evaluation of competency by supervisors:</p> <ul style="list-style-type: none"> <li>• Insertion of peripheral venous needle or catheter (3)</li> <li>• Insertion of nasogastric tube (3)</li> <li>• Insertion of feeding tube (3)</li> <li>• Insertion of Ewald tube for lavage (3)</li> <li>• Arterial puncture (3)</li> <li>• Arterial catheter (3)</li> <li>• Simple skin suturing (1)</li> </ul> <p>The intern may perform the following procedures under the supervision of a higher-level resident or Attending physician:</p> <ul style="list-style-type: none"> <li>• Thoracentesis (5)</li> <li>• Paracentesis (3)</li> <li>• Lumbar puncture (5)</li> </ul>
<b>SUPERVISORY RESPONSIBILITIES</b>	Medical students

## Supervision Policy

TITLE	Post Graduate Year–2 Resident
REPORTS TO	Program Director, Chief Medical Resident, Senior Level Resident
POSITION SUMMARY	A PGY-2 resident is a supervised trainee who serves as inpatient team leader, consultant, or outpatient physician with general supervision by an Attending physician or PGY-3 resident. PGY-2 residents are responsible for supervising two PGY-1 residents, one to two third-year MSM medical students, and 16 to 20 patients. The PGY-2 resident may make independent assessments and decisions about treatment, but must get approval from an Attending physician or PGY-3 resident before performing or ordering invasive procedures or escalating care where significant risk is involved (example, starting pressors, IV antiarrhythmics, etc.)
COMPETENCIES AND ESSENTIAL FUNCTIONS	
In the Second Year of Training	<ul style="list-style-type: none"> <li>• The resident writes admission notes on each patient.</li> <li>• In conjunction with the Attending, manages the ongoing care of hospitalized patients.</li> <li>• Supervises interns and medical students.</li> <li>• Arranges follow-up and placement for hospitalized patients in conjunction with case management.</li> <li>• Writes discharge summaries on all patients admitted to his or her team.</li> </ul>
KNOWLEDGE, SKILLS, AND ABILITY	<ul style="list-style-type: none"> <li>• The PGY-2 resident may perform procedures with supervision if qualified and evaluated as competent by supervisors as listed in the PGY-1 job description.</li> <li>• In addition, the PGY-2 resident may place central venous catheters after being privileged to do so by performing appropriately the following numbers of supervised procedures:               <ul style="list-style-type: none"> <li>○ Internal jugular vein catheterization (5)</li> <li>○ Subclavian vein catheterization (5)</li> </ul> </li> <li>• The following procedure must at all times be performed in the presence of an Attending physician:               <ul style="list-style-type: none"> <li>○ Insertion of right heart/pulmonary artery catheters (5)</li> <li>○ Endotracheal intubations</li> </ul> </li> </ul>
SUPERVISORY RESPONSIBILITIES	PGY-1 residents and medical students



TITLE	Post Graduate Year–3 Resident
<b>REPORTS TO</b>	Program Director, Chief Medical Resident
<b>POSITION SUMMARY</b>	A senior level resident functions semi-autonomously in performing the same duties as a PGY-2 resident. The PGY-3 resident must discuss important decisions about diagnosis or treatment with the Attending physician or other staff physicians. The third-year resident supervises ward rotations for two to three PGY-1 and two residents, one to two third-year medical students, and 16 to 20 patients.
<b>COMPETENCIES AND ESSENTIAL FUNCTIONS</b>	The senior resident may perform all of the procedures described for Level 1 and 2 if he or she has met the qualifications and has been evaluated competent by supervisors. The senior resident may write orders and prescriptions for inpatients and outpatients.
<b>KNOWLEDGE, SKILLS, AND ABILITY</b>	PGY-3 residents may perform a screening flexible sigmoidoscopy under direct supervision by a certified Attending physician.
<b>SUPERVISORY RESPONSIBILITIES</b>	PGY-1, PGY-2, and medical students

	<b>MOREHOUSE SCHOOL OF MEDICINE</b> INTERNAL MEDICINE RESIDENCY PROGRAM POLICIES AND PROCEDURES	POLICY NUMBER	IM-13
		EFFECTIVE DATE	01/21/2015
		PAGE(S)	04
	<b>SUBJECT: RESIDENTY PROCEDURE REQUIREMENTS AND LOGGING POLICY</b>		SUPERSEDES

## Residency Procedure Requirements and Logging Policy

### I. BACKGROUND

- 1.1. Residents must be able to competently perform all medical, diagnostic, and surgical procedures considered essential for the area of practice.
- 1.2. In accordance with the ABIM, the MSM IM Residency Program has a number of procedures in which the resident must demonstrate competency prior to completion of his or her residency training.

### II. PURPOSE

- 2.1. The purpose of this policy is to delineate how residents and the MSM IM Residency Program will track procedures. Documentation on supervision of specific procedures is included within the MSM IM Supervision Policy.
- 2.2. All residents are given an ABIM Procedure log book at the beginning of their residency training. In addition, interns receive information on required procedures at the beginning of their training.
- 2.3. It is expected that interns and residents are first supervised by an upper level resident or Attending competent in the procedure prior to performing the procedure, unless it is a procedure where competence is expected at the end of medical school training (e.g., venipuncture). Attending physicians should be notified of all patient procedures other than venipuncture and IV line placement.
- 2.4. Residents record procedures in their log book as directed.
  - 2.4.1. If the log contains PHI such as a medical record number, then the log must be kept secure at all times.
  - 2.4.2. After they have been logged, procedures are signed off by a supervising resident or an Attending physician.
  - 2.4.3. Residents have also been instructed on logging their procedures in New Innovations and this is the preferred method of logging. Residents can log their procedures into NI as often as they like, but it must be done at least monthly.
  - 2.4.4. Procedures will be tracked by the residency program every six (6) months at the semi-annual evaluation. If there are required procedures in which residents do not appear to be getting enough experience, the Program will work with residents, faculty, and staff to expand exposure to those procedures.

- 2.5. For the five (5) procedures that residents must be able to perform competently (see chart below), the resident must perform the procedure at least five (5) times over three (3) years of training to demonstrate competence. After the resident has successfully performed those procedures twice under supervision, they may supervise other residents and interns performing the procedure.
- 2.6. Regarding simulation, required procedures such as ACLS and training for code blue situations are done at least twice per year by the chief medical residents and ICU Attendings.
- 2.7. Education/Preparation
  - 2.7.1. The program recommends the NEJM procedure video library for the purpose of viewing and reviewing procedures.
  - 2.7.2. Videos can be accessed at [www.nejm.org/multimedia/medical-videos](http://www.nejm.org/multimedia/medical-videos).

### **III. ABIM COMPETENCY REQUIREMENTS FOR INTERNAL MEDICINE TRAINEES**

- 3.1. Safety is the highest priority when performing any procedure on a patient. ABIM recognizes that there is variability in the types and numbers of procedures performed by internists in practice. Internists who perform any procedure must obtain the appropriate training to safely and competently perform that procedure. I
- 3.2. It is also expected that the internist be thoroughly evaluated and credentialed as competent in performing a procedure before he or she can perform a procedure unsupervised.
- 3.3. For certification in internal medicine, ABIM has identified a limited set of procedures in which it expects all candidates to be competent with regard to their knowledge and understanding. This set includes:
  - 3.3.1. Demonstration of competence in medical knowledge relevant to procedures through the candidate's ability to explain indications, contraindications, patient preparation methods, sterile techniques, pain management, proper techniques for handling specimens and fluids obtained, and test results;
  - 3.3.2. Ability to recognize and manage complications; and
  - 3.3.3. Ability to clearly explain to a patient all facets of the procedure necessary to obtain informed consent.
- 3.4. For a subset of procedures, ABIM requires all candidates to demonstrate competence and safe performance by means of evaluations performed during residency training. The set of procedures and associated competencies required for each are listed below.
- 3.5. To help residents acquire both knowledge and performance competence, ABIM believes that residents should be active participants in performing procedures. Active participation is defined as serving as the primary operator or assisting another primary operator.


## Residency Procedure Requirements and Logging Policy

- 3.6.** ABIM encourages program directors to provide each resident with sufficient opportunity to be observed as an active participant in the performance of required procedures.
- 3.7.** In addition, ABIM strongly recommends that procedural training be conducted initially through simulations. At the end of training, as part of the evaluation required for admission to the Certification Examination in Internal Medicine, program directors must attest to each resident’s knowledge and competency to perform the procedures.
- 3.8.** ***ABIM does not specify a minimum number of procedures to demonstrate competency; however, to ensure adequate knowledge and understanding of the common procedures in internal medicine, each resident should be an active participant for each procedure five (5) or more times.***
- 3.9.** Competency is required in the following procedures:

	Know, Understand, and Explain				Perform Safely and Competently
	<ul style="list-style-type: none"> <li>• Indications</li> <li>• Contra-indications</li> <li>• Recognition and Management of Complications</li> <li>• Pain Management</li> <li>• Sterile Techniques</li> </ul>	Specimen Handling	Interpretation of Results	Requirements and Knowledge to Obtain Informed Consent	
Abdominal paracentesis	X	X	X	X	
Advanced cardiac life support	X	N/A	N/A	N/A	X
Arterial line placement	X	N/A	X	X	
Arthrocentesis	X	X	X	X	
Central venous line placement	X	X	N/A	X	
Drawing venous blood	X	X	X	N/A	X
Drawing arterial blood	X	X	X	X	X
Electrocardiogram	X	N/A	X	N/A	
Incision and drainage of an abscess	X	X	X	X	
Lumbar puncture	X	X	X	X	
Nasogastric intubation	X	X	X	X	
Pap smear and endocervical culture	X	X	X	X	X

	Know, Understand, and Explain				Perform Safely and Competently
	<ul style="list-style-type: none"> <li>• Indications</li> <li>• Contra-indications</li> <li>• Recognition and Management of Complications</li> <li>• Pain Management</li> <li>• Sterile Techniques</li> </ul>	Specimen Handling	Interpretation of Results	Requirements and Knowledge to Obtain Informed Consent	
Placing a peripheral venous line	X	N/A	N/A	N/A	X
Pulmonary artery catheter placement	X	N/A	X	X	
Thoracentesis	X	X	X	X	

- 3.10.** Grady Teaching Hospital, the major teaching hospital for the MSM IM Residency Program, has a “Central Line” test and special procedures which all providers must abide by in order to place central lines at Grady Hospital.
- 3.11.** Providers must do five (5) supervised central lines and get 100% on the “Central Line Test” in order to be certified to perform central lines.
- 3.12.** Further information is available from the chief medical residents at Grady (references [www.abim.org](http://www.abim.org); [www.gradynet.org](http://www.gradynet.org)).

	<b>MOREHOUSE SCHOOL OF MEDICINE</b> INTERNAL MEDICINE RESIDENCY PROGRAM POLICIES AND PROCEDURES	POLICY NUMBER	N/A
		EFFECTIVE DATE	01/19/2015
		PAGE(S)	02
	<b>SUBJECT: RESIDENT CONCERN AND COMPLAINT PROCESS</b>	SUPERSEDES	

### Resident Concern and Complaint Process


The Internal Medicine Residency Program follows all MSM and GME policies for resident concerns and complaints available in policy manuals on the MSM website: <http://www.msm.edu/Education/GME/index.php>.

To ensure that residents are able to raise concerns, complaints, and provide feedback without intimidation or retaliation, and in a confidential manner as appropriate, the following options and resources are available and annually communicated to residents and faculty.

Step	Procedure
1	Discuss the concern or complaint with your chief resident, service director, program manager, associate program director, and/or program director as appropriate.
2	If the concern or complaint involves the program director and/or cannot be addressed in step one, residents have the option of discussing issues with the department chair or service chief of a specific hospital, as appropriate.
3	If the resident is not able to resolve the concern or complaint within his or her Program, the following resources are available:
	<ul style="list-style-type: none"> <li>For issues involving Program concerns, training matters, or work environment, residents can contact the Graduate Medical Education Director (404-752-1011 or <a href="mailto:tsamuels@msm.edu">tsamuels@msm.edu</a>).</li> </ul>
	<ul style="list-style-type: none"> <li>For problems involving interpersonal issues, the Resident Association president or president elect may be a comfortable option to discuss confidential, informal issues apart and separate from the resident's parent department.</li> </ul>
	<ul style="list-style-type: none"> <li>Residents can provide anonymous feedback/concerns/complaints to any department at Morehouse School of Medicine by completing the online GME Feedback form found at the following website: <a href="http://fs10.formsite.com/bbanks/form33/index.html">http://fs10.formsite.com/bbanks/form33/index.html</a>. Comments are anonymous and cannot be traced back to individuals.</li> </ul>

Step	Procedure
	<p><b>NOTE: Personal follow-up regarding how feedback, concerns, or complaints have been addressed by departments and/or GME will be provided only if residents elect to include their name and contact information in the comments field.</b></p>
	<ul style="list-style-type: none"> <li>• The MSM Compliance Hotline(1-888-756-1364) is an anonymous and confidential mechanism for reporting unethical, non-compliant, and/or illegal activity. Call the Compliance Hotline to report any concern that could threaten or create a loss to the MSM community including:               <ul style="list-style-type: none"> <li>○ Harassment—sexual, racial, disability, religious, retaliation</li> <li>○ Environment Health and Safety—biological, laboratory, radiation, laser, occupational, chemical and waste management safety issues</li> <li>○ Other reporting purposes:                   <ul style="list-style-type: none"> <li>▪ Misuse of resources, time, or property assets</li> <li>▪ Accounting, audit, and internal control matters</li> <li>▪ Falsification of records</li> <li>▪ Theft, bribes, and kickbacks</li> </ul> </li> </ul> </li> </ul>

Refer to the online version of the MSM GME Policy Manual for detailed information regarding the Adverse Academic Decisions and Due Process policy.

	<b>MOREHOUSE SCHOOL OF MEDICINE</b> INTERNAL MEDICINE RESIDENCY PROGRAM POLICIES AND PROCEDURES	POLICY NUMBER	GME 17
		EFFECTIVE DATE	04/02/2013
		PAGE(S)	02
	<b>SUBJECT: USMLE STEP 3 REQUIREMENT POLICY</b>	SUPERSEDES	04/01/2011

## USMLE Step 3 Requirement Policy

### I. PURPOSE

- 1.1. The purpose of this policy is to ensure that the quality of Graduate Medical Education (GME) programs at Morehouse School of Medicine (MSM) meets the standards outlined in the Graduate Medical Education Directory: “Essentials of Accredited Residencies in Graduate Medical Education” (AMA-current edition) and the Internal Medicine (IM) Residency Program goals and objectives.
- 1.2. A resident who will be prepared to undertake independent medical practice shall have completed requirements to obtain a physician’s license.

### II. SCOPE


All Morehouse School of Medicine (MSM) administrators, faculty, staff, residents, and accredited affiliates shall understand and support this policy and all other policies and procedures that govern both GME programs and resident appointments at MSM.

### III. POLICY

- 3.1. Internal Medicine residents must pass USMLE Step 3 by their 24<sup>th</sup> month of residency.
  - 3.1.1. Internal Medicine residents must present the official results of their USMLE Step 3 examination to the residency program director before the last working day of the resident’s 20<sup>th</sup> month which is, in a normal appointment cycle, February.
  - 3.1.2. Internal Medicine residents who have not passed Step 3 by the end of the 20<sup>th</sup> month will not receive a reappointment letter to the IM Residency Program at the regular time.
- 3.2. Internal Medicine residents who pass USMLE Step 3 between the 21<sup>st</sup> and 24<sup>th</sup> month, will receive a reappointment letter to a residency program at the time of receipt of the results, if this is the sole reason for not receiving an appointment letter.
- 3.3. An Internal Medicine resident who passes USMLE Step 3 beyond the outer parameters of this policy (e.g., passes in the 25<sup>th</sup> month) shall not be allowed to continue in the residency program. However, that resident may reapply to the program subject to review by the assistant dean for Graduate Medical Education in consultation with the program director and the director of Graduate Medical Education.



- 3.4.** Internal Medicine residents who transfer to MSM at the PGY-1 or PGY-2 level are subject to this policy.
- 3.4.1.** Internal Medicine residents who change status after beginning training in a PGY-1 preliminary position in internal medicine or surgery to a categorical position in another MSM program are recognized as a transfer resident.
- 3.4.2.** This policy applies even if the resident remains in internal medicine or surgery (preliminary to categorical).
- 3.5.** Internal Medicine residency shall not select transfer residents above the PGY-2 level for an MSM appointment if they have not passed USMLE Step 3.
- 3.6.** Internal Medicine residents shall be briefed on this policy in the annual GME Orientation.
- 3.6.1.** Internal Medicine residents who have not passed USMLE Step 3, but are still within the time limits, must sign a Letter of Understanding that they acknowledge the policy.
- 3.6.2.** A copy of the Letter of Understanding is co-signed by the GME director and shall be placed in the resident's educational file as well as in the Office of Graduate Medical Education file.
- 3.7.** Individual waivers to this policy may be considered by the associate dean for Graduate Medical Education under the following circumstances:
- Extended illness or personal leave;
  - Personal hardship or extenuating circumstances.

	<p align="center"><b>MOREHOUSE SCHOOL OF MEDICINE</b> INTERNAL MEDICINE RESIDENCY PROGRAM POLICIES AND PROCEDURES</p>	POLICY NUMBER	GME 08
		EFFECTIVE DATE	06/01/2014
		PAGE(S)	07
	<b><u>SUBJECT: PROFESSIONALISM POLICY</u></b>	SUPERSEDES	N/A

**Professionalism Policy**

(Resident Code of Conduct, Dress Code and Social Media Guidelines)

**I. PURPOSE**

- 1.1. Residents are responsible for fulfilling any and all obligations that the Residency Programs, clinical sites, and GME deem necessary for them to begin and continue duties as a resident, including but not limited to:
  - 1.1.1. Attending orientations, receiving appropriate testing and follow-up if necessary for communicable diseases, fittings for appropriate safety equipment, necessary training and badging procedures (all of which may be prior to appointment start date)
  - 1.1.2. Completing required GME, hospital and Program administrative functions in a timely fashion and before deadlines such as medical records, mandatory on-line training modules and surveys, or other communications
- 1.2. All Internal Medicine faculty members are responsible for educating, monitoring, and providing positive examples of professionalism to residents.
- 1.3. Refer to the GME Concern/Complaint Procedure regarding specific professionalism reporting systems and resources.

**II. SCOPE**

- 2.1. All Morehouse School of Medicine (MSM) administrators, faculty, staff, Residents, and academic affiliates shall understand and support this and all other policies and procedures that govern both Graduate Medical Education programs and Resident appointments at Morehouse School of Medicine.
- 2.2. The Internal Medicine Residency Program is committed to training residents in *Professionalism* as well as the five (5) other required ACGME competencies.
- 2.3. Professionalism lectures and retreats are well integrated into the curriculum and include:
  - 2.3.1. An overview of Professionalism Milestones during orientation,
  - 2.3.2. Quarterly professionalism conferences and professionalism-related workshops and presentations during retreats.

- 2.3.3.** In addition the MSM IM faculty and chief residents are expected to model professionalism to the residents in all clinical settings and in their interactions with patients, staff, other faculty members, residents, and students.
- 2.3.4.** The program director will ensure that all program policies relating to professionalism are distributed to residents and faculty members. A copy of the program policy on professionalism is included in the official Program Policy Manual and provided to each resident upon matriculation into the program.

### **III. POLICY**

#### **3.1. Professionalism—Code of Conduct**

- 3.1.1.** Residents are responsible for demonstrating and abiding by the following professionalism principles and guidelines. Physicians must develop habits of conduct that are perceived by patients and peers as signs of trust. Every physician must demonstrate sensitivity, compassion, integrity, respect, and professionalism, and must maintain patient confidentiality and privacy. A patient's dignity and respect must always be maintained. Under all circumstances, response to patient needs shall supersede self-interest.
- 3.1.2.** Residents are responsible for completing hospital, program, and GME educational and administrative assignments by given deadlines that include:
  - 3.1.2.1.** Timely completion of evaluations and program documentation;
  - 3.1.2.2.** Logging of duty hours, cases, procedures, and experiences;
  - 3.1.2.3.** Promptly arriving for educational, administrative, and service activities.
- 3.1.3.** A medical professional consistently demonstrates respect for patients by his or her performance, behavior, attitude, and appearance. Commitment to carrying out professional responsibilities and an adherence to ethical principles are reflected in the following expected behaviors:
  - 3.1.3.1.** Respect patient privacy and confidentiality.
  - 3.1.3.2.** Knock on the door before entering a patient's room.
  - 3.1.3.3.** Appropriately drape a patient during an examination.
  - 3.1.3.4.** Do not discuss patient information in public areas, including elevators and cafeterias.

- 3.1.4.** Respect patient self-autonomy and the right of a patient and a family to be involved in care decisions.
  - 3.1.4.1.** Introduce oneself to the patient and his or her family members and explain roles in the patient's care.
  - 3.1.4.2.** Wear name tags that clearly identify names and roles.
  - 3.1.4.3.** Take time to ensure the patient and his or her family members' understanding and informed consent of medical decisions and progress.
- 3.1.5.** Respect the sanctity of the healing relationship.
  - 3.1.5.1.** Exhibit compassion, integrity, and respect for others.
  - 3.1.5.2.** Ensure continuity of care when a patient is discharged from a hospital by documenting who will provide that care and informing the patient of how that caregiver can be reached.
  - 3.1.5.3.** Respond promptly to phone messages, pages, email, and other correspondence.
  - 3.1.5.4.** Provide reliable coverage through colleagues when not available.
  - 3.1.5.5.** Maintain and promote physician/patient boundaries.
- 3.1.6.** Respect individual patient concerns and perceptions.
  - 3.1.6.1.** Comply with accepted standards of dress as defined by each hospital.
  - 3.1.6.2.** Arrive promptly for patient appointments.
  - 3.1.6.3.** Remain sensitive and responsive to a diverse patient population, including but not limited to diversity in gender, age, culture, race, religion, disabilities, and sexual orientation.
- 3.1.7.** Respect the systems in place to improve quality and safety of patient care.
  - 3.1.7.1.** Complete all mandated on-line tutorials and public health measures (e.g., TB skin testing) within designated timeframe.
  - 3.1.7.2.** Report all adverse events within a timely fashion.
  - 3.1.7.3.** Improve systems and quality of care through critical self-examination of care patterns.

- 3.1.8.** A professional consistently demonstrates respect for peers and co-workers.
  - 3.1.8.1.** Demonstrate respect for colleagues by maintaining effective communication.
  - 3.1.8.2.** Inform primary care providers of patient's admission, the hospital content, and discharge plans.
  - 3.1.8.3.** Provide consulting physicians all data needed to provide a consultation.
  - 3.1.8.4.** Maintain legible and up-to-date medical records, including dictating discharge summaries within approved hospital guidelines.
  - 3.1.8.5.** Inform all members of the care team, including non-physician professionals, of patient plans and progress.
  - 3.1.8.6.** Provide continued verbal and written communication to referring physicians.
  - 3.1.8.7.** Understand a referring physician's needs and concerns about his or her patients.
  - 3.1.8.8.** Provide all appropriate supervision needed for those one is supervising, by informing and involving supervising faculty of any changes in patient status, and by providing informed and safe handoffs to colleagues who provide patient coverage.
  - 3.1.8.9.** Acknowledge, promote, and maintain the dignity and respect of all healthcare providers.
- 3.1.9.** A professional consistently demonstrates respect for diversity of opinion, gender, and ethnicity in the workplace.
  - 3.1.9.1.** Maintain a work environment that is free of harassment of any sort.
  - 3.1.9.2.** Respect the opinions of all health professionals involved in the care of a patient.
  - 3.1.9.3.** Encourage team-based care.
  - 3.1.9.4.** In addition, professionals are held accountable to specialty-specific board and/or society codes of medical professionalism.

**3.2. Professionalism—Dress Code**

- 3.2.1.** Residents must adhere to the following policies or procedures to reflect a professional appearance in the clinical work environment. Residents are also held accountable to relevant individual hospital/site and MSM institution policies.
- 3.2.2.** Identification—Unaltered ID badges must be worn and remain visible at all times. If the badge is displayed on a lanyard, it should be a break-away variety.
- 3.2.3.** White Coats—A long white coat that specifies the physician’s name and department should be worn.
- 3.2.4.** Personal Hygiene:
- 3.2.4.1.** Hair must be kept clean and well groomed. Hair color or style may not be extreme. Long hair must be contained as so to not drape or fall into work area.
- 3.2.4.2.** Facial hair must be neat, clean, and well-trimmed.
- 3.2.4.3.** Fingernails must be kept clean and of appropriate length.
- 3.2.4.4.** Scent of fragrance or tobacco should be limited or minimized.
- 3.2.4.5.** Shoes/Footwear must be clean, in good repair, and of a professional style appropriate to work performed. No open-toed shoes may be worn during patient care activities. Shoes must have fully enclosed heels or secured with a heel strap for safety purposes. Clean athletic shoes, appropriate for the work environment ,can be worn on call days with scrubs.
- 3.2.4.6.** Jewelry must not interfere with job performance or safety.
- 3.2.4.7.** The following items are inappropriate and not permitted:
- Pins
  - Buttons
  - Jewelry
  - Emblems, or insignia bearing a political, controversial, inflammatory, or provocative message
- 3.2.4.8.** Tattoos—Every effort must be made to cover visible tattoos.

**3.2.4.9.** Clothing must reflect a professional image, including:

- Dress-type pants and collared shirts.
- Skirt and dress length must be appropriate length.
- Clothing should cover back, shoulders, and midriff and have a modest neckline (no cleavage).
- No leggings worn as pants.
- No hoodies without a long white coat.

**3.2.4.10.** Scrubs—Residents may wear scrubs in any clinical situation where appropriate. When not in a work area, a white coat should be worn over scrubs. Hospital-based policies on scrubs should be followed at all times.

**3.3.** Professionalism—Social Media Guidelines

**3.3.1.** Because social media blurs the line between personal voice and institutional voice, these guidelines were created to clarify how best to protect personal and professional reputations when participating.

**3.3.2.** In both professional and institutional roles, employees need to adopt a common sense approach and follow the same behavioral standards online as they would in real life, and are responsible for anything they post to social media sites either professionally or personally.

**3.3.3.** For these purposes, *social media* includes but is not limited to social networking sites, collaborative projects such as wikis, blogs, and microblogs, content communities, and virtual communities.

**3.3.4.** Adopt the following best practices for all social media sites, including personal sites:

**3.3.4.1.** Think before posting—There is no such thing as privacy in the social media world. Before you publish a post, consider how it would reflect on you, your department or unit, and on the institution.

**3.3.4.2.** Search engine databases store posts years after they were published, so posts could be found even if they were deleted; and comments may be forwarded or copied.

**3.3.4.3.** Be accurate—Verify your information for accuracy, spelling, and grammatical errors before posting. If an error or omission ends up being posted, post a correction as quickly as possible.

**3.3.4.4.** Be respectful—The goal of social media is to engage your audience in conversation. At times, that comes in the form of opposing ideas. Consider how to respond or disengage in a way that will not alienate, harm, or provoke.

- 3.3.4.5.** Remember your audience—Though you may have a target audience, be aware that anything posted on your social media account is also available to the public at large, including prospective students, current students, staff, faculty, and peers.
- 3.3.4.6.** Be a valuable member—Contribute valuable insights in your posts and comments. Self-promoting behavior is viewed negatively and can lead to you being banned from a website or group in which you are trying to participate.
- 3.3.4.7.** Ensure your accounts' security—A compromised account is an open door for malicious entities to post inappropriate or even illegal material as though it were from you. If you administer a hospital/school/ college/department/unit social media account, be sure to use a different password than for your personal accounts. Follow best practices in selecting and protecting your university account passwords.
- 3.3.5.** Guidelines for all social media sites, including personal sites:
  - 3.3.5.1.** Protect confidential and proprietary information
    - 3.3.5.1.1.** Do not post confidential information about MSM, students, faculty, staff, patients, or alumni
    - 3.3.5.1.2.** Do not post information that is proprietary to an entity other than yourself.
    - 3.3.5.1.3.** Employees must follow all applicable Federal privacy requirements for written and visual content, such as FERPA and HIPAA. Failure to do so comes at the risk of disciplinary action and/or termination.
  - 3.3.5.2.** Respect copyright and fair use.
    - 3.3.5.2.1.** When posting, be aware of the copyright and intellectual property rights of others and of the university.
    - 3.3.5.2.2.** Refer to MSM system policies on copyright and intellectual property for more information/guidance.
  - 3.3.5.3.** Do not imply MSM endorsement.
    - 3.3.5.3.1.** The logo, word mark, iconography, or other imagery shall not be used on personal social media channels.
    - 3.3.5.3.2.** Similarly, the MSM name shall not be used to promote a product, cause, political party, or candidate.