

FLORIDA HOSPITAL MEDICAL CENTER  
INTERNAL MEDICINE RESIDENCY PROGRAM  
HOUSE OFFICER'S MANUAL

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Attachment 1 Promotion Criteria

## **INTRODUCTION**

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

## **PROGRAM GOALS AND OBJECTIVES**

### Goals:

- To train internal medicine residents to competently practice general internal medicine in preparation for ambulatory and hospital practice, further subspecialty training, or an academic career.
- To assure board certification status for all residents.
- To assure competency in six areas: medical knowledge, patient care, professionalism, systems-based practice, interpersonal and communication skills, and practice-based learning improvement.

### Objectives:

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

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

- General Internal Medicine: Inpatient and ambulatory, episodic, consultative and continuous care
- Subspecialty Internal Medicine: Geriatric Medicine, Cardiology, Endocrinology, Gastroenterology, Hematology/Oncology, Infections Disease, Nephrology, Pulmonology, Rheumatology, Critical Care Medicine and Allergy/Immunology
- Non-Internal Medicine Specialties: Gynecology/Women's Health, Orthopedics, ENT, Psychiatry, Ophthalmology, Neurology, Rehabilitation Medicine, Emergency Medicine, and Dermatology
- Procedural Internal Medicine
- Interdisciplinary care: Ethics, Occupational Health, Medical Genetics, Quality Assessment and Improvement, Preventive Medicine, Medical Informatics, Critical Reading Skills, Domestic Abuse, Pain Management, Adolescent Health, End-of-Life Care, Law and Public Policy, Physician Impairment, Substance Abuse and Risk Management
- Research & Scholarly Activities

## **AMBULATORY MEDICINE**

The major experience in ambulatory medicine is the general medicine continuity clinic. Each house officer is assigned to clinic one half day per week in which he/she will be exposed to a variety of patients typical of an internist's practice. Teaching is patient-centered with care directed at acute problems as well as primary prevention and maintenance of wellness. All patients seen in the clinic must be discussed with the attending physician prior to discharge.

## **INPATIENT MEDICINE**

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

## **EMERGENCY MEDICINE**

Each resident will participate in a minimum of one month of emergency medicine that fosters training in acute episodic care. The experiences will provide exposure to a wide variety of illnesses from minor to life-threatening conditions. These rotations reinforce skills in patient assessment, cost-effective management of the acutely ill patient, and ambulatory procedures.

## **INTENSIVE CARE**

Rotations in critical care medicine comprise at least 3 months of the residency. The educational premise of the rotations is to train our residents in the principles of management of the critically ill patient. Residents will gain experience in hemodynamic monitoring, mechanical ventilation, nutritional and pharmacological support of the intensive care patient, and management of acute cardiac diseases. The core of the educational experience is patient-based with written curriculum and didactics.

## **PROCEDURES**

Throughout the course of the residency, house officers will have numerous occasions to become proficient with many medical procedures. These include *ACLS (certification is required)*, flexible sigmoidoscopy, thoracentesis, paracentesis, pelvic/breast/rectal examinations, venous and arterial cannulations, hemodynamic monitoring, and lumbar puncture. Additionally, residents will become proficient in the interpretation of EKGs, chest radiographs, basic spirometry, urinalysis, vaginal preps, sputum gram stains, and peripheral blood smears. Performing an invasive procedure on a patient should be viewed in light of indications, contraindications and the need for informed consent. All residents **must** maintain a procedure log to assist with obtaining hospital privileges in the future.

All elective procedures require:

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

## **CONFERENCES**

Attendance at all conferences is required and is monitored. A minimum of 75% attendance is expected for each house officer.

- Morning Report is held 11:00 am -11:45 am Monday thru Friday. The format will generally be the presentation of a recently admitted patient to an attending physician by the medical student, intern, or resident on the service who is caring for the patient. The presentation should be succinct, lasting no longer than five minutes and emphasize the pertinent points of the history and physical examination. The discussion, which follows, will address important aspects of the history and physical examination, formulation of a complete differential diagnosis, and management of the disease process in the individual patient. In order to effectively discuss each case, the presenter should prepare to answer pertinent questions concerning the patient's work-up, including lab values and test results. Any available radiology studies, EKGs, or slides should be brought to the conference when possible. The presenter should also have a basic knowledge, obtainable from a textbook of medicine or UpToDate, about the patient's diagnosis. This is not intended to be a morbidity and mortality conference; however, the managing physicians should prepare to defend their decisions and reasoning. **Attendance at morning report is required for residents on ward services and encouraged for all others.**
- Noon conference begins at 12:00 PM Monday-Friday. The noon conferences consist of forty-five minute didactic sessions on both general medicine and subspecialty topics. Lecturers are faculty members who present topics from a planned 36-month curriculum designed to provide each resident with a broad knowledge base of Internal Medicine. In addition, the noon conferences cover topics in preventive medicine, pain management, adolescent medicine, end-of-life care, substance abuse, QA/QI, critical reading skills, law and public policy, physician impairment, medical genetics, and domestic violence. The conferences are directed at providing information pertinent to the American Board of Internal Medicine (ABIM) certification examination.
- Morbidity and Mortality, a QA/QI conference, is held monthly. The residents present cases with unexpected or unusual outcomes with the intent to avoid future adverse outcomes and improve the quality of patient care.
- Journal club occurs monthly.
- House Staff meetings occur each month. Their purpose is to discuss issues and problems that pertain to the residency.
- Clinical Pathology Conference occurs monthly. This conference is a case presentation with a review of the pertinent histologic findings by a pathologist.

## **CURRICULUM/EDUCATION**

The academic residency in Internal Medicine provides a competency-based curriculum of didactic sessions and interactive case-based conferences. This curriculum is intended to form a foundation of knowledge that the house officer can expand upon by case-based reading and self-education.

## **PAGERS**

- Each house officer is assigned an alpha numeric pager for use for the duration of the residency training.
- It is the responsibility of the house officer to pay for the replacement of the pager should it be damaged, lost or stolen.
- Pagers are given to house officers so that the Internal Medicine program and other personnel who might require their assistance may contact them. In addition, conference reminders/cancellations and any other pertinent information may be sent via text message. Pages received at home are infrequent but may be important. Housestaff officers are encouraged to leave their pagers on whenever reasonable. All residents on call or must return their pages promptly at any hour.
- As part of the routine admission orders, house officers should list their physician numbers. It is advisable to record the physician number and contact number (*use provided name stamps*) each time orders are written.

## **READING**

Reading and self-education are the most successful methods to achieve a strong knowledge base in Internal Medicine. Additionally, the house officer is expected to remain up to date with the current Internal Medicine literature, especially that relevant to his current patients. *The New England Journal of Medicine* and the

*Annals of Internal Medicine* are both highly recommended. UpToDate is the best computer-based resource available.

## **RESEARCH**

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

## **SCHOLARLY ACTIVITY**

As a requirement of the RRC for Internal Medicine, all residents must complete a scholarly activity before finishing the residency. This requirement may be fulfilled only with a properly completed research project.

## **SUPERVISION**

Supervision is defined at three levels: General, Direct, and Personal

- General supervision means that the care or procedure is conducted under the staff member's overall direction and control but the physician's presence is not required at the time of care.
- Direct supervision requires that the physician must be immediately available to furnish assistance and direction.
- Personal supervision means that the staff physician must be in attendance in the room during the procedure.

## **GENERAL SUPERVISION POLICY**

- The program director is responsible for supervising the resident. Responsibility for the specific supervision may be assigned to a staff member on various academic rotations. Residents are members of the medical staff as defined in the hospital by-laws. They provide care to patients assigned to their attending physician.
- All patients receiving care at this institution are assigned to a member of the attending staff. The staff member responsible for the care of the patient will provide the appropriate level of supervision based on the nature of the patient's condition, the likelihood of major changes in the management plan, the complexity of care, and the experience and judgment demonstrated by the residents being supervised.
- As part of the training program, residents are given progressive responsibility for the care of patients and to act in a teaching capacity and provide supervision to less experienced residents and students. It is the decision of the staff member, with advice from the program director, as to which activities the resident will be allowed to perform within the context of the assigned levels of responsibility. The overriding consideration must be the safe and effective care of the patient.
- Documentation of supervision will be by progress note or signature by the attending physician or reflected within the resident's progress notes at a frequency appropriate to the patient's condition.
- Inpatient Supervision: In general, patients admitted by residents to the hospital who are in stable condition will receive General supervision. The resident should immediately notify the attending physician at the discretion of that attending (e.g. for every patient admitted or for selected patients). The attending physician will be expected to see the patient and review the management plan within 24 hours.
- Outpatient Clinic: Residents seeing patients in an outpatient clinic will receive direct supervision. Management plans for new patients or revision of management plans will be reviewed before the patients have left the clinic.
- Emergency Department: Residents assigned to the emergency department will receive Direct or Personal supervision depending on the severity of the problem and experience of the resident. Residents providing consultation or care to patients followed by their respective services receive General supervision by the staff of their service. Dispositions of these patients may be discussed by phone with the appropriate staff member and/or reviewed on return to an outpatient facility. If the patient is admitted, the treatment plan will be reviewed by the attending faculty the next day.
- Operating Room or Special Procedure Facility: Residents performing diagnostic procedures that require a high level of expertise in performance or interpretation will receive General, Direct, or

Personal supervision by a faculty member depending on the experience and proficiency previously demonstrated by the resident.

- Emergency Care: In an emergency, defined as a situation where immediate care is necessary to preserve life or prevent serious impairment of health, residents are permitted to perform everything possible to save a patient from serious harm pending arrival of more qualified staff. The appropriate staff practitioner will be notified as soon as possible.
- At the beginning of the curriculum, the supervisory policy is again stated in a condensed fashion. When the residents and faculty discuss the curriculum at the start of each month, they should also discuss supervision. Faculty may vary individually as to when they wish to be notified. Nonetheless, housestaff must be able to contact their attending physician promptly at all times. If a resident encounters any situation in which he feels that attending supervision is inadequate, he should immediately notify the chief residents or program director.

### **Lines of Responsibility for each Training Site**

#### Ward Medicine Teams:

The Attending physician is ultimately responsible for the care of all ward medicine patients and for the supervision of all medical team members. The senior medical resident supervises and is responsible for the actions of interns and medical students. The intern is supervisory to medical students and reports to the senior resident and Attending physician.

#### Night Float:

The same lines of responsibility for Ward Medicine teams apply to Night Float.

#### General Medical Outpatient Clinic and Continuity Clinic:

The Attending physician is ultimately responsible for the care of all outpatients. Each individual resident is responsible for his or her own patients. Supervision is by the Attending physician directly.

#### Specialty or Subspecialty Consult Services and Specialty or Subspecialty Inpatients and Outpatients:

The resident is directly responsible to the Specialty or Subspecialty Attending physician, who is ultimately responsible for patient care whether inpatient or outpatient. If a team structure exists for a Specialty or Subspecialty service, the senior resident will provide limited supervision to the junior resident or student.

### **Care to Non-Teaching Patients (All Sites)**

Interns and Residents may be called to assist in the emergency care of patients who are not on the teaching services. In these circumstances, the Residents will act as good Samaritans, providing assistance in emergency situations where the life or limb of the patient may be at risk. The Resident or Intern should stabilize the patient and immediately speak with the patient's attending physician. The attending physician of the patient will be expected to come into the hospital immediately to take care of his/her patient and the responsibility of the Resident physician should be terminated at that time. If the Resident encounters any difficulty with the physician under these circumstances, the teaching attending should be contacted and the situation resolved.

### **TEACHING**

An integral part of the learning experience is the ability to teach others. Residents in charge of a ward service are expected to provide bedside teaching as part of the daily ward activity.

### **JOB DESCRIPTIONS**

#### **Intern:**

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

Responsibilities:

- The intern is expected to arrive at the hospital in time to evaluate all assigned patients prior to morning work/attending rounds. It is impossible to conduct effective work rounds if you have not seen your patients before rounds begin.
- The intern is expected to attend all noon conferences and morning report while on inpatient services.
- The intern must perform and document a complete history and physical examination (using old records), develop a differential diagnosis, and implement a diagnostic and therapeutic plan. A complete ROS (10+ systems) must be part of this evaluation. The completed H and P must be charted within 24 hours of admission and may not be completed by a medical student.
- The intern should use all available preprinted orders.
- The intern must write the admission orders. They must read the resident admission note and discuss the assessment and plan with the resident or attending prior to any major interventions.
- The intern must provide daily care for each patient on the service including a daily assessment, progress note, and daily orders.
- The intern must supervise and instruct medical students on the proper way to perform and document a history and physical examination. The intern must supervise and teach invasive procedures to the student and supervise, instruct, and sign medical student orders. To summarize, the intern is responsible for the instruction of the medical student.
- The intern must maintain close communication with family members and guardians, especially when a change in the condition or prognosis of a patient occurs. Thorough documentation of all discussions with the patient and family is essential.
- The intern must follow-up all laboratory, radiological, and other diagnostic test results with documentation in the chart in a timely manner. This includes test results that return after patient discharge.
- The intern must communicate with colleagues concerning each patient's test results, plans of investigation or treatment, and other relative aspects of their care.
- The intern should complete all discharge summary dictations on the day of discharge.
- Prior to changing services at the end of the rotation, the intern must write a comprehensive off-service note.
- The intern should participate in consult service clinics, conferences, and meetings that do not conflict with fixed educational and outpatient responsibilities (such as medicine noon conference and continuity clinic).

#### Outpatient Clinics:

- All interns are assigned 1/2 day per week of continuity clinic. Clinic attending physicians teach outpatient diagnosis and management of chronic medical illnesses here as well as prevention and screening.
- All afternoon clinics begin at **1:15 PM**.
- Clinic is a required experience that is not pre-empted by any event other than emergency inpatient care. In case of an emergency, the resident or attending should be notified of the situation and your need to go to clinic.
- Interns assigned to MICU are exempt from weekly continuity clinic.
- Clinic cancellations for urgent/emergent reasons (serious illness, family emergency, etc.) must have the approval of the clinic attending physician.

#### **RESIDENT JOB DESCRIPTION (PGY 2-3)**

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

#### Responsibilities:

- Teach the intern how to work-up and care for patients and ensure that all patients on the service receive appropriate care.
- Oversee each medicine admission, supervising the interns and students.
- Write legible and educational resident admission notes on new patients including a brief differential diagnosis and a plan outlining the work-up and treatment.

- Hold work rounds. These are morning work rounds with interns conducted daily prior to attending rounds. Interns should have seen their patients, reviewed labs, obtained reports of diagnostic studies and have their notes on the chart prior to morning work rounds.
- Provide direct patient care when the PGY-1 has exceeded the twelve patient maximum.
- Supervise and teach medical students working on the teams.
- Supervise all procedures performed by the intern or students on the service.
- Coordinate attending rounds assuring timely initiation and completion of teaching rounds.
- Assure all team members attend morning report and are well prepared when presenting cases.
- Assure that team members are present and adequately prepared for rounds.
- Assure interns conduct daily sign-out rounds with a thorough checkout list.
- Review daily student and intern notes for quality assurance (i.e. check for legible notes which define an accurate problem list and plan of action, review lab data, and coordinate discharge planning). Follow-up notes on patients previously admitted are expected at least every other day.
- Review the level of care daily when patients are in the units or on telemetry to see if a lower level of care is appropriate.
- Provide a complete list of all patients on service with their problems and pending work-up to the oncoming supervisory resident at the time of monthly switch-over.
- Respond to and lead resuscitation teams.

#### Consult and Subspecialty Rotations:

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

#### Outpatient Clinics

- All residents will continue their previously scheduled weekly continuity clinic.
- Clinics are required experiences not to be pre-empted by any event other than urgent/emergent inpatient care.
- Residents rotating through MICU rotation will not be required to attend continuity clinic during the rotation.
- During ED rotations, residents will be required to attend continuity clinic but not secondary or subspecialty clinics. If the resident has an overnight shift prior to continuity clinic, the clinic will be cancelled in accordance with RRC requirements.
- During night float months, residents will attend a Friday morning continuity of care clinic.

### **ATTENDING PHYSICIAN TEACHING AND SUPERVISION RESPONSIBILITIES**

Conduct combined or management/teaching rounds with the house staff at least 12 hours per week. At least five hours out of the 12 hours must be devoted to teaching activities beyond management. These rounds should not interfere with morning report or noon conference and must include case presentations, interpretation of data, discussion of pathophysiology, differential diagnosis, management, use of technology, use of best evidence and patient values in decision making, disease prevention, and bedside teaching. Attending physicians should also:

- Review the rotation curriculum with the housestaff at the beginning of the month. The curriculum is available on line and is emailed to each attending at the beginning of the month.

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

**PROFESSIONAL CONDUCT** House officers are expected to maintain a high level of professional conduct. Professionalism is one of the six clinical competencies in which residents must demonstrate proficiency in order to successfully complete residency. Professionalism includes maintaining a professional appearance as well as demonstrating a high standard of moral and ethical behavior. Some examples of expected behavior that should be maintained throughout a physician's career are listed below. Other examples are given in the Academic Appeals Process section.

***Residents must read and sign the "Code of Professional Conduct".***

Communication:

- Discuss treatment plans or changes in status with patients and families daily
- Personally call all consultants at the time the consult order is written
- Call the patient's primary care provider upon admission and discharge and send a copy of the discharge summary to the physician's office
- Discuss issues concerning patient management with fellow colleagues personally and in a professional manner. Do not write inflammatory or disparaging remarks about colleagues in the chart.
- Notify the appropriate personnel including hospital paging operators immediately about any call schedule changes

Confidentiality:

- All residents and staff must comply with federal HIPPA guidelines.
- Respect patient privacy at all times. Avoid using patients' names and personal information in public places. Shred all documents with personal information, including patient census lists.

Honesty:

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

Appearance:

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

Dedication:

- Possess a sound work ethic
- Follow a diligent reading regimen
- Ensure proper follow-up of inpatient and outpatients
- Develop a good working relationships with colleagues and consultants
- Comply with the 80 hour work week and 30 hour continuous duty rule
- Always be on time.
- Promptly respond to all pages.

Respect :

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

## **EVALUATION OF HOUSE OFFICERS**

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

- Mini-CEX: During the PGY-1 year, all house officers will perform at least six mini-CEX's under the observation of an attending physician. These will be done in different venues, i.e., ward, ED, MICU, clinic, etc. These should be documented in the provided booklet and must be turned in to complete the intern year.
- In-training examination: There is a yearly in-training examination in October to aid the residents in assessing their knowledge. Although the results of this test are not used for decisions concerning promotion, this examination should be taken seriously. The in-training examination has been shown to be predictive of ultimate performance on the ABIM certifying examination.
- The curriculum always requires an end of month global evaluation by the attending physician. Other evaluation methodology includes 360 degree evaluations (peers, nurses, patients, etc.), ACLS certification, and procedure logs.
- End of rotation exam: a written exam will be given over assigned reading for each required rotation
- Chart Review: Chart review will be done twice yearly on a sample of continuity outpatients for each resident and will be done each month as an on-going assessment or each rotation.
- Residents have assigned advisors to aid them with their progress quarterly and inform them of any weaknesses. Residents may change their faculty advisor by asking another faculty member to be their advisor. If the faculty member agrees to take on the responsibility of being an advisor, the resident will then need to notify the program director. Faculty advisors also meet weekly to discuss the progress of all residents in the program.
- The house officer will also have the opportunity to evaluate the attending physicians monthly and annually. These evaluations are valued, extensively reviewed, and aid in faculty counseling. Once a year these evaluations are aggregated and used for feedback with complete preservation of resident anonymity.
- There will be two semi-annual evaluations of each resident by the outpatient clinic attending physicians for the continuity clinic.
- There will be two semi-annual evaluations for housestaff by the Program Director. The end-of-year evaluation must be summative, written, and address the competencies.
- Procedures will be documented in the Procedure log book and signed by the supervising physician if possible. Procedures will be recorded in the Resident Portfolio and tracked for timely completion of required procedure competency.
- ABIM annual tracking report is completed by the Program Director with the assistance of the resident's faculty mentor and other members of the core faculty.
- Conference attendance is monitored by a sign in sheet and recorded in the resident portfolio. Seventy five percent attendance at required conferences is necessary.
- Scholarly activity is mandatory for all residents for graduation. The proposed activity must be approved by the Program Director or other designated faculty member and only an original, scientifically designed project with data collection and analysis is acceptable. Residents are encouraged to develop projects as teams with other residents, faculty and health care personnel.

## **DISCIPLINARY ACTION**

- Residents who are perceived to be having serious academic or other program-related difficulties will be referred to the Clinical Competence Committee (CCC) by the program director. The CCC will review the resident's record and allow the resident to appear before the committee, if the resident

desires, before giving recommendations to the program director. The final decisions relating to the resident's progress in the program are made by the program director.

- Resident's files are considered to be confidential and can only be reviewed by others on a "need to know basis." Approval for access to files must be obtained from the program director.

Residents are guaranteed disciplinary and academic due process. The GME Residency Requirements and Procedure for Academic Review can be found in the GME Manual.

## **EVALUATION AND IMPROVEMENT OF THE TRAINING PROGRAM**

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

- Curriculum and Subspecialty Education Coordinators Committee: This committee plays a key role in curriculum development and implementation and in monitoring the subspecialties. It meets quarterly and is comprised of the Subspecialty Education Coordinators, Key Clinical Faculty, Associate Program Director and Program Director.
- Faculty Committee: This committee conducts the annual review of the program as well as monitors RRC compliance. It meets at least weekly and consists of the Program Director, Associate Program Director and Key Clinical Faculty.
- Evaluation of Faculty and Training Program: Residents are expected to fill out monthly evaluations of the faculty and rotation and yearly evaluations of the training program. This information is vital to efforts to improve the training experience for residents. All evaluations of the faculty and the training program by residents are confidential. The faculty receives a summary of all evaluations annually and the program is assessed annually by confidential survey.
- Meetings with faculty mentors (quarterly) and with the program director (semiannually) are good times to discuss program content in addition to the formal processes described above.

## **CHANGE OVER DAYS**

Residents and Faculty change over every 4 weeks.

## **DUTY HOUR RESTRICTIONS, VACATION, AND OTHER ABSENCES**

The internal medicine residency program adheres strictly to the RRC guidelines. They are summarized below and the entire policy can be viewed online at [www.acgme.org](http://www.acgme.org) under resident duty hours.

- The program will assure each housestaff officer has at least one 24-hour period away from the hospital averaged over a four week period for a minimum of four days off per four weeks.
- The resident's duty hours will be limited to 80 hours per week averaged over a four week period. Residents may not be on duty more than 30 continuous hours and must have at least 10 hours off between shifts. Post-overnight call residents must leave the hospital premises promptly at 1 pm or earlier if they started the previous day before 7 a.m. Teamwork is essential in order to comply with the RRC guidelines.
- Following an overnight call, housestaff must not care for any new inpatients.
- The ward team should work together in assigning days off for the month. This should be done on the first day of the rotation to assure that all team members get the required number of days off.
- Interns should cover for each other on their days off. The resident may offer to be the primary provider if patient volume or complexity dictates since interns may not round on more than 12 patients. The resident is generally expected to cover the junior intern's patients but may assign their care to another intern at his discretion.
- Housestaff on consult services and other electives are off at least one weekend day.
- Days off are built into the ED schedules.
- Hours spent moonlighting must be counted toward the 80-hour work week.

#### Vacation:

- Vacations are allowed only during elective/selective rotations.
- A holiday schedule is constructed so that all housestaff will receive 6 days off during the holiday period.
- Each PGY 1, 2, and 3 receives four weeks of vacation.
- A vacation is considered 5 working days. If the 5 days are taken as Monday-Friday, then surrounding weekends will also generally be granted for a total of 9 days.
- Any unusual vacation requests will require program director approval. No vacation greater than 3 weeks in duration will be granted, including those that entail foreign travel. Vacations of 2 weeks or more duration must be taken during back to back elective months, with part of the vacation occurring at the end of one elective and the remainder at the start of the next elective. Any other arrangements must be approved by the program director. Remember that you must have 15 working days of a rotation to receive credit. If foreign travel is anticipated, it is the resident's responsibility to have complied with all visa restrictions and rules.
- For those residents who must renew their visa status, this should be accomplished during planned vacations. Additional time off or educational leave will not be granted to accomplish visa renewal.
- Vacation requests must be submitted 3 months prior to the month for which vacation is requested. Late requests may be considered but are not guaranteed. Once the monthly call schedule is released, changes will only be made to correct errors.
- House officers must notify their continuity clinics of any planned time off at least **12 weeks prior to the planned vacation**.
- Residents should verify the approval of their vacation requests prior to making any non-refundable purchases such as airline tickets. Do not purchase airline tickets for the mid-year holidays until the holiday schedule is completed.

#### Educational leave:

In order to encourage scholarship, up to five days of educational leave (per year in PGY 2 and 3) is available to all residents during the course of the residency. This leave must be approved by the program director and is generally limited to elective months. For unapproved requests or requests that extend beyond the allowable days, the resident may use vacation days. The program encourages resident presentations at state, regional, and national meetings. Days spent at such a conference do not count as leave, but travel days count as days off.

#### Sick leave / personal leave:

All residents are allowed 20 days throughout each year for vacation or illness (brief or under the care of a physician) or illness/death in close family members. Periods of time longer than this may be covered under the Family Leave Act and are handled on a case by case basis. While leave under these circumstances may cause no loss in standing, it may necessitate additional time to satisfy completion of the minimum months required by the resident's training program.

#### Time off for interviews:

Although it is recognized that days off for interviewing for fellowship training or securing employment after your residency may be necessary, these should be kept to a minimum. All requests for days off for interviewing must be approved by the Program Director. Vacation days will be used. Interview days should be scheduled during ward or intensive care months only as a last resort.

#### Maternity & Paternity Leave – Review GME Manual

#### Maximum Leave Time:

The American Board of Internal Medicine mandates a maximum of 13 weeks for all types of Leave of Absences (LOA). This includes all types of vacation and leave during a 36-month internal medicine residency. Leave in excess of 13 weeks will need to be made up with additional training time for residents to be eligible to take the certifying examination in Internal Medicine. The ABIM discourages more than one month of leave per year. Any additional ("make-up") time must be completed by August 31 of your final year to take the certifying examination on schedule.

#### **MOONLIGHTING / SUNLIGHTING POLICY**

- Any resident who wishes to moonlight/sunlight must obtain written approval from the Program Director. Moonlighting must never cause a resident to work more than 80 hours per week.
- Moonlighting/sunlighting is not allowed during medicine wards or any ICU months.
- No moonlighting/sunlighting pre-call, post-call or when on back-up call.
- During ER months, any moonlighting/sunlighting must be separated by at least 10 hours from any ER shift.
- Moonlighting/sunlighting cannot interfere with scheduled afternoon or weekend rounds.
- PGY-1 residents may not moonlight/sunlight.
- No moonlighting/sunlighting during sick leave or maternity leave. No sunlighting during leaves of absence.
- Moonlighting hours combined with residency work hours must not exceed 80 hours per week when averaged over a 4 week period.
- Moonlighting or Sunlighting off campus will require a Florida Medical license and proof of malpractice coverage.

#### **CHARTING**

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

#### Legibility:

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

#### Dating and Timing:

Any entry into any chart must be dated and timed according to the actual time of writing, not observance. This will clearly demonstrate the time at which you addressed a problem. All orders must also be timed and dated. Both notes and orders should be signed with "MD" or "DO" after your name. Add your physician number after your name (*always use your name stamp*).

#### **ORDERS**

##### **Policy on Order Writing**

Orders: Orders shall be exclusively written by the Ward Interns and Residents involved in the care of the patient and not by the attending or sub specialists. This will ensure that the ward teams are constantly abreast of the care of each patient on the teaching service. The only exception whereby an attending physician, consultant or another physician may write orders is when an emergency situation occurs, a special procedure

is being performed by the consultant (EGD, cardiac catheterization, etc.), or a special medication order (chemotherapy) requires that the consulting physician write or countersign the orders.

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

**TRANSFERS** All transfers between floors, units, and teams require a full set of orders and a transfer note. Transfers from the floor to the ICU should have orders and transfer note written by the ward intern or resident. Transfers from ICU to the floor must have orders and a transfer note written by the ICU intern or resident.

## **MEDICAL RECORDS**

One of the major components of "quality assurance" is timely completion of the medical record; specifically, an appropriately detailed discharge summary dictated on the day of the patient's discharge. At the time of discharge the house officer should make a quick review of the chart and co-sign any verbal orders, consults, or student notes. The summary should be dictated on the day of the patient's discharge. The resident may be suspended from clinical duties until all charts are completed, which may result in an extension of training time. Failure to complete medical records within the allotted time has an adverse impact not only on reimbursement for physician services but also on patient care.

## **SIGN-OUT**

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

## **WARD ADMISSIONS**

### **Limitations on Admissions and Patient Census:**

1. Admissions to interns are capped at 5 new admissions plus 2 transfers during an admitting day and 8 new admissions during a 48-hour period.

*2. When supervising more than one intern residents are capped at 10 new admissions per admitting day plus 4 transfers or 16 new patients in a 48-hour period.*

3. Residents are responsible for the ongoing care of no more than 20 patients at a time, including the intern's patients being supervised. If the service has only one intern, the resident is capped at 14 patients and the intern at 10.

4. Interns are responsible for the ongoing care of no more than **10** patients at a time.

### **Readmissions:**

1. Any patient readmitted to the medicine service within the same calendar month will be transferred back to the intern who cared for the patient previously. This transfer should occur the day following admission including weekends and if the intern originally following the patient has the day off.

2. It will be the responsibility of the transferring resident to make the original team aware of the transfer. Readmissions transferred between two medicine services will be counted as new admissions.

3. Patients transferred to the ICU from a medicine service, then transferred back to a medicine service will also count as transfer admissions.

#### **ICU transfers:**

Patients will be transferred from the ICU to General Medicine services will count as transfer admissions.

#### **MICU LIMITATIONS ON ADMISSIONS AND PATIENT CENSUS**

Admissions caps are the same as outlined for ward services. As per RRC guidelines, interns are capped at 5 new admissions plus 2 transfers during an admitting day and 8 new admissions during a 48-hour period. Residents are capped at 10 new admissions plus 4 transfers per admitting day and 16 new admissions in a 48-hour period, including the intern's patients being supervised. However, these caps are generally not approached in the ICU setting. The most important RRC guidelines observed are the maximum 80-hour work week, the 30-hour work period, and the no new patient rule after 24 hours.

#### **SUBSPECIALTY SERVICES**

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

#### **RESIDENT SELECTION, PROMOTION and GRADUATION, REMEDIATION and DUE PROCESS, and CONTRACT RENEWAL**

##### **Resident Selection**

Medical students must apply through ERAS and register for the National Resident Matching Program. Required material include ERAS application, Dean's letter, medical school transcript, 3 letters of recommendation, USMLE step 1 and step 2 (if available) scores, and a personal statement. Applicants from LCME schools must participate in the matching program. Applicants from non-LCME schools must apply through ERAS but may be considered for selection prior to the match in some circumstances. All candidates must have a personal interview. The results of the interview together with the other application materials will be used to create an application ranking for the match. The core faculty together with the Program Director will form a Resident Selection Committee to finalize the rank list and to offer any prematch offers to some candidates who are eligible for prematch selection.

##### **Resident Promotion and Graduation**

To be promoted to the next year of training, the resident must:

1. Complete the curriculum outlined for each year of training in a satisfactory fashion.
2. Receive a satisfactory or superior rating on every rotation and for every component of clinical competence for the residency level (see the Attachment 1 below for guidance on promotion criteria for each level of training and the Core Competencies in the curriculum).
3. Be judged as capable of performing in a satisfactory fashion at the next level of training.

To graduate from the program, the resident must additionally:

1. Complete all requirements for the ABIM and RRC.
2. Be certified as competent for all required procedures.
3. Complete their scholarly activity requirements and present their project at the research forum.

##### **Resident Remediation and Due Process**

Residents with academic or other professional or competency difficulties shall be identified as early as possible. Discussions with the faculty mentor and Program Director will ensue to try to solve the problem. The options include: personal mentoring, adjusted clinical supervision, schedule changes, psychological

evaluation and/or counseling, extension of training time and learning impairment assessment. A personal remediation plan will be developed and monitored primarily by the faculty mentor and Program Director. In most instances, a Remediation Contract will be proposed and signed by the resident and faculty mentor. In the event that remediation is unsuccessful or delayed or involves unethical or unprofessional behavior, the Clinical Competence Committee will meet to develop a plan for the resident. A single serious act, or repeated acts of less serious, unprofessional or unethical behavior may be grounds for immediate dismissal from the program. The Clinical Competence Committee meetings will have minutes recorded. Residents may seek Due Process procedures as outlined in the GME manual if they dispute the findings of the Clinical Competence Committee, in event of dismissal from the program or failure to be promoted to the next level or failure to graduate from the program or for non-renewal of contract.

### **Non-Renewal of Contract**

A resident's contract may not be renewed (not including dismissal for unprofessional or unethical behavior) when the Program Director in conjunction with the Clinical Competence Committee determines that the resident has failed remediation, or has not met the requirements for promotion or graduation. When possible, notice of contract non-renewal will be given at least 4 months before the end of the contract.

### **Program Personnel Contact Information**

#### **Program Director**

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#### **Assistant Program Director**

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Attachment 1

### **Florida Hospital Medical Center Internal Medicine Residency Program**

#### **Promotion Criteria**

#### **PGY-1 Level**

#### **Patient Care**

- ❖ Prioritize a patient's problems
- ❖ Prioritizes a day of work
- ❖ Monitors and follows up patients appropriately
- ❖ Performs satisfactorily on Mini CEX
- ❖ Demonstrates caring and respectful behaviors with patients and families.
- ❖ Gathers essential/accurate information via interviews and physical exams and reviews other data.
- ❖ Knows indications, contraindications, and risks of some invasive procedures
- ❖ Competently performs some invasive procedures.
- ❖ Provides services aimed at preventing or maintaining health.
- ❖ Works with all health care professionals to provide patient-focused care.

#### **Medical Knowledge**

- ❖ Uses written and electronic reference and literature sources to learn about patients' diseases
- ❖ Demonstrates knowledge of basic and clinical sciences.
- ❖ Applies knowledge to therapy

#### **Practice Based Learning and Improvement**

- ❖ Understands his or her limitations of knowledge
- ❖ Asks for help when needed
- ❖ Is self motivated to acquire knowledge
- ❖ Uses PubMed, Up-to-Date, and Ovid and other computerized sources of results and information to enhance patient care.
- ❖ Accepts feedback and develops self-improvement plans.

#### **Interpersonal and Communication Skills**

- ❖ Writes pertinent and organized notes
- ❖ Has timely and legible medical records
- ❖ Uses effective listening, narrative and non-verbal skills to elicit and provide information.
- ❖ Works effectively as a member of the health care team

#### **Professionalism**

- ❖ Establishes trust with patients and staff
- ❖ Does not refuse to treat patients
- ❖ Is honest, reliable, cooperative and accepts responsibility
- ❖ Shows regard for opinions and skills of colleagues
- ❖ Is free from substance abuse or satisfactorily undergoing rehabilitation
- ❖ Demonstrates respect, compassion and integrity.
- ❖ Is responsive to the needs of patients and society, which supersedes self-interest.

#### **System Based Practice**

- ❖ Is a patient advocate
- ❖ Has constructive skepticism
- ❖ Advocates for high quality patient care and assists patients in dealing with system complexity.

### **PGY-2 Level**

#### **Patient Care**

- ❖ Prioritize a patient's problems
- ❖ Prioritizes a day of work
- ❖ Monitors and follows up patients appropriately
- ❖ Performs satisfactorily on Mini CEX
- ❖ Demonstrates caring and respectful behaviors with patients and families.
- ❖ Gathers essential/accurate information via interviews and physical exams and reviews other data.
- ❖ Knows indications, contraindications, and risks of some invasive procedures
- ❖ Competently performs some invasive procedures.

- ❖ Provides services aimed at preventing or maintaining health.
- ❖ Works with all health care professionals to provide patient-focused care.
- ❖ Understands and weighs alternatives for diagnosis and treatment
- ❖ Uses diagnostic procedures and therapies appropriately
- ❖ Elicits subtle findings on physical examination
- ❖ Obtains a precise, logical and efficient history
- ❖ Interprets results of procedures properly
- ❖ Is able to manage multiple problems at one
- ❖ Makes informed decisions about diagnosis and therapy after analyzing clinical data.
- ❖ Develops and carries out management plans.
- ❖ Considers patient preferences when making medical decisions.
- ❖ Triage patients to appropriate location

### **Medical Knowledge**

- ❖ Uses written and electronic reference and literature sources to learn about patients' diseases
- ❖ Demonstrates knowledge of basic and clinical sciences.
- ❖ Applies knowledge to therapy
- ❖ Is aware of indications, contraindications and risks of commonly used medications and procedures
- ❖ Demonstrates knowledge of epidemiologic and social-behavioral sciences.
- ❖ Applies the basic, clinical, epidemiologic and social behavioral science knowledge to the care of the patient.

### **Practice Based Learning and Improvement**

- ❖ Understands his or her limitations of knowledge
- ❖ Asks for help when needed
- ❖ Is self motivated to acquire knowledge
- ❖ Uses PubMed, Up-to-Date, and Ovid and other computerized sources of results and information to enhance patient care.
- ❖ Accepts feedback and develops self-improvement plans.
- ❖ Undertakes self-evaluation with insight and initiative.
- ❖ Facilitates the learning of students and other health care professionals.

### **Interpersonal and Communication Skills**

- ❖ Writes pertinent and organized notes
- ❖ Has timely and legible medical records
- ❖ Uses effective listening, narrative and non-verbal skills to elicit and provide information.
- ❖ Works effectively as a member of the health care team
- ❖ Creates and sustains therapeutic and ethically sound relationships with patients and families.
- ❖ Provides education and counseling to patients, families and colleagues.
- ❖ Is able to discuss end of life care with patients/families

### **Professionalism**

- ❖ Establishes trust with patients and staff
- ❖ Does not refuse to treat patients
- ❖ Is honest, reliable, cooperative and accepts responsibility
- ❖ Shows regard for opinions and skills of colleagues
- ❖ Is free from substance abuse or satisfactorily undergoing rehabilitation
- ❖ Demonstrates respect, compassion and integrity.
- ❖ Is responsive to the needs of patients and society, which supersedes self-interest.
- ❖ Displays initiative and leadership
- ❖ Is able to delegate responsibility to others
- ❖ Demonstrates commitment to on-going professional development.
- ❖ Demonstrates commitment to ethical principles pertaining to the provision or withholding of care, patient confidentiality, informed consent, and business practices.
- ❖ Demonstrates sensitivity to patient culture, gender, age, preferences and disabilities.
- ❖ Acknowledges errors and works to minimize them.

### **System Based Practice**

- ❖ Is a patient advocate
- ❖ Has constructive skepticism
- ❖ Advocates for high quality patient care and assists patients in dealing with system complexity.
- ❖ Uses systematic approaches to reduce errors.
- ❖ Participates in developing ways to improve systems of practice and health management.

### **PGY-3 Level**

#### **Patient Care**

- ❖ Prioritize a patient's problems
- ❖ Prioritizes a day of work
- ❖ Monitors and follows up patients appropriately
- ❖ Performs satisfactorily on Mini CEX
- ❖ Demonstrates caring and respectful behaviors with patients and families.
- ❖ Gathers essential/accurate information via interviews and physical exams and reviews other data.
- ❖ Knows indications, contraindications, and risks of some invasive procedures
- ❖ Competently performs some invasive procedures.
- ❖ Provides services aimed at preventing or maintaining health.
- ❖ Works with all health care professionals to provide patient-focused care.
- ❖ Understands and weighs alternatives for diagnosis and treatment
- ❖ Uses diagnostic procedures and therapies appropriately
- ❖ Elicits subtle findings on physical examination
- ❖ Obtains a precise, logical and efficient history
- ❖ Interprets results of procedures properly
- ❖ Is able to manage multiple problems at one
- ❖ Makes informed decisions about diagnosis and therapy after analyzing clinical data.
- ❖ Develops and carries out management plans.
- ❖ Considers patient preferences when making medical decisions.
- ❖ Triage patients to appropriate location
- ❖ Reasons well in ambiguous situations
- ❖ Spends time appropriate to the complexity of the problem

#### **Medical Knowledge**

- ❖ Uses written and electronic reference and literature sources to learn about patients' diseases
- ❖ Demonstrates knowledge of basic and clinical sciences.
- ❖ Applies knowledge to therapy
- ❖ Is aware of indications, contraindications and risks of commonly used medications and procedures
- ❖ Demonstrates knowledge of epidemiologic and social-behavioral sciences.
- ❖ Applies the basic, clinical, epidemiologic and social behavioral science knowledge to the care of the patient.
- ❖ Demonstrates an investigatory and analytic approach to clinical situations

#### **Practice Based Learning and Improvement**

- ❖ Understands his or her limitations of knowledge
- ❖ Asks for help when needed
- ❖ Is self motivated to acquire knowledge
- ❖ Uses PubMed, Up-to-Date, and Ovid and other computerized sources of results and information to enhance patient care.
- ❖ Accepts feedback and develops self-improvement plans.
- ❖ Undertakes self-evaluation with insight and initiative.
- ❖ Facilitates the learning of students and other health care professionals.
- ❖ Analyzes personal practice patterns systematically, and looks to improve.
- ❖ Compares personal practice patterns to larger populations.

- ❖ Locates, appraises and assimilates scientific literature appropriate to specialty.
- ❖ Applies knowledge of study design and statistics.

### **Interpersonal and Communication Skills**

- ❖ Writes pertinent and organized notes
- ❖ Has timely and legible medical records
- ❖ Uses effective listening, narrative and non-verbal skills to elicit and provide information.
- ❖ Works effectively as a member of the health care team
- ❖ Creates and sustains therapeutic and ethically sound relationships with patients and families.
- ❖ Provides education and counseling to patients, families and colleagues.
- ❖ Is able to discuss end of life care with patients/families

### **Professionalism**

- ❖ Establishes trust with patients and staff
- ❖ Does not refuse to treat patients
- ❖ Is honest, reliable, cooperative and accepts responsibility
- ❖ Shows regard for opinions and skills of colleagues
- ❖ Is free from substance abuse or satisfactorily undergoing rehabilitation
- ❖ Demonstrates respect, compassion and integrity.
- ❖ Is responsive to the needs of patients and society, which supersedes self-interest.
- ❖ Displays initiative and leadership
- ❖ Is able to delegate responsibility to others
- ❖ Demonstrates commitment to on-going professional development.
- ❖ Demonstrates commitment to ethical principles pertaining to the provision or withholding of care, patient confidentiality, informed consent, and business practices.
- ❖ Demonstrates sensitivity to patient culture, gender, age, preferences and disabilities.
- ❖ Acknowledges errors and works to minimize them.
- ❖ Is effective as a consultant

### **System Based Practice**

- ❖ Is a patient advocate
- ❖ Has constructive skepticism
- ❖ Advocates for high quality patient care and assists patients in dealing with system complexity.
- ❖ Uses systematic approaches to reduce errors.
- ❖ Participates in developing ways to improve systems of practice and health management.
- ❖ Demonstrates ability to adapt to change
- ❖ Provides cost effective care
- ❖ Understands how individual practices affect other health care professionals, organizations, and society.
- ❖ Demonstrates knowledge of types of medical practice and delivery systems.
- ❖ Practices effective allocation of health care resources that does not compromise the quality of care.