

**LOUISIANA STATE UNIVERSITY
HEALTH SCIENCES CENTER IN
SHREVEPORT**

DEPARTMENT OF MEDICINE



**RESIDENCY HANDBOOK
2009 – 2010**

TABLE OF CONTENTS

Preface	page 5
Program Overview and Goals	page 5
Educational Program	page 6
<i>Mentoring Program</i>	page 7
<i>Conferences</i>	page 7
<i>Testing and Evaluation</i>	page 9
Global Evaluations	page 10
Objective Examinations	page 11
Clinical Evaluation Exercises	page 12
Procedure Documentation	page 13
<i>Research and Scientific Writing</i>	page 14
<i>Textbooks and Educational Resources</i>	page 16
<i>Clinical Rotations, Policies, and Responsibilities</i>	page 16
Typical Schedule	page 16
Elective Rotations	page 18
<i>General Medicine Rotations</i>	page 19
General Medicine Ward Schedule	page 19
Conferences	page 19
<i>Team Members, Working Hours, Call Responsibilities, and Days Off</i>	page 20
Patient Assignments	page 20
PGY-1 Responsibilities	page 21
Upper Level Resident (PGY-2,3,4) Responsibilities	page 21
<i>Other Key “General” Rotations</i>	page 22
Medicine Intensive Care Unit (MICU)	page 22

Emergency Department	page 22
General Medicine Continuity Clinic	page 23
Ambulatory/Consultative Care (GMACC) Rotation	page 23
Primary Care Clinic (PCC)	page 24
Pre-operative Consultation Clinic	page 24
Day Admitting Service	page 24
General Medicine Consultation Service	page 24
Night Float Admitting/Consultation Service	page 24
Community Practice Rotation	page 25
Subspecialty Rotations	page 25
Ward Services	page 25
Subspecialty Consultation Services	page 26
<i>Moonlighting</i>	page 26
Program Administration	page 27
<i>Resident Evaluation and Curriculum Committee</i>	page 27
<i>Remediation, Probation, and Disciplinary Actions</i>	page 27
<i>Benefits</i>	page 30
<i>Leave Policy</i>	page 32
Vacation (Annual) Leave	page 32
Educational Leave	page 33
Sick Leave	page 33
Leave Without Pay (LWOP)	page 34
Other Types of Leave	page 34
<i>Miscellaneous Policies, Procedures</i>	page 35
Communication, E-mail, and Phones	page 35
Lockers	page 36

Dress Code	page 36
Program and Faculty Evaluations	page 36
Pagers	page 37
<i>Hospital Policies</i>	page 37
Campus Education Day	page 37
Employee Health Screening	page 37
Tuberculosis Skin Testing	page 38
Chaperones	page 38
Informed Consent	page 38
Licensure	page 38
VISA/Immigration Issues	page 38
Drug Screening	page 39
Stress	page 39
Department of Medicine Residency Council	page 39
Grievance Procedures	page 40
Complaints/Suggestion Box	page 40
Clinical Competence	page 41
<i>The General Competencies</i>	page 41
Resident Portfolios	page 42
<i>Criteria for Resident Advancement</i>	page 43
Delineation of Lines of Responsibility	page 44
<i>Resident Levels of Care</i>	page 45
History of the Internal Medicine Training Program at LSUHSC-S	page 49
Appendix	page 50

PREFACE

The 2009 edition of the *Department of Medicine Residency Handbook* outlines the objective, policies, and procedures that will guide the Internal Medicine training program for the 2009-2010 academic year. The administrative sections are designed to supplement the University Hospital's *Graduate Medical Education Committee (GMEC) Policy Manual* and *Resident Manual – Policies and Procedures*. Residents should become familiar with all three documents, and use them to guide their professional activities and conduct within the training program. These are excellent resources to answer questions related to both hospital and Department of Medicine policies.

Residents are required to acknowledge receipt of an e-mail containing the text of this handbook and all program curricula by signing the roster that will be provided by the Residency Coordinator. Your signature will indicate your understanding that you are responsible for reading and abiding by the information in the Handbook. Any questions concerning the information contained herein should be directed to the program director or an associate program director. An updated copy of each document is available on the program web site.

PROGRAM OVERVIEW AND GOALS

The Department of Medicine is dedicated to ***leadership and excellence in patient care, research, and education***. To this end, the physicians, facilities, and programs of the department are resources that are available to citizens and health care professionals of Louisiana and the surrounding area. The mission of the department is fulfilled, to a large extent, within the context of our outstanding residency and fellowship programs. Residents serve as the primary physicians for most patients at the University Hospital, and provide a large part of the inpatient care at our major affiliated institution, Overton Brooks Veterans Affairs Medical Center (OBVAMC). As well, residents have a key role in the education of the medical students of LSU Health Sciences Center in Shreveport (LSUHSC-S), and often become the role models that influence career patterns, as well as professional attitudes and habits that will endure throughout a lifetime of practice.

The clinical ideal of the department is compassionate, evidence-based care using state-of-the-art diagnostic and therapeutic modalities. Residents assume hands-on responsibility for patient care, with an appropriate degree of independence in management decisions. Experienced faculty physicians provide close supervision and oversight of all care, in an atmosphere that fosters cooperation and mutual respect.

The primary goal of the residency program is to provide in-depth training in general Internal Medicine. Our aim is to develop physicians who can provide competent care across the breadth of Internal Medicine, in both the primary care and consultative roles. As well, the program seeks to prepare residents for subsequent training in the subspecialties of Internal Medicine, and for professional careers in a variety of settings and roles.

The faculty believes that the following elements are essential to the training of general internists:

- ❖ Encounters with patients with a wide variety of common and unusual diseases.

- ❖ Interaction with a knowledgeable faculty dedicated to teaching.
- ❖ Exposure to an environment that stimulates scientific inquiry and prepares the resident for lifelong learning.
- ❖ Balanced emphasis on both practical patient care and the latest medical science.
- ❖ Opportunities to formulate research questions and carry out scientific investigations under the guidance of an experienced faculty mentor.
- ❖ Opportunities to develop teaching skills and use them with peers and students.
- ❖ Exposure to the business of medicine and diverse practice systems.
- ❖ Emphasis on communication skills, with exercises designed to enhance these skills.
- ❖ Emphasis on ethical, socio-economic, and cultural issues that are pertinent to the practice of medicine.
- ❖ Interaction with physicians and health care professionals from diverse ethnic and cultural backgrounds.

The residency program is structured to fulfill all requirements and standards of the American Board of Internal Medicine (ABIM) and the Residency Review Committee (RRC) for Internal Medicine of the Accreditation Council for Graduate Medical Education (ACGME). Local policies supplement these and are designed to enhance the effectiveness of the program, as we make the most efficient use of the resources available to the department. The department chairman and program directors believe that change and innovation are essential to the continued success of the residency program. Thus, all clinical and educational aspects of the program are under continuous review, with the goal of increasing the effectiveness of the training. The input of the residents is an important part of this process.

EDUCATIONAL PROGRAM

Learning in a residency program is a continuous process, much of which takes place incidentally in the course of patient care and interaction with other residents, subspecialty fellows, and the faculty. Attending rounds are conducted daily on most rotations, and are the most valuable formal educational experience. In addition, didactic conferences supplements residents' clinical experiences. All sections of the department participate in these, together with selected faculty from other departments. A number of additional tools and resources have been developed to enhance residents' learning experience, and to evaluate and document their progress in the training program. These are described throughout this *Handbook*.

MENTORING PROGRAM

The purpose of the mentoring program is to provide one faculty member with whom a

resident can discuss his/her educational progress, adjustment to the demands of being a resident, and problems related to any aspect of the program. As well, mentors may give advice on future career goals and the best ways to achieve these, including guidance in research activities that will enhance their opportunities. Residents who receive a marginal or unsatisfactory evaluation from an attending or do not achieve satisfactory scores on objective examinations may be asked by their mentors to discuss the problem in order to devise a plan to address any deficiencies. Those who exhibit evidence of stress or questionable professional conduct may be required by the program director to meet with their mentors. Otherwise, the frequency with which residents interact with their mentors is a matter of mutual preference, but we recommend meetings at least twice a year. Early in the academic year, each incoming resident is assigned a faculty mentor. Unless preference for a specific faculty member is voiced, assignment of mentors is arbitrary. If the “chemistry” between the resident and mentor is lacking, the program directors will attempt to identify a more suitable faculty mentor.

CONFERENCES

While conference attendance must be balanced against the demands of patient care, it is an integral part of the program that has a direct bearing on outcome of patient care, performance on the annual In-Training Examination, and success on the ABIM Certification Examination. Therefore, *categorical medicine residents at all levels are required to **attend 60% of all conferences** throughout the year, including Morning Report.* Be sure to register your attendance on the sign-in sheet at each conference. Attendance is calculated twice a year, and will be discussed with program directors at semi-annual evaluation conferences. Failure to meet the minimal attendance requirement may result in loss of moonlighting privileges, denial of elective requests or educational leave, or denial of promotion. *In addition, conference attendance records will be used to determine the order of selection in the vacation lottery conducted each spring. **You should not claim credit for attendance at any conference if you were not present for the majority of the discussion.***

For those assigned to the OBVAMC, Grand Rounds on Tuesday is available by live video transmission from LSUHSC. Otherwise, the faculty there offers a parallel series of conferences. Residents assigned to other facilities should attend all noon conferences at LSUHSC. If you want to eat lunch during noon conferences, please allow enough time to get your food and arrive on time. Morning attending rounds on both ward and consult services should end by 11:45 a.m. when possible. **Under no circumstances should attending rounds be conducted during conference times**, nor should patients be seen in the clinics unless there is an emergency. Please report any violations of this policy to a program director.

Scheduled Conferences (*subject to change*)

Morning Report

Daily, Monday – Friday: 8-9 a.m. at LSUHSC; 7:30-8:30 a.m. at OBVAMC.

This conference is mandatory for residents assigned to ward services other than the MICU, except the days you are off-duty or assigned to a morning continuity clinic. Residents assigned to the Intensive Care Unit at LSUHSC are exempt.

Residents assigned to subspecialty consultation rotations must attend unless there is a conflict with scheduled procedures or clinical responsibilities at another training site (cardiac stress testing, morning clinics at OBVAMC, morning

continuity clinics, and the geriatrics rotation). Residents present patients, as assigned by the chief resident. Selected faculty members are invited to discuss pertinent aspects of each case, with an emphasis on basic clinical skills, diagnostic reasoning, pathophysiology, and practical management.

At LSUHSC, a key aspect of Morning Report each day is the **evidence-based research** of a question that is developed at the end of the case discussion. A resident (usually from a subspecialty rotation) is assigned to search the medical literature via the Internet, with the assistance of a research librarian. The results of the search are presented at the next Morning Report. In addition, this information, together with a brief synopsis of the case history, is sent by e-mail to all residents and faculty. Links to online articles are provided. *Residents who are not present for the Morning Report at LSU are encouraged to review this information daily. It is an important practical learning tool, and may be a source of questions for periodic self-assessment examinations.*

Noon Conferences:

Conferences are presented at noon each day, Monday through Friday, excluding university holidays. Unless otherwise announced, all sessions take place in the Department of Medicine conference room, 6-201. A weekly conference schedule is published and sent by e-mail to all residents. It is also posted on bulletin boards on the sixth floor. The various formats include:

Core Curriculum Conferences (two or three days a week): Typically, these are presented on a three-year cycle. All sections of the department and selected faculty from other departments participate, according to the schedule below (subject to change). *Residents in the second, third, and fourth years may be assigned thirty-minute “mini-lectures” as a part of these conferences.*

July	Clinical skills and basic patient care
August	Clinical skills and basic patient care
September	Cardiology
October	Endocrinology and Metabolism
November	Infectious Diseases
December	Geriatrics
January	Nephrology and Hypertension
February	Pulmonary/Critical Care Medicine
March	Gastroenterology
April	Rheumatology
May	Hematology/Oncology
June	General Internal Medicine

Medical Grand Rounds (Tuesdays, August through May; Room 3-322): A state-of-the-art lecture on a topic relevant to Internal Medicine, presented by a faculty member or invited guest.

Morbidity and Mortality Conferences (monthly): Recent cases from the Medical Service or seen by consultation services are presented to illustrate key

management points. The chief resident is responsible for selection of the cases. Residents and attendings are encouraged to bring appropriate cases to the attention of the chief resident or a program director. *The purpose of M & M is not to air “mistakes” publicly. Our goal is to discuss ideal management in a collegial, non-threatening atmosphere that fosters learning for everyone.*

Clinicopathologic Conference “CPC” (monthly): Recent cases from the Medical Service, with presentation and in-depth discussion of autopsy or biopsy findings. Residents and faculty from the Department of Pathology participate, together with faculty from the Department of Medicine. Residents and faculty are encouraged to suggest appropriate cases for this conference.

Journal Club (monthly): Each month, two residents present an article selected by the associate program director for education. Typically, these are from the discipline of the core curriculum topics for the month. The discussion, led by program directors and invited faculty members, addresses the design of studies, statistical analysis, strength and limitations of findings, and clinical applicability.

Medicine/Pediatrics Infectious Diseases Conference (fourth Monday; Room G-221): Cases and lectures are presented by both departments.

Lagniappe Conferences (as announced): Topics such as medical ethics, patient communication, professionalism, cross-cultural and socioeconomic issues, stress management, leadership, and medical economics are presented throughout the year by faculty or invited guests.

TESTING AND EVALUATION

Overview

Resident evaluation is a continuous, multi-dimensional process. Competency must be documented in six areas: **medical knowledge; patient care; practice-based learning and improvement; interpersonal and communication skills; professionalism, and system-based practice.** *Promotion to the next level of training is based on achievement of certain milestones in the six competencies*, as described elsewhere in this *Handbook*. Specific tools have been developed for evaluation of residents in each of these competencies. A single global evaluation each month from an attending no longer meets the ACGME requirements. The specific evaluation tools we utilize are described below. A key concept is the **360-degree evaluation** process. This entails evaluation “from every angle” by multiple individuals whom residents encounter in the process of patient care, including faculty attendings, peers, medical students, nurses, and even patients. The program directors review all of these at the time of the residents’ semi-annual evaluation conferences. All evaluations and other documentation of competence are completed via the *MyEvaluations* on-line system.

Global Evaluations

Each resident receives a **monthly evaluation by the attending physician(s)**, using a format developed by the ABIM. It addresses each of the competencies and overall clinical

competence. Narrative comments are required. When submitted by the faculty, these evaluations are sent immediately through *MyEvaluations* to the resident, who then has the opportunity to comment on the evaluation. Either party may also submit confidential comments related to the evaluation to the program director. *The attending faculty must also give the resident a verbal assessment of the performance during the rotation*, with an emphasis on both strengths and weaknesses. If the attending does not initiate this discussion, the resident should ask him or her to do so. Those with any concerns about their performance, should ask the attending for an interim assessment midway through the rotation.

Each month, all residents assigned to inpatient teams complete an **anonymous peer evaluation** of other residents on the team. These are a key part of the evaluation process, and the program directors will review them in semi-annual evaluations and in counseling residents. However, *the anonymity of the evaluations will always be respected*.

All residents receive a **semi-annual clinic evaluation** from the faculty in the General Medicine Continuity Clinic. Though this evaluation is submitted by one member of the General Medicine Section, the faculty develops the evaluations as a group.

An online **“praise card”** or **“early concern note”** may be submitted to the program director at any time. These can be initiated by a peer or faculty member who has dealt with a resident’s work in any capacity (consultations, night float hand-offs, on-call cross cover, etc.) The praise or concern may relate to a resident’s general performance or to a specific occurrence, such as an astute diagnosis, general management (good or bad) of a difficult situation, or breaches in communication or professionalism. *Faculty members and residents are encouraged to use these liberally*. They are not forwarded to the resident concerned, and the program directors will use discretion in sharing their content.

Each month, residents assigned to inpatient services at LSUHSC receive a **composite evaluation by nurses** on wards 7G, 7K, and in the MICU. **Primary Care Clinic nurses** complete an evaluation of the residents assigned each month to the General Medicine Ambulatory and Consultative Care Service. These evaluations address issues such as responsiveness to patients and families, availability, responsiveness to nursing staff, documentation and order writing, and personal appearance. A similar evaluation is submitted semi-annually by the **General Medicine Continuity Clinic nurses**.

All residents receive a **semi-annual verbal and written evaluation** by one of the program directors. These evaluations summarize all monthly evaluations, monthly and In-Training Examination scores, conference attendance, patients seen in the continuity clinic, completion of charts and other administrative requirements, quality improvement reports from the hospital, scholarly activity, and any other aspect of training that has come to the attention of the program staff. As a part of this process, residents may be asked to assess their own strengths, weaknesses, and goals. The resident and program director will devise a specific plan to deal with any problems and to maximize the effectiveness of the training experience.

A **tracking evaluation** on each resident is submitted annually to the **American Board of Internal Medicine** by the program director. Residents are rated in each of the competencies (including interviewing, physical examination, and procedural skills under patient care), in overall clinical competence, and in moral and ethical behavior. In addition, an overall performance rating of superior, satisfactory, marginal, or unsatisfactory is recorded.

The ratings in each category do not represent a mean of those submitted by the attending faculty during the preceding twelve months. They are solely the assessment of the program director, and are based on all available information, including formal evaluations, personal observation, examination scores, peer review reports, and various administrative reports. Residents who receive an unsatisfactory rating in any category, or a marginal rating in overall clinical competence in the PGY-3 year, must repeat the year to receive credit toward board certification. Details are available at www.abim.org. The tracking evaluation also includes a listing of the number of clinical evaluation exercises you have completed during the year that involve faculty observation of your interviewing, examination, and counseling skills.

Program, Faculty, and Peer Evaluations

Residents are asked to complete the following evaluations monthly or annually:

- Attendings: At the end of each rotation, you will be assigned an on-line evaluation of each faculty member who supervised you. You must make at least brief narrative comments. *These evaluations are anonymous*, but are maintained for use as needed by the individual faculty members and the department. The program director, department chairman, and section chiefs take these into account when making attending or teaching assignments and when counseling faculty members. As well, they are an important part of the teaching portfolio which is submitted when a faculty member is being considered for promotion or teaching awards.
- Peers: On inpatient services, you will be assigned an evaluation of each resident with whom you worked. *These evaluations are anonymous*. If they are used in counseling, the program directors will make every possible attempt to keep your identity confidential. Any perceived intimidation as a result of an evaluation you have submitted must be discussed promptly with the chief resident, a program director, or your mentor.
- Subspecialty rotations: You will be assigned an evaluation at the end of each subspecialty rotation. *These are anonymous*, and are used in the evaluation of the effectiveness of the education program. Typically, the subspecialty coordinators receive a composite of the evaluations at the end of each academic year.
- Annual program evaluation: In May or June of each year you will be asked to complete an on-line evaluation of the training program as a whole. Please give a thoughtful analysis of the strengths and weaknesses of the program, together with suggestions for improving the quality of the training experience. *This evaluation is anonymous*.
- General Medicine Continuity Clinic attendings: In May or June, you will be assigned an annual evaluation for each attending in clinic. This should address only your experience with them in the clinic, not on the wards. *This evaluation is anonymous*.
- ACGME program evaluation: Each year, residents are assigned an online evaluation of the program from the ACGME. It covers many of the same issues as the annual program evaluation. *This evaluation is anonymous*.

Objective Examinations

All categorical medicine residents and preliminary medicine residents who are not matched to a PGY-2 program are required to take the American College of Physicians (ACP) ***In-Training Examination (ITE)*** in October. This day-long exam measures the resident's knowledge against that of internal medicine residents throughout the United States at the same level of training. *Annual leave is not permitted the days the examination is scheduled.* The chief resident will arrange coverage for inpatient teams and other essential services on the days of the exam. The department uses the ITE to track residents' medical knowledge and the effectiveness of the education program, but the major objective of the exam is self-assessment. A detailed performance report and analysis is provided to each resident. This may identify areas in which more focused independent study is needed. The ITE results will never be used as the *sole* criterion for promotion in the program. It is one of many factors considered in evaluating residents. Policies of the ACP prohibit use of the results in the selection process for fellowship training. Any resident who is asked to provide scores for this purpose should inform the program director of this request. The ACP has a mechanism at the national level to deal with this issue.

Examinations developed by the department are scheduled periodically, usually quarterly. These relate to the discipline that was the topic of core curriculum conferences during the month (see schedule above). Questions may also come from topics covered in Morning Report, Grand Rounds, and other scheduled conferences. As well, electrocardiogram interpretation may be included. *Categorical residents may miss no more than one exam during the year. Residents who are off-duty or otherwise unavailable the day of the exam should make arrangements with the administrative staff to complete it at another time.* Residents assigned to the VAMC may take the exam there. Like the In-Training Examination, these exams are an important self-assessment tool. Residents should use them as a stimulus to independent study in areas in which knowledge gaps are identified.

A ***cognitive examination on procedures*** will be given annually. All residents are required to take the exam and achieve a satisfactory score before completing training. See details below under Procedure Documentation.

Clinical Evaluation Exercises (CEX)

Many clinical skills will be evaluated and documented by short ***clinical evaluation exercises***. For example, a faculty member or fellow may observe a resident taking a focused history for a specific problem such as chest pain; performing a focused physical examination, such as the musculoskeletal or abdominal exam; giving a patient instruction on a medication regimen; discussing an advanced directive with a patient or family; or interpreting a laboratory panel or other diagnostic study. This tool can be adapted to document a resident's performance in any of the six competencies and in any clinical setting. Residents who research questions developed during Morning Report (see above) may receive credit for a CEX in evidence-based medicine. These exercises should take no more than a few minutes to complete, including the time for faculty critique. Beyond their value for evaluation, they are excellent learning opportunities. If the resident does not demonstrate appropriate skills on any CEX, it must be repeated at a later time.

*Categorical residents must complete a minimum of **24 clinical evaluation exercises each year**, an average of two per month. Each of the six competencies must be covered. However, particular emphasis must be placed on faculty **observation of your interviewing,***

examination, and counseling skills. As noted above, the number of exercises in each of these three categories is reported to the ABIM as part of the tracking evaluation each year. **Four exercises are required in each of these skills.** Residents are responsible for entering the exercise online, using the appropriate form available in MyEvaluations. The forms are forwarded to the faculty member, who critiques the exercise. *Exercises that are submitted more than seven days after the encounter may not be accepted.*

Individual faculty members may require residents to **demonstrate skill in performing a complete history and physical examination** at some time during the year. You can receive credit for two CEX's: one for interviewing skills and the other for examination skills.

Procedure Documentation

Since 2006, the ABIM and the Internal Medicine RRC of the ACGME have required documentation of residents' ability to perform safely and competently only certain very basic procedures. These include *advanced cardiac life support (ACLS), venipuncture, arterial puncture, Pap smear and endocervical culture, and peripheral venous line placement.* In addition, trainees must know, understand, and explain the indications, contraindications, complications, pain management, sterile technique, specimen handling, requirements for obtaining informed consent, and interpretation of results, as applicable, for the following procedures: *abdominal paracentesis, arterial line placement, arthrocentesis, central venous line placement, incision and drainage of an abscess, lumbar puncture, nasogastric intubation, pulmonary artery catheter placement, and thoracentesis.*

However, it is **the policy of the Department of Medicine** that residents certify their ability to perform *paracentesis, arterial line placement, arthrocentesis, central venous line placement, lumbar puncture, and thoracentesis,* in addition to the procedures required by the ABIM and ACGME. The following policies guide procedure certification and documentation:

- For each required procedure, residents must perform a designated number satisfactorily under the supervision of an upper level resident *who is certified in the procedure*, a fellow, or a faculty member.
- Residents are responsible for entering the procedure online through MyEvaluations. *Procedures that are entered over seven days after being performed may not be accepted.* The form will be sent electronically to the supervisor of procedure for evaluation and comments. The evaluation will indicate not only technical skill, but also knowledge of the indications, contraindications, complications, and interpretation of the results ("cognitive skills" on the evaluation form).
- Paper evaluation forms are available for documentation of procedures when the faculty or resident observer is not a member of the Department of Medicine or the Emergency Department. However, the exercise still must be documented online. The program director may be designated as the observer for the procedure, after the paper documentation is submitted to the education coordinator.
- Many residents enter training with proficiency in basic procedures such as venipuncture, arterial puncture, and peripheral IV line insertion. Therefore, a single observation of these procedures will suffice for documentation of competency. The

observer may be an upper-level resident, fellow, faculty member, experienced nurse, nurse practitioner, certified phlebotomist, or respiratory therapist.

- For ACLS, the requirement for certification of competence must be met by successful completion of a formal ACLS course under the direction of an American Heart Association-certified instructor. PGY-1 residents who enter the program without current ACLS certification, and who do not participate in the course offered during the hospital orientation, must arrange to take a course as soon as possible.
- Note: Current ACLS certification is required for assignment to the OBVAMC, though not LSUHSC. The department will attempt to schedule a one-day recertification course at the VAMC at no cost late in the PGY-2 year. At the present time, LSUHSC is unable to provide recertification unless the resident bears the cost personally.
- For other procedures, the minimum numbers that must be completed satisfactorily under supervision for certification of competence are:

Abdominal paracentesis: 3	Lumbar puncture: 3
Arterial puncture: 3	Pap smear/endocervical culture: 5
Arthrocentesis: 3	Thoracentesis: 5
Central venous line placement: 5	
- The ACGME requires that residents must perform ACLS, pap smears, and endocervical cultures throughout training. Pelvic examinations should be a routine part of the care of patients on the wards and in the general medicine clinics.
- The cognitive aspects of procedures (indications, contraindications, complications, pain management, sterile technique, specimen handling, informed consent requirements, and interpretation of results) will be covered in core curriculum conferences during July and August. A written curriculum for required procedures will be provided.
- A written examination covering the cognitive aspects of procedures will be offered at some point during the year. As noted above, *all residents must take the exam and achieve a satisfactory score.*

Beyond the basic certification, additional experience may be required in order to become adept at certain procedures. *Some hospital credentialing committees require documentation of a larger number of certain procedures, such as thoracentesis. Hospitals also may require documentation of other procedures performed during training, such as cardiac stress testing and pulmonary artery catheter placement, before giving you privileges for these skills.* The program director routinely receives requests for such documentation, even for residents who trained years ago. Thus, it is prudent to document as many procedures as possible during training.

If additional procedures are relevant to a resident's future practice, the program will attempt to provide opportunities to gain proficiency in them. Examples include skin biopsies, cryosurgical removal of skin lesions, incision and drainage of abscesses, and joint and soft tissue injections. Residents typically receive adequate experience in cardiac stress testing and the procedures performed in the ICU setting. Beyond the experience on standard rotations, we

do not routinely offer rotations to gain proficiency in procedures that will be part of a resident's chosen fellowship program.

Effective July 1, 2009, the Pulmonary and Critical Care Section will offer a Procedure Service for the entire hospital. Residents will be assigned to this service, typically for one-week blocks, as a part of the General Medicine Ambulatory and Consultative Care or other multidisciplinary rotations. This will be an optimal time to achieve initial certification in many procedures and to refresh one's skills subsequently. Many procedures will be performed under ultrasound guidance, which is becoming the standard of practice in many hospitals.

RESEARCH AND SCIENTIFIC WRITING

The ability to formulate a research question, conduct a literature review, design an investigative project, and write a scientific paper or abstract is highly desirable for residents in internal medicine. Research opportunities abound within the Department of Medicine. Residents that desire to pursue meaningful research during training are encouraged to inquire about the research interests of various faculty members and discover a mentor with whom they can work. Those with projects in mind should seek out a faculty member in the area of interest. Program directors can help guide this process.

Categorical Medicine residents are required to complete and submit an abstract or poster suitable for submission to a scientific meeting or a journal by the end of their training. You will not be authorized to take the ABIM Certification Examination until you have met this requirement. Beyond abstracts or manuscripts stemming from formal research, reports of single cases, or a short series of cases illustrating an unusual disease or an uncommon aspect of a common problem, may be submitted. The report must be in a standard format, with appropriate terminology (including spelling, punctuation, and grammar), and, if applicable, statistics. Many residents enter the American College of Physicians Associates abstract competition. Abstracts may be sent to both the state and national competition. The deadline for submission is usually October, but the program director must have these in hand with ample time for editing. *Each resident must be the primary author on one article, poster, or abstract.* While residents may collaborate on scholarly writings, a single submission cannot fulfill the requirement for more than one resident.

The department will offer a number of presentations related to research, including lectures on statistics, as part of the noon conference schedule. In addition, the Research Division of the School of Medicine sponsors a number of conferences throughout the year that are open to residents. With appropriate documentation, residents who attend these may receive conference attendance credit.

Research Electives

Residents who have a meaningful research project in progress under faculty sponsorship may petition the program director for one or two months to complete the work. In most cases, this will be in the final year of training. Research electives may be approved earlier in training on a case-by-case basis. The following policies apply:

- Residents granted elective research time must complete an on-line certification required for all investigators at LSUHSC-S, and must have demonstrated a commitment to

research. Attendance at lectures and other activities pertinent to research will be evaluated prior to approval of the elective.

- Requests for the elective must be in writing, and include specific objectives for the month. The research mentor must support the request in writing.
- All requests will be presented to the Department of Medicine Resident Education and Evaluation Committee, which will make a recommendation to the program director to approve or deny the petition.
- To be approved for a research elective, a resident must be performing well in all aspects of the program, including the annual in-training examination, and must meet the all administrative requirements of the program and hospital, including the standards for clinical evaluation exercises, and conference attendance.
- Research electives cannot replace required experience in medical subspecialties and ambulatory care. Arrangements to fulfill all requirements and allow time for research must be discussed with the program director well in advance.
- Under Medicare policies related to the funding of graduate medical education, residents assigned to research electives must attend Morning Report, noon conferences, journal clubs, and their weekly continuity clinic.
- After completion of a research elective, residents will be required to give a “mini-lecture” reporting on their study at a noon conference.
- Residents on research electives will be evaluated using the ABIM Research Evaluation form.

TEXTBOOKS AND EDUCATIONAL RESOURCES

Subject to the availability of educational grants, incoming residents may be provided certain basic reference materials. In addition, an educational stipend is given to each resident annually (see section on *Benefits*). *Resident who do not own an electronic handheld information device should consider applying the stipend to the purchase of one.* In addition to being a handy source of medical information, these are useful for documenting clinical evaluation exercises, procedures, and patient information. The *MyEvaluations* software allows you to download duty hour, clinical evaluation exercise, and procedure documentation from a handheld device into the online system.

A number of textbooks, covering all disciplines of internal medicine, are available for reference in the Department of Medicine Conference Room (6-201). Please do not remove these from that room. Many Internet resources are available by links from the LSUHSC library web site, including *Up-to-Date*, *MD Consult*, *PubMed*, and a large number of online journals. These can be accessed from computer terminals located throughout the hospital. Because of stipulations in licensing agreements, not all of these are available from your home computer. E-journals, however, may be available through a proxy server.

CLINICAL ROTATIONS, POLICIES, AND RESPONSIBILITIES

TYPICAL SCHEDULE

The schedules outlined below are illustrative only. Individual schedules will depend on the number of residents (including residents from other departments) and the rotations that are available. Residents who take two-week vacations during ambulatory care months may be scheduled for an additional month in this area in the third year. Over three years, a resident's schedule will always conform to ACGME and ABIM standards.

First Year (PGY-1):

<i>Categorical:</i>	General medicine/subspecialty wards ++	6-7 months
	Emergency Department	1 month
	Medical subspecialties	1-2 months
	Ambulatory/consultative care **	2-3 months
	Medical Intensive Care Unit	1 month
<i>Preliminary:</i>	General medicine/subspecialty wards ++	7-8 months
	Electives	3 months
	Emergency Department (optional)	0-1 month
	Ambulatory/consultative care **	1 month
<i>Primary Care</i>	General medicine/subspecialty wards ++	7 months
	Medical Intensive Care Unit	1 month
	Emergency Department	1 month
	Ambulatory/consultative care **	1 month
	Primary care ambulatory block	1 month
	Subspecialty ambulatory block	1 month

Second Year (PGY-2):

<i>Categorical</i>	General Medicine wards	4 months
	Subspecialty wards	1-2 months
	Community internal medicine	1 month
	Medical subspecialties ##	4 months
	Ambulatory/consultative care **	2 months
	Medical Intensive Care Unit	1-2 months
<i>Primary Care</i>	General Medicine wards	4 months
	Medical Intensive Care Unit	1 month
	Primary care ambulatory block	2 months
	Subspecialty ambulatory block	2 months
	Ambulatory/consultative care	1 month
	Neurology/Psychiatry	1 month
	Community internal medicine	1 month

Third Year (PGY-III):

<i>Categorical</i>	General Medicine wards	1-2 months
	Subspecialty wards ++	1 month

	Community practice	1 month
	Geriatrics	1 month
	Dermatology	1 month
	Medical subspecialties ##	4 months
	Ambulatory/consultative care **	2 months
	Medical Intensive Care Unit	1 months
<i>Primary Care</i>	General Medicine wards	2 months
	Medical Intensive Care Unit	1 month
	Ambulatory/consultative care **	1 month
	Primary care ambulatory block	2 months
	Subspecialty ambulatory block	1 month
	Community internal medicine	1 months
	Geriatrics	1 month
	Dermatology	2 weeks
	Sports medicine	2 weeks
	Electives	2 months

++ Subspecialty ward rotations include Cardiology, Hematology/ Oncology, and Nephrology.

** The Ambulatory/Consultative Care rotation includes the Primary Care Clinic; day admissions; night float admissions/consultations; general medicine consultations; the procedure rotation; and experience in selected clinics outside the Department of Medicine, including Gynecology, Ophthalmology, Otorhinolaryngology, and Psychiatry. PGY-1 residents on this rotation may be assigned to one week of ward for vacationing interns at the VA Hospital.

In the second and third years, subspecialty rotations may be combined with the procedure rotation, night float, and vacation, on a case-by-case basis.

Subspecialty and Elective Rotations

The ACGME requires that residents have sufficient experience in all subspecialties of internal medicine. This offers the best preparation for the American Board of Internal Medicine Certification Examination and for practice in a variety of settings. However, we are also committed to providing residents with the training that will prepare them for their individual career plans. Accordingly, *some* subspecialty rotations may be limited to two weeks to provide time for other experiences. The following policies are in effect for 2009-2010:

- All electives require approval of the program director.
- The resident must specify in writing the specific objectives of an elective and identify the supervising faculty.
- Residents may elect to repeat a core subspecialty rotation once, or may concentrate in a limited aspect of the discipline during a second rotation. However, the program director may limit repeat rotations to two weeks.

- Electives must occupy the resident's full time. Requests for electives designed to provide "reading time" will be denied unless part of a structured remediation process.
- Electives in areas outside the Department of Medicine will ordinarily not be approved unless part of a multi-disciplinary experience (e.g., a combined rotation in Pathology and Radiology, or Radiology and non-operative orthopedics).
- Electives at institutions outside Shreveport will be handled on a case-by-case basis, but will ordinarily not be approved because of the administrative "red tape" (including approval by university officials beyond the Department of Medicine).
- Full rotations (3 or 4 weeks) are usually required in Cardiology (stress tests/consults), Endocrinology, Infectious Diseases, and Rheumatology (including non-operative orthopedics, sports medicine, and rehabilitation experience).
- The Program Director may require a full rotation or a repeat rotation in any discipline in which a resident consistently has low scores on the In-Training Examination.
- Residents will not always be assigned to both inpatient and consultation rotations in Nephrology and Hematology/Oncology, though both experiences are preferable. The program director may require both if there is evidence that the resident's knowledge and skill in these areas is deficient.
- Residents assigned to the Cardiology Consultation Service are expected to perform stress tests and participate in some consultations. Beyond this, they may elect to have focused experience in one or more areas in this field, including, but not limited to, electrocardiography, echocardiography, and ambulatory electrocardiography. Requests for these experiences will be handled by the program director on a case-by-case basis.
- Within the first year or the first four months of the second year, the program will provide a resident experience in the field in that he/she anticipates applying for fellowship training. Requests to work under a specific faculty member solely to enhance competitiveness for a fellowship will be accommodated only if the assignment can be made without inconvenience to other residents or substantive changes in the master schedule.
- Electives designed solely to gain experience in procedures that are an integral part of fellowship training are discouraged. The program director will disapprove them if there is evidence that the resident needs more experience in other areas.
- Requests for electives in specific calendar months must be justified.
- Residents on elective rotations will be assigned to post-call coverage, call-back, and weekend ward coverage under the usual policies.
- Residents on elective rotations are required to attend their continuity clinics, Morning Report, and all noon conferences, unless specifically excused by the program

director.

- Policies relating to research electives are listed above.

GENERAL MEDICINE ROTATIONS

General Medicine rotations are the focal point of training in Internal Medicine. The curricula and educational objectives for the rotations are published separately. Valuable information is also contained in *Ward Policies 2009-2010*.

General Medicine Ward Schedule

Monday through Friday (*LSUHSC; times may vary at the OBVAMC*)

~7:00 – 8:00 am: Work rounds (exact time set by resident and attending)

8:00 – 9:00 am: Morning Report **

9:00 – 11:45 am: Work/Attending rounds ** (exact time set by attending)

12:00 – 1:00 pm: Noon conference

1:00 – 5:00 pm: Ward duties/Continuity clinic

*** Morning General Medicine Continuity Clinic, if assigned, takes precedence over Morning Report and attending rounds.*

Weekends and Holidays

The attending and upper level resident will set the time of rounds.

Conferences

See schedule under *Educational Program*. Ambulatory care conferences are scheduled for residents assigned to the General Medicine Ambulatory and Consultative Care rotation (other than night float), and for those attending morning continuity clinics on the days of the conferences.

Team Members, Working Hours, Call Responsibilities, and Days Off

Each general medicine team at LSUHSC and OBVAMC consists of two PGY-1 residents; one upper level resident; junior and senior medical students, and a faculty attending. Faculty from the General Medicine Section and a number of subspecialties serve as attendings on the general medicine wards. Residents are not allowed annual leave while assigned to a general medicine ward. (However, under hospital policies annual leave must be approved for a certain number of residents from other departments who are assigned to the general medicine wards at the OBVAMC.) Students are an integral part of the teams, but their activities are governed by specific guidelines related to patient workups, call schedule, and days off. These are available electronically on the program website. *When students are assigned to your team, please do not deviate from the written policies.*

The priorities of patient care are the major determinant of the hours you work. However, the department adheres strictly to all ACGME standards related to duty hours. The current policies governing these are included in the Appendix. Please read these carefully.

In-house *call is every fifth night*. If your previous rotation involved night call, and you are scheduled for call within three nights of your previous call, please notify the chief resident or educational coordinator as soon as you see the schedule.

Patient Assignments

Patients will be assigned to ward teams in accordance with the policies set forth in *Ward Policies 2009-2010*. *These may be revised as necessary during the year*. The total number of patients permitted on a team, and the number of new admissions in specified periods of time are governed by ACGME guidelines. These are available on the ACGME website (www.acgme.org). Team numbers are reviewed daily in Morning Report.

PGY-1 Responsibilities

Each PGY-1 resident assigned to a ward team will generally be given primary responsibility for approximately half the patients, but works under the close supervision of the upper level resident and attending faculty. The management plan for each patient should always be discussed with these supervisors. The upper level resident is the team leader and will assign specific responsibilities. *PGY-1 residents should perform and write-up the admission history and physical exam on the majority of patients admitted to the team during the day and on all patients admitted during on-call nights. The problem/diagnosis and identity of each patient a PGY-1 categorical medicine resident evaluates primarily must be documented online in MyEvaluations*. As a criterion for advancement to PGY-2 responsibilities, *at least 120 histories and physical examinations* must be documented. The records of patients may be reviewed by the Resident Education and Evaluation Committee.

When on call, PGY-1 residents are a part of the code (resuscitation) team for the entire hospital, exclusive of critical care units. A “code beeper” must be received from the previous day’s call team at the beginning of each call day. *This is the first on-call responsibility that day*. All members of the code team should respond to every code, and remain there until the upper-level resident dismisses you.

On-call PGY-1 residents will be paged by the nurses for problems that arise in all patients on the Medicine Service. This includes patients on your own team, other general medicine teams, and subspecialty teams. You will cover specified wards or teams, as indicated on the call schedule. Individual nurses will have different thresholds for calling you, and you must use sound judgment in responding to all questions and requests. *Some problems can be handled by phone. Many cannot. If there is any doubt, evaluate the patient at the bedside and document your findings in the record*. Experienced nurses are a valuable resource in patient care, but must not dictate management of a patient. Not every problem requires intervention with drugs. If there is doubt after evaluating a patient, the advice of the upper-level resident should be requested. *The supervising resident must be informed immediately about any patient who is critically ill or has a potentially unstable problem*.

Any anticipated problems in patients must be brought to the attention of the PGY-1 resident who will be covering the team at night. A brief verbal report on patients who may become unstable or have lab/diagnostic studies pending can save valuable time for those on call.

Upper Level Resident (PGY-2,3,4) Responsibilities

The upper-level resident is responsible for making focused work rounds with PGY-1 residents daily and overseeing all aspects of patient management. As the team leader, he/she works on behalf of the attending, who has ultimate responsibility for the patient. The faculty must be kept informed of all major issues related to the care of any patient, including recommendations made by consultants. The upper-level resident also has a key role in the education of the PGY-1 residents and medical students assigned to the team. *Teaching should be a part of every day's activities.* The preparation and presentation of "mini-lectures" is an excellent educational tool for both the presenter and those who listen. As well, it is useful to ask other team members to research and report on focused topics.

The on-call upper level resident is the leader of the "code team" for the entire hospital, exclusive of critical care units. A multi-disciplinary team responds to each code, but the team leader is responsible ultimately for the resuscitation effort. For patients on other services, the Medicine resident should remain in the area, even if a resident or faculty member from that department chooses to supervise the patient's care.

Typically, the upper-level resident assigns the clinical responsibilities of PGY-1 residents and students, and coordinates their days off. However, attending faculty preferences should be paramount in determining how the team functions. If there is conflict between attending and departmental policies, discuss the situation with the chief resident or a program director. Other resident responsibilities are discussed in *Ward Policies 2009-2010*.

OTHER KEY "GENERAL" ROTATIONS

Medical Intensive Care Units (MICU)

LSUHSC: Three teams, each consisting of one PGY-1 (or upper level resident from another program) and one upper-level internal medicine resident, are assigned each month. The teams are in a "long call – off –short call" rotation scheme. The schedule and precise responsibilities are determined by the medical director of the unit and the program director, and conform to ACGME duty hour guidelines. First-year residents may or may not be assigned to attend their General Medicine Continuity Clinic. If so, the dates will be listed on the monthly schedule. The resident on the "short call" team may be assigned to cover a post-call ward team in the afternoon, and should make attending rounds with that team in the morning. At night, the MICU team cross-covers patients the Coronary Care Unit (CCU).

OBVAMC: One upper-level resident and two PGY-1 residents (or upper-level resident from another program) are assigned each month to the MICU. This team has in-house call responsibilities every fifth night, in rotation with four General Medicine teams, and admits patients to other teaching teams. Assigned residents are exempt from the General Medicine Continuity Clinic.

Emergency Department

The Emergency Department (ED) rotation is under the supervision of the Department of

Emergency Medicine. Each PGY-1 categorical resident is assigned to the ED one month. Assignment is optional for Preliminary Medicine residents. Those who elect not to be assigned will have other rotations of comparable work load, assigned individually by the program director. The schedule in the ED is determined by the staff of that department, but must conform to ACGME guidelines. Any problems or concerns should be discussed first with the ED faculty. Unresolved issues may be brought to the attention of the internal medicine program director or chief resident. Medicine residents assigned to the ED may or may not be required to attend their assigned General Medicine Continuity Clinic two weeks of the month. If clinics are assigned, this will be indicated on the monthly schedule.

General Medicine Continuity Clinic

Each resident in the Department of Medicine, including preliminary medicine residents, is assigned to the General Medicine Continuity Clinic one half day a week throughout training. You are exempt from the clinic only when you are on leave, post call, or assigned to the OBVAMC MICU rotation or night float. As noted above, residents assigned to the MICU at LSUHSC or to the ED *may* be assigned for two clinics in each of those months. *No resident is authorized to cancel a clinic for any other reason.*

Effective July 1, 2009, the ACGME requires that internal medicine residents have 130 half-day continuity clinic sessions during the three years of training, increased from 108 previously. To meet this number, categorical residents on the General Medicine Ambulatory and Consultative Care rotation will be assigned one or two additional continuity clinic sessions each week. These will be on random days, depending on the availability of rooms and faculty. Policies for the scheduling and assignment of patients for the extra clinics are in development.

Guidelines for work in the clinic are included in the Appendix. Each resident will follow a panel of patients throughout training. Some patients will be transferred from residents who have left the program. Others will be patients encountered in the hospital, ED or other clinics, or referred from various sources. *The ACGME no longer establishes the number of patients that residents must see, but the program director and General Medicine Section faculty may develop policies that govern this. Residents must document the number of patients you see each session in a log book maintained in the clinic.* These numbers will be reviewed during semi-annual evaluation conferences with a program director.

Between scheduled clinic visits, residents are required by the ACGME to be accessible to participate in the management of their continuity panel of patients. This may include follow up of laboratory and diagnostic studies and accepting telephone calls from patients between clinic visits (during regular duty hours). Residents *should expect to be notified when their patients are admitted to the hospital, and look in on them occasionally.* The patient's clinic physician may be a valuable source of information to the team caring for the patient, and the patient will usually be returned his/her care after discharge.

The importance of continuity of care in the clinic cannot be over-emphasized. Each resident bears responsibility for maintaining a high standard in this area. Patients who are discharged from the hospital must be returned to the care of the physician who knows them best. If that physician cannot be identified, or if no appointment is immediately available, a

member of the ward team may schedule an interim visit in his/her clinic. Discharged patients who must be scheduled in the Primary Care Clinic should be returned to the primary physician as soon as possible.

General Medicine Ambulatory/Consultative Care (GMACC) Rotation

Ten to twelve residents from all levels are assigned to this rotation each month. They work as a team to provide care through the Primary Care Clinic (PCC), the pre-operative consultation clinic, the General Medicine consultation service, and the day admitting service. In addition, they fill some night float team positions and gain ambulatory care experience in a number of specialties outside the Department of Medicine. A detailed schedule is published at the beginning of each month. Changes in this schedule may be necessary to cover unexpected absences of residents or unusually heavy patient loads in the PCC. *Only the chief resident is authorized to make changes, however, and will do so only upon request of the General Medicine faculty in the clinic and after a thorough analysis of the need.* Residents may be “pulled” from Psychiatry only with consent of the program director.

Primary Care Clinic (PCC)

This clinic shares space with the General Medicine Continuity Clinic and provides a similar spectrum of care. Most patients are seen on an appointment basis, but not in a continuity mode. When possible, established patients of the clinic are seen on a walk-in basis. Patients who are discharged from the Medicine Service of the hospital may be scheduled for this clinic, either as their primary source of care when appropriate, or on an interim basis prior to being seen in the continuity clinic or a subspecialty clinic (see above). Clinic hours are from 8:00 am to 12:00 noon, and from 1:00 pm to 5:00 pm, Monday through Friday. Residents assigned to the PCC attend their weekly continuity clinic. In addition, they may be asked to see continuity clinic patients for residents who are excused from clinic on post-call days.

Pre-operative Consultation Clinic

This clinic meets on Monday afternoons in the continuity clinic/PCC area. Patients are referred from all operative services in the hospital. Residents gain valuable experience in assessing the operative risk of patients with medical problems and in providing recommendations for peri-operative care.

Day Admitting Service

This responsibility may be filled by an upper-level resident assigned to the GMACC or a subspecialty consultation service, or by the MICU “short call” resident for the day. The resident responds to the Emergency Department and clinics for all consultations for admission or urgent care. Any questions about the appropriateness of admissions should be discussed with a faculty member.

General Medicine Consultation Service

Upper-level residents assigned to this service provide initial and follow-up consultative care for hospitalized patients outside the Medicine Service. In addition, the resident receives

calls from outside physicians and hospitals requesting transfer of patients to LSUHSC. *Requests for transfer of patients requiring tertiary care should be referred to the appropriate subspecialty section in many cases.* Administrative problems related to transfers should be referred to a general medicine faculty member, the chief resident, or the program director. *All transfers must be coordinated with the Physician's Referral Service,* and are subject to bed availability. Please refer to the Transfer Policy in the Appendix. On-call and float residents who have answered consultations should refer patients needing follow-up care to this service. All consultations must be discussed with the general medicine faculty member assigned to that responsibility each week. The faculty will make rounds on these patients as appropriate.

Ambulatory Care Clinic Conference (8 am, Wednesday through Friday): This conference is coordinated by an associate program director, with presentations by residents, General Medicine faculty, and invited guests. The format varies, and may include mini-lectures on common office problems, electrocardiogram interpretation, discussion of questions from the Medical Knowledge Self-Assessment Program (MKSAP), or presentation and discussion of patients seen by the general medicine consultation service or the pre-operative consultation clinic. Attendance is mandatory for all residents assigned to the GMACC (except the night float resident) and for residents assigned to a morning continuity clinic on a day the conference is scheduled.

Night Float Admitting/Consultation Service

LSUHSC-S: Typically, one upper-level and one PGY-1 resident are assigned for one-week rotations: For duty hours, see *Ward Policies 2009-2010* in the Appendix. "Odd days" at the beginning and end of the month will be assigned randomly. This team answers Emergency Department consultations and evaluates newly-admitted patients after the on-call team has admitted six patients. On weekends and holidays, the upper-level resident is also the backup for the LSUHSC on-call team prior to the usual time for beginning float responsibilities, if that team admits over ten patients, exclusive of transfers. Monday through Friday, patients evaluated will usually be discussed with a faculty member at 7:30 a.m. *During the overnight hours and on weekends and holidays, administrative and patient care questions should be referred to the attending faculty of the on-call team for that night.*

OBVAMC: Effective July 1, 2009, one upper-level resident will be assigned to a night float rotation, subject to availability. In addition to admitting patients after the on-call team has received the specified number of admissions, this resident will cover the VA MICU. *Specific policies for this rotation are being developed and are subject to change by the Chief of the Medical Service.* The resident will check-out the ICU patients the next morning with the faculty or fellow assigned to the unit, and may discuss other admissions with these physicians.

Community Practice Rotation

Two PGY-2 or 3 residents are assigned each month to a large group practice based at Willis-Knighton Medical Center North. This experience in a community hospital setting affords the opportunity to see the practice of general internal medicine outside the academic medical center. Working under the supervision of one member of the group, each resident has first-hand experience with office practice, hospital care, hospital consultations, and long-term care. There is an emphasis on the business of medicine and the unique aspects of practice in this setting. This is a Monday-Friday rotation without overnight call, but residents may assist with

admissions until approximately 9 pm one night a week when their assigned preceptor is on call for the group. Assigned residents attend noon conferences and their continuity clinics at LSU.

SUBSPECIALTY ROTATIONS

Ward Services

The Department of Medicine has subspecialty ward teams in Cardiology, Hematology/Oncology, and Nephrology at LSUHSC. The learning objectives of these rotations are listed in curricula for the subspecialties. Two PGY-1 residents and one upper level resident are assigned to each of these teams. Residents on subspecialty teams work closely with subspecialty fellows and faculty. Junior medical students are assigned to these teams for two-week blocks. Responsibilities are similar to those on general medicine ward teams, but specific details of each rotation will be determined by the attending and the fellow. The department chairman and program director set limits on the patient census for these teams, in consultation with the respective section chief. In addition to the daily noon conferences of the department, residents on these teams may attend conferences of the subspecialty section.

Subspecialty Consultation Services

When assigned to a subspecialty consultation service, the attending faculty and/or fellow determine the resident's responsibilities and schedule, subject to all ACGME duty hour regulations and department policies. In addition to answering consultations and working in clinics, residents attend conferences of the subspecialty. Upper level residents on consult services will have a limited number of call/cover/backup responsibilities on the general medicine teams, as outlined in the *Ward Policies 2009-2010*. Subspecialty residents also attend their assigned continuity clinic each week. These responsibilities take precedence over any clinics or conferences of the service to which you are assigned. However, when possible these clinics and conferences will be taken into account when making schedules.

MOONLIGHTING

Moonlighting is a privilege that is granted to residents who are performing satisfactorily in all aspects of the training program. Currently, the Department of Medicine does not sponsor any "In-house" moonlighting. If established, these must be included in the average maximum work hours that are allowed by the ACGME, and are subject to all other duty hour restrictions. United States Citizenship and Immigration Services (USCIS) regulations prohibit residents who are working under a J-1 visa from moonlighting.

Moonlighting outside LSUHSC is permitted, but requires prospective permission, and the frequency must be set and monitored by the program director. However, the time is not subject to ACGME duty hour regulations. Policies of the Louisiana State Board of Medical Examiners effectively preclude international medical graduates from moonlighting until they complete a basic residency. For moonlighting that is not sponsored the Department of Medicine, residents must secure their own liability insurance. Forms to request moonlight privileges and to initiate on-going monitoring are available in the office of the education coordinator. To be eligible for moonlighting, a resident must have:

- Satisfactory evaluations in every category for each rotation over the past six months.
- Conference attendance of at least 60% over the past six-month period.
- No probationary status in the program.
- A record of timely completion of all administrative requirements established by the hospital and department.
- Satisfactory performance on the annual In-Training Examination and periodic exams administered by the department.
- Satisfactory progress toward completion of the required clinical evaluation exercises.

Moonlighting privileges may be curtailed by the program director if either he or the Resident Education and Evaluation Committee deems that moonlighting is not in the best interest of the resident. Discovery that an ineligible resident is moonlighting will be grounds for disciplinary action, including possible termination.

PROGRAM ADMINISTRATION

Resident Education And Evaluation Committee

The Department of Medicine Resident Education and Evaluation Committee consists of the program directors, chief residents, and selected faculty members from various sections of the Department of Medicine, appointed annually by the chairman of the department. The program director is the chairman of the committee. In personnel actions requiring a vote, the chairman does not cast a vote except in case of a tie. Responsibilities of the committee are:

- Evaluate the knowledge base, clinical competence, professional attributes, and practice patterns of all residents in the program.
- Evaluate, at the request of the program director, any concerns related to individual residents, and recommend a course of action to deal with the issue.
- Recommend promotion, remediation, counseling, or termination of residents.
- Monitor the residency curriculum on an on-going basis and recommend any revisions needed to enhance the education of residents.
- Study and recommend to the program director and department chairman changes in the administration of the program.
- Study any other matter requested by the department chairman.

Meetings of the committee are scheduled at the discretion of the program director, but take place at least quarterly. Any personnel action of the committee is in the form of a

recommendation to the department chairman, who must approve it before implementation. A quorum of the committee must be present for a vote on any personnel matter. Other matters may be decided by less than a quorum if there is a clear consensus that would not be overturned by a quorum, and committee members whose responsibilities are concerned directly with the matter are present for discussion. Minutes of all meetings will be maintained and approved at the next meeting. The department faculty as a whole will review the curriculum and house staff policies annually in a general faculty meeting or by e-mail vote, and may make additional recommendations for changes.

REMEDATION, PROBATION, AND DISCIPLINARY ACTIONS

Each resident must become familiar with the Due Process and Grievance section of the hospital *Graduate Medical Education Committee Policy Manual*. The policies and procedures described in this section of the department *Handbook* outline the process for dealing with remediation, probation, and disciplinary matters within the Department of Medicine, prior to any review through the mechanisms described in the *GMEC Policy Manual*. If there is unintentional conflict with hospital policies, those of the hospital will prevail.

- Any monthly or semi-monthly resident evaluation by the attending faculty containing a *marginal* (4 on a scale of 1 to 9) or *unsatisfactory* (1 to 3 on a scale of 1 to 9) rating in any category or competency is transmitted electronically to the program directors and the resident's mentor through *MyEvaluations*. The resident will be counseled by a program director or the resident's mentor. A record of the counseling will be prepared for inclusion in the resident's file. Both the counselor and the resident will sign the written record. The resident has the right to discuss any adverse evaluation with the faculty member submitting the evaluation, and should ask for such a discussion if it has not already occurred.
- Adverse evaluations submitted by other residents are also transmitted to the program directors and mentors. The program director will use discretion in handling these, in order to preserve the anonymity of the evaluation. However, they may be the basis for any of the actions described below.
- *Marginal* evaluations will generally require only counseling, although a consistent pattern of such evaluations may result in further action, including denial of promotion or contract renewal.
- For the *first unsatisfactory evaluation in a single category*, no action may be taken beyond counseling and formulating a plan to ensure that no further unsatisfactory or marginal evaluations occur. Exceptions are allegations that suggest egregious failure to carry out professional responsibilities or to practice medicine in a safe manner, or allegations of criminal conduct. In these cases, the program director, with the concurrence of the department chairman, may take immediate action. This may include probation for a specified period of time, suspension for a specified period of time (with or without pay), administrative leave pending investigation, or termination. As soon as possible thereafter, but within two weeks, the Resident Education and Evaluation Committee will be convened to discuss the matter and ratify, or decline to ratify, the decision of the program director. If the committee does not ratify the decision, it will suggest another course of action.

- If a resident receives an *unsatisfactory rating for overall clinical competence* on a monthly or semi-monthly evaluation by an attending faculty, the Resident Education and Evaluation Committee will review the resident's performance formally. This review must take place within one month of the receipt of the evaluation by the program director, unless the conditions in the above paragraph apply. The program director, with the concurrence of the department chairman, elect not to convene the committee if a subsequent evaluation within the same month gives the resident a satisfactory rating and there is clear evidence that the first rating is not a true reflection of the resident's performance; or if discussion with the committee is deemed to be inappropriate for any reason.
- The committee will also review any *second unsatisfactory evaluation in single categories or competencies*, even if the resident is not rated unsatisfactory in overall clinical competence or the two ratings are in different categories. At the discretion of the program director, this review may take place at a called meeting of the committee or at the next regularly scheduled meeting.
- Following a review in either of these situations, the committee's possible courses of action include, but are not limited to, probation for a specified period of time, mandatory remediation under a specific plan, and/or mandatory professional counseling.
- In all cases scheduled for review by the committee, the resident will be provided a written summary that outlines the alleged nature of the unsatisfactory performance, and will sign the summary to indicate that he or she has received it. This signature indicates only that that the summary was received, not that the resident agrees with the content.
 - The resident may prepare a written statement addressing the allegations for presentation to the committee, and will be offered the opportunity to appear before the committee to present any relevant information. The resident may submit to questions from the committee, but is not required to do so. After hearing all parties and appropriate discussion, the committee may request more information before making a decision.
 - Following the meeting of the committee, the resident will be informed in writing of the committee's recommendation to the department chairman and the factors considered by the committee in its decision. For a recommendation of probation, the terms of the probation and a proposed action plan will be included. The resident may request the opportunity to appear before the committee prior to the recommendation being forwarded to the department chairman, if he or she did not address the committee previously. The committee meeting for this purpose must take place within one week after the resident receives the written summary, or as soon thereafter as a quorum of the committee can be assembled.
 - The program director will inform the resident of the department chairman's decision as soon as possible after being notified of that decision in writing.

- While a resident is on probation, any subsequent unsatisfactory evaluation in any category, will be grounds for termination, subject to a formal decision by the committee. Other grounds for termination may be specified in the terms of the probation.
 - Any disciplinary or adverse action is subject to the due process provisions outlined in the *Graduate Medical Education Policy Manual*. In all cases, this right will be reiterated to the resident by the program director when he or she is informed of the committee's action.
- **Termination** from the training program may occur for a number of reasons. These include, but are not limited to the following:
- Inadequate performance when on academic probation (See above section).
 - Illicit drug use, subject to the provisions of the impaired physician program. (See section on *Drug Screening*).
 - Refusal to submit to a reasonable request by the program director, based on cause, for drug screening.
 - Lack of progress in training after appropriate counseling and remediation, as judged by the Resident Education and Evaluation Committee.
 - Failure to meet criteria for promotion to the next level of training, after an appropriate opportunity to remedy the deficiencies.
 - Any violation of the annual contract.
 - Serious violation of hospital or department rules and regulations, as outlined in the *GMEC Policy Manual* or this *Handbook* and judged by the Resident Education and Evaluation Committee.
 - Unprofessional behavior of an egregious nature, as judged by the Resident Education and Evaluation Committee.
 - Failure to pass Step 3 of the United States Medical Licensure Examination (USMLE) prior to the beginning of the PGY-3 year. Louisiana State Board of Medical Examiners policies prohibit residents from entering the third year without successful completion of Step 3. The Department of Medicine reserves the right to terminate any resident in this situation and refuse re-admission to the program.
- In all cases of termination, the due process procedures outlined in the *GMEC Policy Manual* will be followed. Prior to any vote on termination, the resident will have the right to address the committee and/or be represented at the committee meeting by his/her faculty mentor or any other faculty member. As indicated above, any termination decision by the Resident Education and Evaluation Committee will be in the form of a recommendation to the department chairman. The program director will give the resident a formal letter that notifies him or her of the decision, informs him/her that the recommendation has been forwarded to the department chairman, and refers to the applicable due process procedures.

BENEFITS

The following is a list of benefits provided by the Department of Medicine for the 2009-2010 academic year. Benefits may change in subsequent years. See the *House Staff Manual* for a description of additional benefits provided by the hospital.

- Each resident will be provided an **annual educational stipend** for books, review syllabuses, diagnostic equipment, medical information hardware and software, journal subscriptions, or professional memberships, or to supplement registration/travel/accommodations for scientific meetings, in the following amounts:
 - PGY-1: \$300.00
 - PGY-2: \$400.00
 - PGY-3: \$300.00.

- The policies governing the expenditure of these funds are:
 - All uses of this allotment must be applicable to the practice of residents during the basic residency or preliminary medicine year. The program director reserves the right to refuse any expenditures for materials or benefits related solely to another specialty or to a subspecialty of Internal Medicine.
 - *All purchases must be made through the LSUHSC-S bookstore* (unless the items are outside the bookstore's scope of business) through a purchase order (Internal Transaction [IT]) prepared by the residency coordinator's office.
 - Because of the potential number of transactions, *all written materials requested by each resident must be included in one order per year.*
 - All requests for each year must be submitted by March 31, unless prior arrangements are made with the program director.
 - The program director and department chairman must approve carrying stipends over to a subsequent year.
 - Use of funds for educational meetings in conjunction with annual leave will ordinarily not be approved.

- **Board Review Course:** The Department of Medicine sponsors an annual board course locally in late May or early June. The registration fee for this course is waived for PGY-3 residents in the department, and educational leave is granted to those who attend. Residents who elect to attend another review course will be granted a number of days of educational leave equal to the length of the local course, provided that they do not attend that course. Annual leave or leave without pay must be requested for any days in excess of this number. The department is unable to reimburse expenses incurred in attending a course elsewhere, beyond the educational stipend allowed in the PGY-3 year (see policies above).

- On a case-by-case basis, residents may receive partial **reimbursement for expenses incurred in attending a meeting at which they make a scientific presentation**, under the following policies:
 - The amount approved must be negotiated with the program director and department chairman.
 - Educational leave will be granted for such meetings, subject to restrictions mentioned elsewhere in this handbook.

- Stipulations may be placed on the mode of travel and the maximal allowable expenses for meals and lodging related to these meetings.
- For presentations sponsored by the faculty of a subspecialty section, it is expected that any reimbursement will be made by that section. *This must be discussed with the subspecialty section prior to submitting an article/abstract for consideration.*
- Regardless of sponsorship, all travel must be approved in advance by the program director, and permission is subject to availability of coverage for essential patient care responsibilities. Residents and/or sponsoring faculty should *notify the program director of the meeting at the time the presentation is submitted*, not accepted. Failure to do so may preclude approval of educational leave and travel, particularly if the resident is assigned to an inpatient rotation and a change in the assignment cannot be made.
- All travel reimbursement is subject to State of Louisiana regulations. Please ask the residency coordinator for a list of these *prior* to making any travel arrangements.

LEAVE POLICY

Vacation (Annual) Leave

See the hospital *GMEC Policy Manual* for details of the leave policy. The department will grant leave in accordance with this policy, except as described in this section. Annual leave is a benefit granted by the hospital and department. It is an essential time to relax and “re-charge” after months of demanding training and work, and thus cannot be forfeited to shorten training or to make up for absences for other reasons. At the same time, each resident is expected to maintain professional responsibility to patients, colleagues, and the program in the use of annual leave. Leave is dictated not only by hospital and department policies, but also by guidelines of the ABIM, which limits the time away from training during a thirty-six month residency. The following procedures will apply for 2009-2010.

- Leave for 2009-2010 was requested prior to joining the program or during the vacation lottery conducted by the chief residents in April 2009. For those not present or represented by proxy during the lottery, these have been assigned and published by the education coordinator. *Residents who decide to change vacation months must trade personally with another resident.* The educational coordinator and program director will intervene to make changes only after the resident has exhausted all reasonable attempts to trade with someone else, and only for valid reasons such as personal and family medical conditions or other emergencies.
- All leave must be approved in advance. *Requests for vacation (annual) leave are initiated by submitting a leave request through the Internet system established by the Graduate Medical Education Office.* Approval by the department is the responsibility of the *program director* or his designee.
- Residents are encouraged to take leave in one or two-week increments. Generally, this will include 5 or 10 week days and the weekend days before, during, and/or after these days. Longer periods of leave may be approved if these cross two months, and *must be*

discussed with the education coordinator and program director early in the academic year. A three-week vacation within a calendar month will ordinarily not be approved, since credit for training cannot be given for a rotation less than two weeks in length.

- Multiple leave periods of one, two, or three days are discouraged and ordinarily will not be approved.
- Within the months you have selected or been assigned, requests for specific days *must be selected at least four months in advance*, in order to cancel your continuity clinics.
- For residents assigned to the same rotations, requests for leave in specific weeks will be approved on a first-come, first-served basis. Ordinarily, two residents will not be approved for leave the same week, except on the GMACC rotation.
- Please do not book travel accommodations for anticipated leave until the education coordinator approves the dates. The program director will not intervene to change leave dates in such circumstances.
- The education coordinator will notify the manager of the General Medicine Clinic as soon as leave dates are finalized. However, residents should take their projected leave dates into account when scheduling follow-up patients.
- If, after reasonable reminders, a resident does not submit a specific vacation request by the required time, the education coordinator may assign leave dates.
- Except under unusual circumstances, leave for Medicine residents will not be approved during ward or ICU rotations. However, hospital policy dictates that the department must grant leave to a limited number of off-service residents assigned to ward rotations.
- The program director and education coordinator reserve the right to reschedule and/or re-negotiate leave that has been previously approved, if the absence of residents would compromise patient care or the educational program.
- No leave will be granted during the annual In-Training Examination in October.
- Because of residents leaving for new programs and board review courses, priority for leave in June will be given to residents with these considerations. Ordinarily, no two-week leaves will be approved, and leave the last week of the month will be limited to those who are moving to programs at other institutions.
- *Official holidays that occur within a requested leave period will be counted as leave days.* Otherwise, you may be required to cover clinical responsibilities on the holiday.
- During ward and ICU rotations, unexpected absences on weekends or holidays when you are expected to work must be counted as leave in some category.
- Absences for fellowship interviews must be counted as annual leave.

Educational Leave

Educational leave may be granted for the following reasons:

- Licensure examinations (*but not preparation for exams*).
- Board review course (final year of training).
- Any scientific meeting at which a resident makes a scientific presentation.
- Travel for official departmental business.
- Travel related to immigration issues or state licensure.

Sick Leave

See the hospital *GMEC Policy Manual* for general guidelines.

- All residents are allowed ten weekdays of sick leave each academic year, which cannot accumulate across years, and can be used for no purpose other than illness or absences covered by the Family and Medical Leave Act.
- If a resident is absent from scheduled clinical responsibilities on weekends or holidays because of illness (i.e., during inpatient rotations or when scheduled for cover/back-up responsibilities), these must be counted as days of sick leave also.
- Following return to work, a resident must submit a leave request for any day that he/she was away from clinical responsibilities because of medical problems.
- Residents who are unable to work because of illness must notify the chief resident and, if a PGY-1 resident assigned to a ward rotation, the upper level resident on the team. Upper-level ward residents and residents assigned to subspecialty rotations must notify the attending faculty, in addition to the chief resident. Anyone who is sick the day of a scheduled continuity clinic must notify the CLINIC MANAGER and the attending faculty of the clinic as early as possible in the morning. If patients cannot be contacted to reschedule the visit, other residents will be asked to see the patients that day.
- The chief resident or program director may, at any time, require that a resident see another physician to evaluate an illness and determine suitability for work. In all cases, a resident away from clinical responsibilities for over 48 hours because of illness must be seen by another physician.
- The program director may request a physician's written excuse for sick days if there is a pattern of absences or unusual circumstances surrounding the absence.
- Residents who are unable to return from annual leave because of illness must submit documentation of their original travel itinerary, or will be charged additional days of annual leave or leave without pay.
- Residents on ward services who have days off because of illness will usually forfeit an equal number of their days off for that month.

Leave Without Pay (LWOP)

Special circumstances, such as unavoidable time off after annual leave has been exhausted, may warrant leave without pay. This must be arranged with the education coordinator and the program director. Any time lost because of leave without pay may result in extension of the period of training.

Other Types of Leave

See the *GMEC Policy Manual* for guidelines on Family and Medical leave, funeral leave, maternity/paternity leave, special leave, and leave of absence. In all cases, these must be discussed with and approved by the education coordinator and program director. For residents who become pregnant, the Human Resources Department should be notified early in the pregnancy to prepare for Family and Medical Leave (FMLA). Residents are eligible for FMLA after twelve months of employment by the university.

MISCELLANEOUS POLICIES AND PROCEDURES

Resident Files

A file for each resident is maintained in the office of the residency coordinator. Information placed there includes application forms; letters of recommendation prior to joining the program; application CVs; licensure examination scores; correspondence related to training permits, licensure, visas, and hospital credentialing; In-Training and other examination results; rotation schedules; conferences attended; semi-annual written evaluations by program directors; annual tracking evaluation submitted to the ABIM; results of hospital quality assurance audits; record of counseling sessions; summaries of procedures and clinical evaluation exercises; portfolio items (see below), and all other correspondence related to the resident.

Access to a resident's file is limited to the resident, program directors, coordinators, the department chairman, the hospital administration, and outside accreditation agencies. Other faculty members and residents are not permitted access to files. Fellowship program directors are not permitted under any circumstances to see the files of residents who are applying to their programs. Residents are encouraged to review their own files periodically, but we require a signed, dated statement within the file indicating that the review has been done.

Currently, files of all residents are maintained in perpetuity in the department. Frequently, we refer to the files of residents who completed the program many years ago in order to complete hospital credentialing forms. With the development of on-line evaluations, individual evaluations are pass-word protected and available only to coordinators and program directors. Evaluations and other information contained in *MyEvaluations* is archived when a resident completes the program, and is available thereafter only through the educational coordinator.

Upon completion of training, a final summary evaluation is sent to the hospital Graduate Medical Education Office. A file on each resident who has trained at LSUHSC-S is maintained there, but the information therein is usually limited to training dates, contracts and other administrative forms initiated by the hospital, and miscellaneous correspondence.

Communication, E-mail, and Phones

With the size of the Department of Medicine and residents assigned to multiple sites, communication of essential information is often difficult. The campus mail system at LSU is slow, and residents assigned to other hospitals may not check their mail boxes daily. Therefore, all residents in the Department of Medicine are required to have an electronic mail address to which messages can be sent. You must check your e-mail at least every 48 hours unless you are out of town on leave. The on-line evaluation system also requires electronic mail. *Effective July 1, 2009, department correspondence and evaluations will be sent only to your LSU e-mail address. There will be no exceptions to this policy.*

Circumstances may arise that require the department to contact you when you are not on duty and your pager is not active or non-functional. Residents are required to have a telephone or cellular phone with an active number, and must notify the residency coordinator of any changes in numbers. In addition, it is helpful to give the coordinator addresses of e-mail accounts other than LSU that are accessed regularly. Occasionally, contingencies arise that require the program staff to contact a resident who is on leave away from Shreveport and unavailable through the above means. Please give an additional contact information to the chief resident and/or education coordinator before leaving the city. It will be kept confidential.

Lockers

Each resident will be assigned a locker in which to keep personal items secure. These are located in room 6-329, located in the stair hall between the sixth floor of the School of Medicine building and the seventh floor of the hospital.

Dress Code

It is important to maintain a professional appearance that is appropriate to the setting in which you are working. Please see the hospital and department dress codes in the Appendix.

Pagers

The Graduate Medical Education Office will provide you a pager at the beginning of your training. It is important to safeguard your pager at all times. If it is lost or stolen, the cost of replacement must be borne by the Department of Medicine. Expenses such as this limit the money available to support the training program in other ways.

You must carry your pager at any time that you have patient care responsibilities or are on call. When you are an upper level ward resident, it is helpful, though not absolutely required, to have the pager with you even when you aren't on call. On-call residents may need your advice in dealing with problems that arise on your patients. Please make sure that your pager is always functional. Replacement batteries are available from the hospital switchboard operators on the first floor.

Hospital Policies

There are a large number of hospital policies covering every aspect of patient care, as well as administrative issues. If you have any questions about how to deal with a particular

issue, a good resource is the hospital web site: www.sh.lsuhs.edu. Many of the policies you need are posted there. The program director and program staff are good sources of information also.

It is the responsibility of the Department of Medicine to insure that all residents meet all the hospital requirements listed below. Educational leave, moonlighting privileges, and electives may be suspended if you fail to comply.

- **Campus Education Day:** All hospital employees, including residents, are required to complete certain education requirements set forth by federal, state, and university regulations. Among the topics included are fire safety, violence in the workplace, Medicare compliance, equal employment opportunity, and professionalism. *This educational program is completed on-line* during the month of your birth. PGY-1 residents who participate in the hospital orientation prior to July 1 must still complete the on-line training during their birth month.
- **Employee Health Screening:** During your first year, you will be scheduled for an appointment with the Employee Health Service (located on the eighth floor of the hospital) to review your immunizations and complete other required health screening. *Please do not ignore this appointment.* If the time is inconvenient, you may call and reschedule.
- **Tuberculosis skin testing** will be performed annually on each employee. Usually, this testing is performed the same month for all internal medicine residents, unless you become due for testing earlier. For PGY-1 residents, the testing may be part of your employee health screening.
- **Chaperones:** The hospital policy on Patient Rights and Responsibilities states that a patient has the right to have one's own gender present during certain parts of a physical examination performed by a health care worker of the opposite sex. Please do not deviate from this policy when examining a woman's chest, abdomen, or pelvis, or when performing a genital or rectal exam on a male patient. The chaperone does not have to be a nurse or nursing assistant. Another resident or a student may act as your chaperone. In addition, you should always use judgment during any patient encounter that takes place in private, even if you are not touching the person. In the past, residents have been falsely accused of inappropriate behavior even while taking a history. In many cases, this has stemmed from the physician's refusal to give requested controlled substance prescriptions. If you have any concern about a patient's motives or emotional stability, please request that someone be present with you in the room at all times.
- **Informed Consent:** You should become thoroughly familiar with the hospital policy on informed consent (Policy number 5.16.1). A *general consent for treatment* is obtained at the time of registration. *Specific consent* must be obtained for designated procedures, including chemotherapy, administration of blood products, and HIV testing. In addition written consent is required before making any picture of a patient, even if the person's identity cannot be determined from the photograph.

Licensure

It is the responsibility of each resident to deal personally with the Louisiana State Board of Medical Examiners on issues relating to your license to practice medicine or temporary permit for training. The program will provide any letters or other documentation needed to satisfy board requirements. The education coordinator is a good source of information related to licensure issues. All fees are your responsibility. Temporary and training permits will be issued for a period of up to two years, during which time you are expected to pass Step 3 of USMLE. You cannot begin PGY-3 until you successfully complete Step 3.

As noted above, failure to pass Step 3 by the beginning of the PGY-3 year may be grounds for termination from the program. To insure that you meet this requirement, *all residents must show proof that they have **scheduled Step 3 by January 1** of the PGY-2 year, or eighteen months after beginning training. A resident who does not comply with this policy may be placed on probation until it is satisfied.*

Visa/Immigration Issues

Residents who are not citizens of the United States are responsible for maintaining a visa or work status acceptable for training in Louisiana. The program will provide any documentation requested by the United States Citizenship and Immigration Services (USCIS) and the Department of Labor. However, monitoring your status with these agencies is the responsibility of the Legal Affairs Office. Many regulations of USCIS are quite rigid, and there is little we can do to help you if your visa expires. Because the regulations are complex and change frequently, we routinely refer all questions related to immigration and visas to the Legal Affairs Office. Additional information is available in the *GMEC Policy Manual*.

Drug Screening

The use of any illegal drugs and abuse of prescription drugs is strictly prohibited. Prior to employment, screening for illicit drugs will be performed on all residents. During the training program, drug screening may be requested if, in the opinion of the department chairman, a program director, or a section chief there is behavior that may reflect drug abuse. The procedures and policies outlined in the Hospital Policy Manual will be followed. Failure to comply with a requested drug screen by the may result in termination. A positive drug screen mandates notification of appropriate authorities and the initiation of a rehabilitation program.

Stress

Residency training in Internal Medicine is inherently stressful. Residents often face long work hours, demanding clinical responsibilities, difficult patients, and the many other frustrations of a training environment. The program directors, chief residents, key clinical faculty, and attending physicians are responsible for monitoring the stress level of all residents in the program.

Signs and symptoms that *may* indicate a high level of stress include:

- ✓ Evaluations from faculty, peers, or nurses indicating problems in interpersonal relationships with the patient care team.
- ✓ Reports of excessive, unfounded criticism of colleagues or the program.

- ✓ An abrupt change in performance in any aspect of the program, including patient care, examination scores, and conference attendance.
- ✓ Excessive sleepiness when not post-call.
- ✓ Tardiness to any assigned responsibility.
- ✓ Failure to complete medical records and other administrative responsibilities in a timely manner.

Periodic house staff meetings will be conducted by the program director and/or chief resident, at which time concerns can be discussed and frustrations vented. Residents are encouraged to talk individually with the chief residents, a program director, mentors, or other faculty members when they perceive that their level of stress is rising. In addition, you must be alert to signs of stress in other residents, and report these confidentially to the chief resident or a program director. *While you may be reluctant to take this step, it is a professional responsibility.* A program director and the chief resident will counsel any resident with signs of stress-related dysfunction. Expert counseling services are available when needed, and may be mandated in serious cases. Sick leave may be granted if the program director judges that a resident is unable to carry out his/her patient care responsibilities or needs respite from the stress of the program.

Department of Medicine Resident Council

The Department of Medicine Resident Council consists of all chief residents for the academic year, the Medicine/Pediatrics chief resident, and at least two residents from both the PGY-1 and PGY-2 levels selected by vote of their peers. There must be at least one representative from the primary care track. This council is distinct from the hospital Residency Council. The chairperson is the current chief resident at LSUHSC. The responsibilities of the council include:

- Meet at least quarterly to review issues that are of concern to the residents. These include, but are not limited to, rotation and call schedules, policies related to admissions, problems in the General Medicine Continuity Clinic, facilities and equipment (team rooms, call rooms, computers, etc.), and conferences.
- Solicit and receive feedback from other residents concerning the above issues or any other areas of concern or perceived stress.
- Study any issue referred to the council by the program director or department chairman.
- Study and seek resolution to any problem referred by an individual resident or group of residents.
- Assist the program director with recruiting and interviews of applicants.
- At the request of the program director, act as an honor council to review certain allegations against a resident related to ethics and professionalism. The opinion of the council in these situations is advisory to the program director and the Resident Education and Evaluation Committee.

All decisions of the council are in the form of written recommendations to the program director and/or department chairman. Either of these may request to meet with the committee to get direct input from its members.

Grievance Procedures

It is the right of every resident to address through formal administrative channels any problem that concerns him or her significantly. However, we strongly urge you to seek resolution of the issue through discussion with your mentor, the chief resident, a program director, the department chairman, or the Department of Medicine Resident Council. If you are not satisfied with the response through these channels, or if it would be inappropriate to discuss the matter within the department, the following mechanisms are available:

- Contact the Vice Chancellor for Clinical Affairs or the Designated Institutional Official (DIO).
- Submit a written statement of the concern to the hospital Graduate Medical Education Office. It will be investigated within thirty days.
- Follow the policy set forth in the LSUHSC-S Human Resource Management Employee Handbook, under “Grievance Procedure.”

Complaint/Suggestion Box

A locked box is available in a team room on the seventh floor of the University Hospital for anonymous complaints and suggestions. Only the chief resident may open this box.

CLINICAL COMPETENCE

On the following pages and in the Appendix, you will find important information concerning educational objectives of the training program, and the levels of responsibility of residents in the various years. A description and curriculum for each general and subspecialty rotation is included on the program web site. At the beginning of each month, you should become familiar with the objectives and education program of the section in which you will be working. Additional information and instructions will be supplied by the section or your attending faculty in an orientation.

The General Competencies

As noted above, the ACGME requires that residents in all specialties be trained and evaluated in six general competencies. This concept is the driving force in all aspects of postgraduate medical training in the United States. Definitions of these competencies, as they apply to internal medicine, have been developed by the ABIM and the Association of Program Directors in Internal Medicine.

Patient Care: Residents are expected to provide patient care that is compassionate, appropriate, and effective for the promotion of health, prevention of illness, treatment of disease, and palliation of symptoms at the end of life.

- Gather accurate, essential information from all sources, including medical interviews, physical examinations, medical records, and diagnostic/therapeutic procedures.
- Make informed recommendations for preventive, diagnostic, and therapeutic interventions that are based on clinical judgment, scientific evidence, and patient preference.
- Develop, negotiate, and implement effective patient management plans and integrate all aspects of

patient care.

- Perform competently the diagnostic and therapeutic procedures essential to the practice of internal medicine.

Medical Knowledge: Residents are expected to demonstrate knowledge of established and evolving biomedical, clinical, and social sciences, and apply their knowledge to patient care and the education of others.

- Apply an open-minded, analytical approach to acquiring new knowledge.
- Access and critically evaluate current medical information and scientific evidence.
- Develop clinically-applicable knowledge of the basic and clinical sciences that underlie the practice of internal medicine.
- Apply this knowledge to clinical problem-solving, clinical decision-making, and critical thinking.

Practice-Based Learning and Improvement: Residents are expected to be able to use scientific evidence and methods to investigate, evaluate, and improve patient care practices.

- Identify areas for improvement and implement strategies to enhance knowledge, skills, attitudes, and processes of care.
- Analyze and evaluate practice experiences and implement strategies to improve continually the quality of patient practice.
- Develop and maintain a willingness to learn from errors and to use errors to improve the system or processes of care.
- Use information technology or other available methodologies to assess and manage information, support patient care decisions, and enhance both patient and physician education.

Interpersonal and Communication Skills: Residents are expected to demonstrate interpersonal and communication skills that enable them to establish and maintain professional relationships with patients, families, and other members of health care teams.

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

Professionalism: Residents are expected to demonstrate behaviors that reflect a commitment to continuous professional development, ethical practice, dealing effectively with diverse populations, and a responsible attitude toward their patients, the medical profession, and society.

- Demonstrate respect, compassion, integrity, and altruism in relationships with patients, families, and colleagues.
- Demonstrate sensitivity and responsiveness to patients and professional colleagues of different genders, ages, cultural backgrounds, religions, sexual preferences, socioeconomic statuses, health behaviors, and disabilities.
- Adhere to principles of confidentiality, scientific/academic integrity, and informed consent.
- Recognize and identify deficiencies in peer performance.

Systems-Based Practice: Residents are expected to demonstrate both an understanding of the contexts and systems in which health care is provided, and the ability to apply this knowledge to improve and optimize health care.

- Understand, access, and utilize the resources, providers, and systems necessary to provide optimal care.
- Understand the limitations and opportunities inherent in various practice types and delivery systems, and develop strategies to optimize care for the individual patient within these systems.
- Apply evidence-based, cost-conscious strategies to the prevention, diagnosis, and management of

disease.

- Collaborate with other members of the health care team to assist patients in dealing effectively with complex systems, and to improve systematic processes of care.

The Department of Medicine has developed specific educational goals in each competency for every rotation and educational level, and specific evaluation tools to document your competence in these areas.

As noted above, *you must take the initiative to ensure that your competence in the six areas is documented.* Some of the evaluations, such as the monthly evaluations by the attending faculty and your peers, will occur routinely. However, clinical evaluation exercises and other evaluation tools that require direct observation may require that you remind the faculty of the need to evaluate you. Program directors will monitor this at the time of your semi-annual evaluations.

Resident Portfolios

Each resident is encouraged to develop a “portfolio” that is contained in your file. Any information that helps document your competence in any of the six areas should be placed there. This might include, but is not limited to, handouts from “mini-lectures” you present at any conferences; thank-you notes and complimentary letters you receive from patients and families; and copies of abstracts, case reports, or scientific articles you write. The program directors will place any letters of commendation that are received in your file.

Criteria for Resident Advancement

Advancement to the next level of training is based on the achievement of certain defined milestones related to the six general competencies. For any resident who does not fulfill the criteria for advancement listed below, the program director may develop a plan for remediation or completion of procedural/clinical exercise/administrative requirements, or may present the resident to the Residency Education and Evaluation Committee for discussion and recommendations.

Advancement from PGY-1 to PGY-2 Responsibilities:

- ◆ Completion of 125 complete medical histories and physical examinations on newly-admitted patients, with random review by faculty members other than the faculty physician of record. (Competency: patient care)
- ◆ Substantial progress in documenting proficiency in the procedural skills required by the ABIM or the program. (Competency: patient care)
- ◆ Satisfactory scores on periodic self-assessment examinations administered by the Department of Medicine. Residents can miss taking no more than one exam during the year. (Competency: medical knowledge)
- ◆ Satisfactory score on an electrocardiography examination administered near the end of the year. (Competency: medical knowledge)

- ◆ Satisfactory score on the procedures cognitive exam administered during the year. (Competencies: medical knowledge; patient care)
- ◆ Satisfactory completion of 24 clinical evaluation exercises. At least four of these each must involve faculty observation of interviewing, examination, and counseling skills (a total of 12). (Competencies: All)
- ◆ Completion of hospital-mandated annual training. (Competencies: professionalism, systems-based practice)
- ◆ Acceptable ratings on evaluations completed by nursing staff. (Competencies: interpersonal and communication skills; professionalism, systems-based practice)
- ◆ Satisfactory overall rating on all monthly evaluations and semi-annual clinic evaluations by attending faculty, with no more than two marginal (4 on scale of 1 to 9) or unsatisfactory (1 to 3 on scale of 1 to 9) in any one competency, or more than three marginal or unsatisfactory evaluations on all competencies without successful remediation or demonstrated improvement, as judged by the program director and Resident Education and Evaluation Committee. (Competencies: All)
- ◆ Demonstrated pattern of timely completion of medical records and all other administrative requirements. (Competency: systems-based practice)

Advancement from PGY-2 to PGY-3 Responsibilities:

- ◆ Demonstrated ability to direct efficient and effective management by a patient care team, as judged by global evaluations by attending faculty physicians on inpatient rotations. Peer evaluations may also be a factor in the assessment. (Competencies: All)
- ◆ Satisfactory overall rating on all monthly evaluations and semi-annual clinic evaluations by attending faculty, with no more than two marginal (4 on scale of 1 to 9) or unsatisfactory (1 to 3 on scale of 1 to 9) in any one competency, or more than three marginal or unsatisfactory evaluations on all competencies without successful remediation or demonstrated improvement, as judged by the program director and Resident Education and Evaluation Committee. (Competencies: All)
- ◆ Higher raw score than in the PGY-1 year on the annual In-Training Examination. (Competencies: patient care, medical knowledge)
- ◆ Satisfactory scores on the periodic self-assessment examinations administered by the Department of Medicine. Residents can miss taking no more than one exam during the year. (Competency: medical knowledge)
- ◆ Satisfactory score on an electrocardiography examination administered near the end of the year. (Competency: medical knowledge)
- ◆ Satisfactory score on the procedures cognitive exam administered during the year. (Competencies: medical knowledge; patient care)

- ◆ Further progress in documenting proficiency in the procedural skills required by the ABIM or the program. (Competency: patient care)
- ◆ Satisfactory number of cases audited through the hospital CQI process without deficiencies. (Competencies: patient care, practice-based learning and improvement)
- ◆ Pattern of continued timely completion of medical records and all other administrative requirements. (Competency: systems-based practice)

Any resident who does not meet all criteria for promotion will be referred by the program director to the Resident Education and Evaluation Committee for a decision concerning promotion. The committee may recommend to the department chairman that the resident be retained at the current level of training; be promoted in a probationary status; or be dismissed from the program after due process.

DELINEATION OF LINES OF RESPONSIBILITY FOR RESIDENTS IN TRAINING

General Considerations:

1. Internal Medicine is a broad field in which the complexity of any problem or patient is modified by a number of factors, including age, co-existing disease, previous treatment, and psycho-social issues. For these reasons, it is difficult to delineate precisely the level of supervision required of a resident who is dealing with a particular problem. Only general guidelines can be established. These are based both on accepted standards of care (stated or implied in the medical literature), and on the experience of the faculty in supervising residents at different levels.
2. In a training program, as in any clinical practice, it is incumbent upon the physician to be aware of his/her own limitations in managing a given patient, and to consult a physician with more expertise when necessary. Physicians with similar levels of training and experience may vary widely in their ability to manage certain types of problems. Appreciation of one's limitations is a goal of the Internal Medicine residency program, and the extent to which a physician asks for consultation when appropriate is assessed on an on-going basis by the program directors and faculty.
3. In a training program, some degree of oversight by the faculty and more advanced residents is always appropriate, even for common problems and uncomplicated patients. This may be done in a variety of ways, including record review and independent evaluation of a patient by the reviewer, even when direct supervision is not required.
4. PGY-1 residents are never assigned to any clinical setting where immediate, on-site consultation and supervision from an upper-level resident or faculty member is not available. The extent to which a PGY-1 resident uses these resources is subject to the considerations in # 2 and # 3 above, as well as the guidelines that follow.

Inpatient Levels of Care

1. The Levels of Care attached to this document are based on a conceptual model developed by the Joint Commission on the Accreditation of Health Care Organizations. These address principally a resident's work in the patient setting. However, to the extent that the clinical management skills in the ambulatory setting overlap these, the same guidelines are applicable.
2. The limits of practice for PGY-2, 3, and 4 residents cannot be separated precisely because the rotation schedule of each resident during these years is different. Skills within a given area will therefore be acquired at varying points. In addition, the precise mix of patients that will be encountered on a given rotation, and therefore the skills that will be acquired through experience, cannot be predicted accurately. Thus, the general considerations above are overarching principles in applying the levels of care.

3. In general, invasive and non-invasive skills (procedures) require supervision until there is documentation that the resident can perform the skill satisfactorily. The number of satisfactory observations required depends on the complexity of the skill and the likelihood of complications. Listed on the accompanying charts is the number established for each skill. Supervision may be by faculty or a more advanced resident. Documentation must be online, through MyEvaluations.com. While it is anticipated that many residents will reach the required number in the PGY-1 year, the requirement continues into the PGY-2 and 3 years until the requirement is satisfied.
4. Some more complex procedures always require supervision. These are listed.
5. For PGY-1 residents who have completed satisfactorily the required number of observed procedures, upper-level supervisors still must insure that the resident's skill is adequate before permitting unsupervised performance of the procedure. Beyond the safety issue, supervisors may be able to offer useful suggestions to facilitate the efficiency and ease of performing the procedure.
6. Procedures performed by off-service residents at any level must be observed until the supervisor is satisfied that the resident has the necessary cognitive and manipulative skills.
7. For all central IV line placements or other invasive procedure with a significant risk of complications (abdominal paracentesis, thoracentesis, and lumbar puncture) by a PGY-1 resident or any resident from another department, an upper-level Medicine resident certified in the procedure must be present. For central line placement, two physicians must be present and must document in writing that the guide wire was identified and discarded at the end of the procedure.
8. It is expected that some of the skills listed under "Cognitive Clinical Management" will be acquired to a satisfactory degree prior to beginning postgraduate training, and that supervision is not required. However, a number of these are observed and assessed during formal clinical evaluation exercises in the PGY-1 year. Others are subject to ongoing assessment during rounds and record review throughout training. These are a part of the written evaluation for every rotation. Any deficiencies in these areas are noted, and the resident is subject to closer evaluation until the deficiency is corrected.
9. The upper-level resident on-call is responsible for all care of patients at night and on weekends and holidays. This includes new admissions and patients already in the hospital. PGY-1 residents who are asked by the nursing staff to deal with problems that arise in patients already on the wards are required to consult with the upper level resident on any issue of an emergent or potentially emergent nature. Nurses have the option of calling the upper level resident if they are not satisfied with the decisions made by the PGY-1 resident, or deem initially that the problem is beyond his/her expertise.
10. Upper-level residents on-call should consult the attending physician of the call team or an appropriate subspecialty consultant for any medical problem that is beyond their level of expertise or experience.

Ambulatory Care

1. In the General Medicine Clinic, Primary Care Clinic, and all subspecialty clinics, residents at the PGY-1 level must review every patient with the faculty before the patient leaves the clinic.
2. PGY-2, 3, and 4 residents working in the General Medicine and Primary Care Clinic are encouraged to review every patient with the faculty before the patient leaves the clinic. However, the attending faculty have the option of supervising care through timely review of the medical records.
3. PGY-2, 3, and 4 residents working in subspecialty clinics must review every patient with the faculty before the patient leaves the clinic.
4. In the rare situation when faculty members in the General Medicine and Primary Care Clinics must leave the clinic because of personal emergencies and back-up coverage cannot be identified quickly, PGY-1 residents must review patients with an upper-level resident before the patients leave the clinic. The upper-level resident may be one assigned to the clinics, the upper level resident on-call in the hospital that day, or one of the chief residents. The faculty will then perform a timely review of the medical records.

5. In the absence of a faculty member in a subspecialty clinic, PGY-1, 2, 3, and 4 residents may review patients with a fellow in that subspecialty.

In-Patient Consultations

1. Patients being seen in consultation by an Internal Medicine subspecialty may be evaluated initially by a resident at any level. In general, however, no recommendations will be placed in the medical record and no diagnostic tests or therapy ordered until the case has been reviewed thoroughly by a fellow or faculty in the subspecialty. The exception is suggesting routine diagnostic tests (basic laboratory or radiographs) that will obviously be needed for the management of the patient.

2. PGY-2, 3, and 4 residents may evaluate independently patients for whom General Medicine consultation is requested. This may occur when assigned to the General Medicine consultation role as a part of the General Medicine Ambulatory and Consultative Care rotation, or as part of the duties of the on-call and night float residents evenings, weekends, and holidays.

3. As a general rule, diagnostic tests and therapeutic modalities are recommendations to the patient's primary team, and the orders should be written by the residents on that team, in conjunction with their attending faculty (see Patient Care Administrative Guidelines).

RESIDENT LEVEL: PGY-1

COGNITIVE CLINICAL MANAGEMENT	NON-INVASIVE CLINICAL MANAGEMENT	INVASIVE CLINICAL MANAGEMENT

<ul style="list-style-type: none"> ▪ Perform and document medical history and physical exam ▪ Develop differential diagnosis and problem list ▪ Develop and document initial plan of care* ▪ Order and interpret routine diagnostic studies ▪ Order and interpret electrocardiogram + (10) * ▪ Modify daily plan of care* ▪ Write daily progress notes ▪ Write orders for routine diagnostic studies, medications, and other care modalities* ▪ Evaluate patients with acute medical problems upon request of nurses or other physicians* ▪ Obtain informed consent for procedures in PGY-1 scope of practice ▪ Order appropriate consults for diagnostic studies, evaluation by other physicians, physical/rehabilitation therapy, specialized nursing care, social services ▪ Initiate discharge planning ▪ Dictate discharge summary ▪ Evaluate new and follow-up patients in outpatient setting 	<ul style="list-style-type: none"> ▪ Perform digital rectal exam + (1) ▪ Perform pelvic, pap smear + (5) <p>Key: + (n): For these procedures and skills, the resident must perform the listed number <u>satisfactorily</u> under the direct supervision of an upper level resident or faculty member, and document the supervision in the on-line Procedure Log through MyEvaluations.com. (The information is password protected; the nurse or supervisor of the procedure should ask the resident to open his/her procedure log to validate that the proficiency. Thereafter the procedure without supervision. However, if difficulty is encountered the resident <u>or the nurse</u> must still call an upper level resident or faculty member for assistance.</p> <p>* Skill may require supervision of an upper level resident or faculty if the disease/ problem involved is unusual or complicated.</p> <p>** Resident should seek help from upper level resident or other specialty if any difficulty encountered.</p>	<ul style="list-style-type: none"> ▪ Perform abdominal paracentesis + (3) ▪ Perform arterial puncture + (5) ▪ Insert central intravenous catheter + (5) ▪ Cardiopulmonary resuscitation (Initial ACLS certification required) ▪ Perform thoracentesis + (5) ▪ Perform arthrocentesis + (3) ▪ Perform lumbar puncture + (3) ▪ Insert urethral catheter** ▪ Insert arterial catheter + (3) ▪ Perform peripheral venipuncture + (1) ▪ Insert peripheral intravenous catheter + (1) ▪ Bone marrow aspiration and biopsy *** ▪ Perform flexible sigmoidoscopy *** <p>*** Procedure always requires presence of fellow or faculty</p>
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RESIDENT LEVEL: PGY-2 , 3 AND 4

COGNITIVE CLINICAL MANAGEMENT	NON-INVASIVE CLINICAL MANAGEMENT	INVASIVE CLINICAL MANAGEMENT
<ul style="list-style-type: none"> ▪ Perform and document history and physical exam ▪ Develop differential diagnosis and problem list ▪ Develop initial plan of care* ▪ Order and Interpret routine diagnostic studies ▪ Order and interpret electrocardiogram + (10) * 	<ul style="list-style-type: none"> ▪ Perform digital rectal exam + (1) ▪ Perform pelvic exam, pap smear + (5) ▪ Initiate/adjust mechanical ventilation * ▪ Order, adjust artificial feeding modalities* <p>Key:</p>	<ul style="list-style-type: none"> ▪ Perform abdominal paracentesis + (3) ▪ Perform arterial puncture + (5) ▪ Insert central intravenous catheter + (5) ▪ Cardiopulmonary resuscitation (Initial ACLS certification required) ▪ Perform thoracentesis + (5)

<ul style="list-style-type: none"> ▪ Modify daily plan of care* ▪ Write daily progress notes ▪ Write orders for routine diagnostic studies, medications, and other care modalities* ▪ Evaluate patients with acute medical problems upon request of nurses or other physicians ▪ Obtain informed consent for procedures in PGY-2,3 scope of practice ▪ Order appropriate consults for diagnostic studies, evaluation by other physicians, physical and rehabilitation therapy, special nursing care, and social services ▪ Initiate discharge planning ▪ Dictate discharge summary ▪ Evaluate new and follow-up patients in outpatient setting ▪ Evaluate patients in the emergency department and on other services in a consultant role ▪ Perform pre-operative evaluations ▪ Supervise clinical management by PGY-1 physicians 	<p>+ (n): For these procedures and skills, the resident must perform the listed number <u>satisfactorily</u> under the direct supervision of an upper level resident or faculty member, and document the supervision in the on-line Procedure Log through MyEvaluations.com. (The information is password protected; the nurse or supervisor of the procedure should ask the resident to open his/her procedure log to validate that the proficiency. Thereafter the procedure without supervision. However, if difficulty is encountered the resident <u>or the nurse</u> must still call an upper level resident or faculty member for assistance..</p> <p>* Skill may require supervision of a fellow or faculty if the disease/ problem involved is unusual or complicated.</p> <p>** Resident should seek help from a fellow or other specialty if any difficulty encountered.</p>	<ul style="list-style-type: none"> ▪ Perform arthrocentesis + (3) ▪ Perform lumbar puncture + (3) ▪ Insert urethral catheter** ▪ Insert arterial catheter + (3) ▪ Perform peripheral venipuncture + (1) ▪ Insert peripheral intravenous catheter + (1) ▪ Bone marrow aspiration and biopsy *** ▪ Perform flexible sigmoidoscopy *** ▪ Insert pulmonary. artery catheter *** ▪ Insert chest tube *** <p>***Procedure always requires presence of fellow or faculty</p>
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Revised March 2008

LSU HEALTH SCIENCES CENTER – SHREVEPORT Department of Medicine

History of the Internal Medicine Residency Program

The Louisiana State University Hospital in Shreveport, and its predecessor institutions, Shreveport Charity Hospital and Confederate Memorial Medical Center, have offered postgraduate medical training for over one hundred years. Over the decades, many of the leading physicians in northwest Louisiana served in apprenticeships. Formal internships began in 1921, and when internal medicine became a recognized specialty in 1936, Shreveport Charity Hospital was at the forefront in instituting a program, which received accreditation that year. For years thereafter, the medicine training program was largely practice-oriented; internists in the city assumed most of the attending physician responsibilities.

After World War II, there was a significant expansion of medical care programs and postgraduate education. Dr. Marion D. Hargrove, Sr., served as the Chief of the Medical Service from 1946 to 1961. He oversaw the transition from Shreveport Charity Hospital to the Confederate Memorial Medical Center, as well as the move into the new hospital complex on Kings Highway in 1953. During the ensuing years, the Medical Service expanded significantly and offered new state-of-the-art clinical programs, including cardiac catheterization and renal

dialysis. After Dr. Hargrove's retirement, Dr. Herbert Tucker headed the Medical Service for the next decade. During his tenure, the LSU School of Medicine in Shreveport opened in 1968, and the hospital became the principal teaching facility for the new school.

The first full-time Department Chairman was Dr. M. D. Hargrove, Jr., who assumed the position in 1970. Dr. Hargrove presided over a dramatic increase in the size of the faculty and led the development of outstanding research efforts to enhance the clinical programs. The Overton Brooks VA Medical Center was integrated fully into the training program, new sections were added, and the first subspecialty training programs were offered. Fellowships in pulmonary diseases and hematology/oncology began in 1972. The nephrology program was added in 1975; infectious diseases in 1977; rheumatology in 1979; gastroenterology and cardiology in 1980; and endocrinology and critical care in 1987. General medicine was established as a separate section in 1980.

When Dr. Hargrove stepped down from the department chairmanship in 1991 to head the school's ethics program, Dr. Ronald George became chairman. Under his guidance, the department and training program continued to keep pace with an ever-changing medical environment. Centers of excellence in rheumatology and oncology were developed and received generous funding from the state of Louisiana. A combined residency program in internal medicine and pediatrics was initiated in 1992. Partnerships forged with Willis-Knighton Health System added to the breadth of the residency and fellowship programs.

Dr. George retired in June 2000. In November of that year, Dr. Daniel Banks became Chairman. He has provided aggressive leadership aimed at strengthening all aspects of the department's programs. A clinical research division was added to provide technical, administrative, and personnel support for industry-sponsored research in the department. Expansion of tertiary care capabilities and the subspecialty faculty has continued. A rotation in transplantation medicine was developed through Willis-Knighton Health System, and resident training in geriatrics now takes place in long term care facilities in the community setting. Over the past three years, the Overton Brooks VA Medical Center has received funding for ten additional internal medicine resident positions, which have added significantly to the training capabilities of the program. The caliber of residents and the training they receive, as judged by performance on the United States Medical Licensure Examinations and the American Board of Internal Medicine certifying examination, have increased markedly.

The Department of Medicine has recently launched new initiatives in the field of primary care in order to provide more general internists for both rural and urban areas of Louisiana and the surrounding states. In 2007, approval was obtained from the ACGME for eighteen additional resident positions on a primary care tract. The first six primary care residents began training in July 2008. In addition, the department plays a major role in the Louisiana Rural Health Information Exchange and the Louisiana Rural Hospital Coalition. A telemedicine program to enhance the care of patients in remote areas was inaugurated in September 2007 and will be a significant resource for the training of both primary care and subspecialty residents.

With the full implementation of the primary care program in 2010, the program will provide training for 93 residents each year, including 16 residents in the combined medicine/pediatrics program. In addition, the Department of Medicine sponsors subspecialty programs with a total of 57 residents, over half of which are graduates of the core program.

The clinical resources for training now include four major hospital systems and patients with a wealth of diseases from a three-state area. The commitment of the department to excellence in patient care, research, and education has made the program competitive for an increasingly strong applicant pool each year.

Revised October 20, 2008

APPENDIX

Key Faculty and Personnel

Administrative Guidelines for Patient Care on the Teaching Service

Back-Up System

Guidelines for Accepting Patient Transfers from Other Facilities

Guidelines for Duty Hours, Days Off

Dress Guidelines

Quality Measures and Discharge Instruction

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**LOUISIANA STATE UNIVERSITY HEALTH SCIENCES CENTER – SHREVEPORT
DEPARTMENT OF MEDICINE**

Administrative Guidelines for Patient Care on the Inpatient Teaching Service

1. *The entire Medicine Service of LSUHSC University Hospital is considered a teaching service. All patients will be admitted to a house staff team under the care of residents. Any faculty member who desires to admit a patient solely under his/her care must discuss the case with the Chairman of the Department of Medicine prior to the admission or as soon as possible thereafter. Circumstances where such a course of action might be appropriate include, but are not limited to, admission of a faculty member or family of a faculty member; admission of a high-level public official or other patients where there is a cogent reason to limit access to the patient; and patient preference, when a long-standing professional relationship would be compromised by admission to a teaching service. These circumstances will occur rarely.*
2. For a patient not part of the teaching service, resident responsibility will be limited to responding to emergencies where waiting for the attending physician would endanger the patient's well-being. As soon as possible after dealing with the emergency, the

resident will notify the attending physician, who is expected to assume responsibility at that point.

3. Residents training in a subspecialty of medicine (“fellows”) may take responsibility for management of patients they admit to the Medicine Service, in conjunction with a supervising faculty member in that subspecialty. These patients will be admitted to a house staff team with the subspecialty faculty member as the attending physician. The team will take no responsibility for the patient, unless he/she is consulted by the subspecialty physician. Most commonly, this would involve a complication of treatment or the discovery of a medical problem necessitating inpatient care that is outside the usual scope of the subspecialty.
4. The standard related to *order writing* in the ACGME Program Requirements for Internal Medicine will be followed. Under these guidelines, it is expected that the vast majority of the orders will be written by a resident, with appropriate oversight by the attending faculty. Exceptions to this policy might include: (1) orders written when the attending physician is covering for the upper level resident during a day off; (2) emergency situations; (3) orders written to prevent a delay in a procedure or diagnostic study that was requested by the residents, e.g., when a necessary order was inadvertently omitted by the resident requesting the procedure, and it is convenient for the attending to correct the oversight as the patient is being transported; and (4) orders clarifying an order previous written by a resident, when the clarification is minor in nature. The attending faculty will notify the residents of any other routine orders that are written.
5. Orders written by a physician assistant assigned to a teaching team must be countersigned by the attending physician. Residents cannot countersign these orders. If the circumstances dictate, the resident may rewrite the order over his/her own signature, and state that the physicians’ assistant order is to be disregarded.
6. Orders implementing the diagnostic and therapeutic recommendations of a consulting physician should generally be written by the primary patient care team, after discussion with the attending faculty. The exceptions are emergency situations and orders related to procedures performed entirely by the consulting service, such as cardiac catheterization, angiograms, and interventional radiology procedures.
7. ACGME guidelines will govern the maximum *number of patients* that are assigned at any one time to a teaching team. These are: 20 for a team with two PGY-1 residents and one upper-level resident; 14 for a team with one PGY-1 and one upper level resident; and 100 for a team with one upper-level resident only. The Program Director and the Chairman of the Department of Medicine may establish lower limits for subspecialty teams, in order to enhance the efficiency of management of patients assigned to these teams.
8. The ACGME guidelines for maximum number of patients assigned to a teaching team will not be exceeded even temporarily during the day.
9. ACGME guidelines will govern the maximum *number of patients that are admitted or transferred* to any teaching team. These are: ten new patients in 24 hours and sixteen in 48 hours to a team with two PGY-1 residents and one upper-level residents, with up

to four transfers from another Internal Medicine service beyond these numbers; ten new patients in 24 hours and sixteen in 48 hours for a team with one PGY-1 resident and one upper-level resident, provided that the upper-level resident does the complete work-up on five of the patients; ten new patients in 24 hours, sixteen in 48 hours, provided that the team census never exceeds the limits outlined in # 7 (an unlikely scenario). Admissions by the night float team are considered transfer patients.

10. The guidelines for admissions to the Medical Intensive Care Unit are identical to those for other inpatient teams. However, the number will necessarily be limited further by the capacity of the unit.
11. When problems arise at night and on weekends and holidays in patients already in the hospital, the on-call team is responsible to their own attending in the care of these patients, even if the patient is assigned to another team. However, continuity of care and professional courtesy dictate that the physicians be notified of the problem when it is feasible to do so.
12. A patient who is readmitted to the hospital during the calendar month is assigned to the team that cared for him/her previously, even if the upper level resident during the previous admission is no longer part of the team. The exception is patients who were admitted to a subspecialty team and return for a problem outside the scope of that subspecialty.
13. See Ward Policies and the Lines of Supervision policy for additional information.

Guidelines for Residents Assigned to General Medicine or Nephrology Transplant Rotations at Willis-Knighton Medical Center

1. The Medical Staff By-Laws of Willis-Knighton Health System will govern all aspects of patient care. Any perceived conflict of these by-laws with ACGME standards or established policies of the Department of Medicine must be discussed immediately with the attending faculty at Willis-Knighton Medical Center. Issues that cannot be resolved in this manner should be brought to the attention of the Program Director and/or Chairman of the Department of Medicine.
2. The designation of teaching service beds is not appropriate in this setting, where the scope of resident involvement is limited. Technically, any patient for whom the physician preceptor is the admitting or consulting physician, and the resident is involved in the care, is considered a teaching patient.
3. ACGME guidelines will govern the maximum *number of patients* that are admitted or assigned at any one time to an individual resident or team (see #7 and #9 above). If a resident is pursuing a hospitalist rotation (i.e., no ambulatory care patient experience), he/she may not relate to more than six preceptors.
4. The preceptor physician or a member of his/her practice group will have total responsibility for all aspects of patient care and resident supervision. Residents will not be in the hospital at any time without immediate supervision.

5. All entries in medical record, including orders and progress notes, must be countersigned before being carried out, unless the preceptor approves the orders verbally to a nurse or administrative clerk. The resident is not permitted to dictate discharge summaries.
6. Under no circumstances will residents provide care to patients for whom the preceptor is not the admitting or consulting physician. Emergency care will be provided through the hospitals unusual "code" procedures.

Guidelines for Residents Assigned to Geriatrics at Christus Schumpert Health System

1. The Medical Staff By-Laws of Christus Schumpert Health System will govern all aspects of patient care. Any perceived conflict of these by-laws with ACGME standards or established policies of the Department of Medicine must be discussed immediately with the geriatrics faculty preceptor. Issues that cannot be resolved in this manner should be brought to the attention of the Program Director and/or Chairman of the Department of Medicine.
2. The designation of teaching service beds is not appropriate in this setting, where the scope of resident involvement is limited. Technically, any patient for whom the physician preceptor is the admitting or consulting physician, and the resident is involved in the care, is considered a teaching patient.
3. ACGME guidelines will govern the maximum *number of patients* that are admitted or assigned at any one time to an individual resident or team (see #7 and #9, page 2 above).
4. The preceptor physician or a member of his/her practice group will have total responsibility for all aspects of patient care and resident supervision. All initial management plans and any major change in plans must be discussed with the preceptor before implementation.
5. All entries in medical record, including orders and progress notes, must be countersigned before being carried out, unless the preceptor approves the orders verbally to a nurse or administrative clerk. The resident is not permitted to dictate discharge summaries.
6. When talking at home telephone call for patients one night a week, all problems requiring a significant change in management plan or transfer to a different level of care (ICU, telemetry) must be discussed with the geriatrics faculty on call before implementation of the plan.
7. Under no circumstances will residents provide care to patients for whom the preceptor is not the admitting or consulting physician. Emergency care will be provided through the hospitals unusual "code" procedures.

Guidelines for Residents in Nursing Homes and Related Institutions

1. The written policies on each institution will govern all aspects of patient care. Any perceived conflict of these policies with ACGME standards or established policies of the Department of Medicine must be discussed immediately with the geriatrics faculty preceptor. Issues that cannot be resolved in this manner should be brought to the attention of the Program Director and/or Chairman of the Department of Medicine.
2. The designation of teaching service beds is not appropriate in this setting, where the scope of resident involvement is limited. Any patient for whom the physician preceptor is the admitting or consulting physician, and the resident is involved in the care, is considered a teaching patient.
3. Because the residents do not have ongoing responsibility for the care of patients in these institutions, numerical limits on admissions or patients under care are not appropriate.
4. The preceptor physician or a member of his/her practice group will have total responsibility for all aspects of patient care and resident supervision. At no time will residents be in any of these institutions without immediate on-site supervision. All management plans must be discussed with the preceptor before implementation.
5. All entries in medical record, including orders and progress notes, must be countersigned before being carried out, unless the preceptor approves the orders verbally to a nurse or administrative clerk.
6. When talking at home telephone call for patients one night a week, all problems requiring a significant change in management plan or transfer to an acute care hospital setting must be discussed with the geriatrics faculty on call before implementation of the plan.
7. Emergency care of patients for whom the preceptor is not the attending physician will be provided in conjunction with the attending and in accordance with institution policies (i.e., relating to calling the 9-1-1 system).

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LOUISIANA STATE UNIVERSITY HEALTH SCIENCES CENTER – SHREVEPORT Department of Medicine

Back-Up System

The following back-up system will be activated when the number of admissions by either the on-call team or the night float team exceeds the limits set by the Accreditation Council for Graduate Medical Education, or when the work load otherwise exceeds the capacity of the residents on duty at the University Hospital or OBVAMC.

- At both the University hospital and the OBVAMC, the upper-level night float resident will be contacted to come in early, provided that the required ten-hour break between assignments is respected.
- The on-call team residents will be asked to assist the night float team, provided that the team has not exceeded its 24-hour limit for admissions.
- Residents assigned to the Medical Intensive Care Unit at the University Hospital will be asked to assist the on-call or night float teams, if their responsibilities permit.
- If none of the above residents can assume the back-up role because of admission caps or other responsibilities (including emergency consultations from other services), the first resident on the monthly back-up schedule will be called.
- At the OBVAMC, residents on the monthly back-up schedule will be called when the number of admissions or the patient care responsibilities cannot be covered adequately by the on-call and night float residents.
- If there is a need for back-up resident coverage beyond that listed above, (e.g., illness/emergency of a resident on call in addition to exceeding admission caps, or unusually heavy patient responsibilities otherwise), the second person on the monthly back-up schedule, if assigned, will be called in. If there is no second back-up, or there is additional need for residents to cover essential services, the chief resident will be called.

Revised June 13, 2008

**LSU HEALTH SCIENCES CENTER—SHREVEPORT
Department of Medicine**

GUIDELINES FOR ACCEPTING PATIENT TRANSFERS FROM OTHER FACILITIES

General Considerations

Under both federal and state statutes, LSUHSC-S must accept patients in transfer when space and resources are available. Requests to transfer patients may be denied only if no beds are available or the patient requires a service that the hospital cannot provide. However, if an out-of-state resident is in a hospital that can provide appropriate care, there is no obligation to accept the patient in transfer. Louisiana residents that request transfer *must* be accepted when resources are available. Refusal of *any* transfer must be approved by the house supervisor, a representative of the hospital administration, or a faculty attending. All patients should be transferred as direct admissions to an inpatient service whenever possible. A transfer patient may be evaluated in the Emergency Department (ED) only with the approval of the faculty attending in the ED.

Residents must become familiar with the hospital transfer policy, which is available as an algorithm on a laminated card. The procedures below guide the responsibilities of

Department of Medicine physicians in the process. Any changes or re-interpretations of hospital policies will supercede these guidelines.

Procedures

- Calls from a physician or nurse at another health care facility requesting transfer of an inpatient to LSUHSC-S should be directed whenever possible to a physician or nurse in the subspecialty concerned with the patient's problem requiring transfer. The decision to accept the transfer is solely the responsibility of that section, except as mentioned below. General medicine residents may accept patients whose problem(s) are more general in nature or involve multiple body systems.
- The patient must be transferred to a unit providing a level of care equal to that the patient is currently receiving at the outside facility (e.g., ICU to ICU, telemetry to telemetry). Patients who are moved from an ICU to a telemetry unit in the referring facility must remain on telemetry at least six hours before transfer to the telemetry unit at LSUHSC-S. Transfers to the ICU or ED must be approved by a physician in that area, even when a subspecialty service has accepted the patient.
- If there is a question about the appropriateness of the transfer or the level of care needed cannot be determined from the available information, the accepting physician may ask that clinical information (e.g., laboratory studies, imaging reports) be faxed or otherwise transmitted to LSUHSC-S for review. However, this process should not delay the transfer unduly. With the concurrence of the attending faculty in the ED and the availability of space, the patient may be evaluated there before a level of care is assigned. However, it is the responsibility of the Department of Medicine physicians to direct that evaluation.
- If the patient is accepted for transfer, the accepting physician will notify the Physicians' Referral Service of the patient's name and the referring physician's name, and provide the telephone number of the referring physician or facility. Physicians' Referral Service will contact the referring facility and check the patient's eligibility for service at LSUHSC. At the same time, the accepting physician will send an admission approval form to the Admitting Office, along with a brief point-of-contact note stating the reason for the transfer. A duplicate copy of the point-of-contact note may be maintained in a convenient location in the hospital (e.g., the cardiac special procedures laboratory, telemetry unit, or MICU).
- The Physicians' Referral Service will maintain contact with the referring facility, and authorize transfer of the patient to LSUHSC when a bed is available. Upon the arrival of the patient, the Admitting Office will notify the medicine admitting resident or on-call resident, who will assign the patient to a general medicine ward team or subspecialty team. The admitting or on-call resident will not be involved in the admission of a patient to the intensive care unit.
- The Physicians' Referral Service will maintain a waiting list of patients who cannot be transferred because beds are not available. This list will be faxed daily, Monday through Friday except holidays, to the Department of Medicine Education Office. For patients pending transfer to the medicine service, the resident assigned to the general medicine consultation service is responsible for reviewing the list daily and maintaining contact with the transferring hospital and physician to ascertain that transfer is still required.

- Nights, weekends, holidays, or anytime when the subspecialty physician accepting the patient is out of the hospital, the medicine on-call resident may complete the admission approval form and point-of-contact note, using information supplied by the accepting physician. After regular hours, the house supervisor and Admitting Office will assume the responsibilities of the Physicians' Referral Service.
- Following the initial assessment of a transfer patient, the general medicine or ICU team will notify the physician or subspecialty service that originally accepted the patient. This notification should take place no later than the next morning, both as a professional courtesy and to expedite patient care.
- When appropriate, a transfer patient may be admitted directly to a subspecialty ward team.
- If the Admitting Office or house supervisor has a question concerning the priority of admission of transfer patients, the issue should be resolved among the physicians of the subspecialty section approving the transfers. The admitting resident or on-call resident will not referee such decisions.
- When a transfer patient is discharged, a discharge summary will be sent to the referring physician.

Summary of Responsibilities

Subspecialty Service Physician:

- ✓ Receive calls from outside hospitals.
- ✓ Accept or decline transfer of patients.
- ✓ If transfer is declined or there is an anticipated delay in effecting the transfer, offer the referring physician appropriate advice in managing the patient.
- ✓ Complete admission approval form and forward to Admitting Office.
- ✓ Complete point-of-contact note and forward to Admitting Office.
- ✓ Notify the Physicians' Referral Service (during regular hours) or the house supervisor (nights, weekends, and holidays) of the patient's acceptance.
- ✓ Provide the Physicians' Referral Service with the referring physician's name, and the telephone number of the referring physician or facility.
- ✓ When necessary, coordinate transfer to ICU or Emergency Room with a physician in that area.

Medicine Admitting Resident/On-call Resident:

- ✓ If appropriate, requests for transfer of patients to a subspecialty physician, either by direct telephone transfer or by passing on telephone numbers.
- ✓ Assign transfer patients who arrive at LSUHSC to a general medicine or subspecialty team.
- ✓ Complete admission approval form and point-of-contact note for patients that are accepted by a subspecialty physician who is out of the hospital (nights, weekends, and holidays). Notify nursing house manager that the patient has been accepted.

Resident on General Medicine Consultation Service

- ✓ Review daily list of patients awaiting transfer from other hospitals, and maintain contact with the hospitals and physicians to insure that transfer to the medicine service is still required.

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LSU HEALTH SCIENCES CENTER – SHREVEPORT Department of Medicine

Guidelines for Resident Days Off

- The Department of Medicine will adhere rigidly to all duty hour policies of the Accreditation Council for Graduate Medical Education (ACGME), as listed in the Common Program Requirements (available online at www.acgme.org), and the Graduate Medical Education Committee (GMEC) of LSU Health Sciences Center in Shreveport (LSUHSC-S), as listed in the GMEC Policy Manual (available online at www.sh.lsuhs.edu/gme). In case of any unintentional conflict between the policies outlined in this document and the policies of the ACGME or GMEC of LSUHSC-S, the policies of those agencies will take precedence.
- The basic policies of the Department of Medicine are:
 - Duty hours must not exceed 80 hours per week, averaged over a four-week period. These hours include all resident patient care and educational activities except at home telephone call (see below). Any in-house moonlighting sponsored by the department will be included in these hours. (Currently, there is no in-house moonlighting for residents.)
 - Residents will be provided 1 day in 7 free of all patient care and educational activities, including beeper call from home, averaged over a four-week period. One day is defined as a continuous 24-hour period free of all responsibilities.
 - There must be a break of at least 10 continuous hours between any duty periods, including attendance at educational activities.
 - In-house call will be no more frequent than every third night.
 - When assigned to overnight call in-house, continuous duty must not exceed 30 hours, including all patient care and educational activities. No new patients may be evaluated after 24 hours of continuous duty.
- Policies related to responsibilities, reporting and oversight of duty hours are:
 - For residents assigned to inpatient rotations, days off should be discussed between the team and the attending faculty early in the month. However, flexibility must be maintained to deal with issues such as patient load, physician illness, and other personal emergencies, provided that there is adherence to the basic policies.
 - Each upper-level ward resident must submit to the chief resident a list of the days off for each member of the team no later than the 5th of the month.
 - It is the responsibility of each resident to bring any problems related to days off

- policy to the attention of the program director and/or chief resident *during* the month in question.
- All residents are required to enter duty hours weekly through *MyEvaluations*. Reports for the previous calendar week are due by 12 noon each Tuesday. The department Education Coordinator will contact residents who are not in compliance with this reporting requirement.
- Specific implementation policies of the department related to days off are:
- The Department will provide coverage for each upper level general medicine ward resident from among the GMACC/consultation service residents for Saturday and Sunday on a weekend that the team does not have Friday, Saturday, or Sunday call. The attending must arrange two more days off for the upper level resident during the month, and provide coverage. In most cases, these will be weekend days or holidays.
 - A PGY-1 resident may be given a day off during the week, but not on the day of his/her continuity clinic day.
 - PGY-1 residents who are on call Friday or Saturday night, or on the eve of a holiday, may, at the discretion of the attending, be allowed to leave at 8 a.m. the next day, and return 24 hours later.
 - The on-call resident and MICU resident will be available to assist with central lines and other procedures when the upper level resident is off on a weekend day, and no coverage has been provided by the department. Seriously ill patients may be checked out to the on-call team after 12 noon.
 - On the days that an attending is covering for a resident, all PGY-1 residents must be present, unless the attending specifically approves one being off.
 - On subspecialty wards, fellows may cover for residents, with the approval of the subspecialty program director. However, fellows also cannot exceed the ACGME guidelines for average hours worked per week.
 - Sick leave taken during the month ordinarily will be subtracted from the days off.
 - Off-service residents who take one week of annual leave during a Medicine ward rotation are entitled to three additional days off during the month.

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**LSU HEALTH SCIENCES CENTER – SHREVEPORT
Department of Medicine**

DRESS GUIDELINES

The Department of Medicine will adhere to the University Hospital Dress Guidelines (Policy Number 2.8.11) as well as the Hospital Scrub Policy (Policy number 4.16), and the general guidelines below. These are applicable to faculty, residents, students, and observers on the medical service.

- During inpatient rotations, and in settings such as the Emergency Department where soiling with body fluids is likely, scrub suits are considered appropriate attire.

- In ambulatory care settings other than the Emergency Department, attire other than scrub suits is usually more appropriate. Though ties are not mandatory for men, several studies have shown that patients feel that they add to the professional demeanor of male physicians. (*Balance that with evidence that nosocomial infections can spread through contamination of ties!*)
- Men must begin each day clean-shaven, or with a neatly-trimmed beard.
- Men must wear socks at all times. Women must wear socks or appropriate hose.
- Regardless of the type of attire, it must be clean at all times, and the overall appearance must be in keeping with generally-accepted professional standards.

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**LOUISIANA STATE UNIVERSITY HEALTH SCIENCES CENTER – SHREVEPORT
DEPARTMENT OF MEDICINE**

Quality Measures and Discharge Instructions

The Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) and the Center for Medicare and Medicaid Services (CMS) have established a series of performance standards (“core measures”) designed to enhance the quality of care of hospitalized patients. Residents should become familiar with these during training and develop the habit of documenting compliance in patients’ medical records. The University Hospital has adopted these as quality improvement indicators, and they are monitored routinely on all inpatients. Disease-specific standards currently in place on the medical service are:

Acute Myocardial Infarction

- ✓ Aspirin prescribed within 24 hours before or after arrival.
- ✓ Beta-adrenergic blocking agent prescribed within 24 hours of arrival, unless there is a contraindication.
- ✓ Aspirin and beta-blocker prescribed at discharge.
- ✓ ACE Inhibitor or ARB prescribed at discharge if the left ventricular ejection fraction is less than 40%.
- ✓ Documentation of smoking history in year prior to admission.
- ✓ Documentation of smoking cessation advice/counseling (includes prescription of nicotine patch or gum; prescription of oral medications; referral to classes or groups; handouts; videos).
- ✓ Documentation of the cause of death, if applicable.

Congestive Heart Failure

- ✓ Appropriate instructions at discharge
 - Level of activity
 - Type of diet

- Follow-up appointments
- List of medications
- Address symptoms that may require return to ED or clinic
- Weight monitoring
- ✓ Documentation of assessment of left ventricular function (prior to admission, during hospitalization, or planned after discharge; may be determined by echocardiogram or gated cardiac scan).
- ✓ Documentation that ACE inhibitor or ARB prescribed if ejection fraction less than 40%, or when described qualitatively as “moderate” or “severe” dysfunction.
- ✓ Documentation of smoking history and counseling.

Pneumonia

- ✓ Documentation of oxygenation assessment (blood gas or pulse oximetry).
- ✓ Documentation of pneumococcal vaccine screening and/or administration for patients over age 65.
- ✓ Blood culture obtained prior to administration of first dose of antibiotics.
- ✓ Documentation of smoking history in year prior to admission.
- ✓ Smoking cessation advice (see modalities above under “Myocardial Infarction”)
- ✓ Administration of first dose of antibiotics within 8 hours of arrival.

The hospital and department have developed a number of tools to aid in compliance with these standards. A pocket card is available to remind you of the standards and to guide your care of patients with these conditions. In addition, standardized, preprinted discharge forms are available for documentation.

Compliance with performance standards is monitored quarterly. Attendings and upper-level residents may be asked to explain any variance. The program director receives a quarterly statement listing any variance attributable to a resident. These are included in your file, and will be discussed at semi-annual evaluation conferences. As well, they are a factor in promotion decisions.