Dear House staff,

I would like to personally take this opportunity to welcome you to New York Medical College @ Westchester Medical Center. I know the road ahead of you is long, but the opportunities are vast. You are entering a place where you are expected to work hard, but are under excellent supervision. You are expected to study hard, but have access to a wide variety of cases from which to learn. You are expected to excel, and are given the means to do so.

I look forward to working with all of you over the next year.

Sincerely,

Sachin Sule, MD, FACP
Program Director
Internal Medicine Residency
Westchester Medical Center
# Table of Contents

- Program Directorship Tree .................................................................................................................. 5
- Department/Program Leadership Biographies ..................................................................................... 6
- Housestaff Photos ................................................................................................................................. 6

Overview of the Division of Internal Medicine .......................................................................................... 18
- Internal Medicine Residency Goals and Objectives ................................................................................ 19
  - Goals and Objectives PGY-1 ............................................................................................................... 20
  - Goals and Objectives PGY-2 ............................................................................................................... 25
  - Goals and Objectives PGY-3 ............................................................................................................... 29
- Internal Medicine Residency Resident Selection, Promotion, Dismissal and Leave Policies .................. 34
  - Criteria for Resident Selection ......................................................................................................... 34
  - Process of Resident Selection ............................................................................................................ 34
  - Criteria for Promotion in the Program .............................................................................................. 34
  - Process of Promotion ......................................................................................................................... 35
  - Criteria for Successful completion of preliminary training year, Internal Medicine ......................... 35
- Graduation, Internal Medicine ............................................................................................................... 35
- Criteria for Dismissal from the Program ............................................................................................... 35
- Process of Dismissal ............................................................................................................................. 36
- Taking Leave From the Program .......................................................................................................... 36
- Supervision and Delineation of Privileges House Staff and Attending Staff .......................................... 37
  - Policy .................................................................................................................................................. 37
    - 1. General Responsibilities of the Department Director .................................................................. 37
    - 2. Specific Responsibilities of Supervisory Attending Staff ............................................................ 38
- Residency Supervision ............................................................................................................................ 40
  - Interns (On Floors and Units) ............................................................................................................ 40
  - Residents (Team or Unit Leaders) ..................................................................................................... 40
  - Attendings .......................................................................................................................................... 40
  - Division Chiefs ................................................................................................................................. 41
  - Chief Medical Resident (CMR) ........................................................................................................... 41
  - Program Director ............................................................................................................................... 41
- Department of Medicine Division Leadership ......................................................................................... 33
- Order Writing, Charting, Medical Records ............................................................................................. 34
- Department of Medicine Discharge Summary Policy ............................................................................ 35
- Procedural Skills .................................................................................................................................... 36
- Educational Opportunities ..................................................................................................................... 38
- Admissions Caps and Limits ................................................................................................................... 38
- Absences ............................................................................................................................................... 38
- Swaps .................................................................................................................................................... 39
- Consults ............................................................................................................................................... 39
- Dress Code ......................................................................................................................................... 41
- Meals .................................................................................................................................................. 42
- HIPAA ................................................................................................................................................ 42
- Autopsies ................................................................................................................................................ 42
- Email ................................................................................................................................................... 43
- Step 3 .................................................................................................................................................. 43
- Housestaff Evaluation ........................................................................................................................... 44
- Patient Age Cut-Off .............................................................................................................................. 44
- 6 Core Competencies ............................................................................................................................ 45
- Study Guides and References .................................................................................................................. 46
Program Directorship Tree

Sachin Sule, MD
Program Director

Chris Nabors, MD
Deputy Program Director
Medical Director, APCC

Melissa Gennarelli, MD
Associate Program Director

Merita Shehu, MD
Associate Program Director

Leanne Forman, MD
Associate Program Director &
Chief, General Internal Medicine
Department/Program Leadership Biographies

Department of Medicine Administration
Chairman

William Frishman, M.D., F.A.C.C., F.A.H.A., M.A.C.P.
Chairman of Medicine
Rosenthal Professor of Medicine
New York Medical College

Director of Medicine
Westchester Medical Center

Acting Chief of Cardiology
Westchester Medical Center
Westchester Heart and Vascular
Medical Research Associates

Dr. Frishman is a nationally renowned clinical cardiologist with an interest in disease prevention, hyperlipidemia, hypertension and cardiovascular pharmacology. He has been the recipient of multiple research grants from the National Institutes of Health and Industry. He has been the recipient of the Distinguished Teacher and Humanism in Medicine Awards from the Association of American Medical Colleges, the Teacher Scholar Award of The American Heart Association, the Preventive Cardiology Academic Award, and a Mastership of the American College of Physicians. He is an editor of two major journals, the *American Journal of Medicine* (the official journal of the Chairpersons of Medicine in North America) and *Cardiology in Review* (an affiliated journal of the American Heart Association done in conjunction with Harvard Medical School). He has written over 1,000 articles related to cardiology, and has authored and edited 10 books, including his magna opus *Cardiovascular Pharmacotherapeutics*, which recently appeared in its 3rd edition. He was a participant on campus in the laboratory where the cardiac stem cell was discovered. Dr. Frishman has served as the first President of the New York State Chapter of the American College of Cardiology, and was a Past President of the New York Cardiology Society. An Army medical officer during the Vietnam and Desert Storm wars, he is also the recipient of the U.S. Commendation for Meritorious Service.

Dr. Frishman is a native of the Bronx and he and his wife have been residents of Westchester for almost 34 years. He is board certified in Internal Medicine, Cardiology and Genetics and was recently on the cover of Westchester Magazine’s Top Doctors Issue. Dr. Frishman enjoys the practice of Medicine and is dedicated to improving care for patients and leading the cardiology section of Westchester Heart and Vascular.
INTERNAL MEDICINE RESIDENCY TRAINING
AT WESTCHESTER MEDICAL CENTER

Under the leadership of Sachin Sule, MD, FACP, Associate Chief of the Division of Internal Medicine and Residency Director, the internal medicine residency program of New York Medical College at Westchester Medical Center is committed to providing outstanding training in internal medicine.

The residency program continuously strives to anticipate the needs of the physicians of today and tomorrow. The educational processes focus on the acquisition of medical knowledge and clinical skills as well as emerging practice patterns.

The Department of Medicine attempts to motivate every house officer to embrace a critical and probing scientific attitude along with a deep compassion for the sick. It is continually evolving and strengthening its program to keep pace with a rapidly expanding body of medical knowledge and technology. A large full-time faculty of more than 80 on-site members is dedicated to teaching and serve as role models for the physicians of tomorrow. Full-time faculty function as general medical attendings, mentors and consultants and provide a collegial relationship between faculty and house staff.

The training curriculum is guided by the "educational milestones" concept which has been put forward by a joint American Board of Internal Medicine (ABIM) and Accreditation Council for Graduate Medical Education (ACGME) Task Force. New York Medical College-Westchester Medical Center is the first training program to widely incorporate the task force's "milestones" into its training program.

House staff will be trained in state-of-the-art transitions of care. The department utilizes an electronic software package (Patient Documentation Transfer System, PDTS), which has won multiple patient safety awards from the ACGME as well as outside quality review agencies.

Postgraduate training in internal medicine consists of three years of assignments to a variety of outpatient and inpatient services. This includes rotations in the Adult Primary Care Center as well as in the Emergency Room and subspecialty clinics. The training program is fully approved by the ACGME and provides all the prerequisites for certification by the American Board of Internal Medicine.

Fellowships are available in all approved areas of subspecialty training at the medical center to qualified internists who seek subspecialty careers.

<table>
<thead>
<tr>
<th>Total Positions Available:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Categorical ................</td>
<td>PGY I</td>
</tr>
<tr>
<td></td>
<td>PGY II</td>
</tr>
<tr>
<td></td>
<td>PGY III</td>
</tr>
</tbody>
</table>

| Preliminary ................| PGY I | 20    |
| Chief Resident ..............|       | 3     |
| Total .......................|       | 65    |

Research is a required activity of all categorical residents and numerous opportunities are available in basic and clinical research. Research methods and statistical analysis are available to house staff.
Christopher Nabors, MD, PhD
Deputy Residency Program Director & Medical Director, APCC
Director of Education Innovations Project Center for Quality Research
Assistant Professor of Medicine, New York Medical College at Westchester Medical Center

Chris Nabors completed his internal medicine residency training at New York Medical College/Westchester Medical Center between July 2005 and June 2008 and then stayed on as chief resident between June 2008 and June 2009.

In July of 2009, Dr. Nabors joined the faculty as an assistant professor of medicine, the Director of the Educational Innovations Project and an associate residency program director. He was quickly promoted to Deputy Program Director. His interests are the development of a computerized, handheld based sign-out system which incorporates patient safety and quality improvement modules. He is active in a variety of quality improvement and electronic medical records initiatives at the medical center and supervises a quality improvement elective for house staff. Data from several of quality improvement projects completed by house staff are being compiled for publication. Dr. Nabors has spearheaded an effort to incorporate educational milestones into the training and evaluation of house staff at the medical center. In July 2014, Dr. Nabors was appointed as the Medical Director of the Adult Primary Care Center (APCC).

Recent Publications

Current Projects

1. Clinical Advisor for Patient Documentation and Transfer (PDTS) handoff communication software. Medtechnotes, LLC, Long Island NY.

This software package is central to New York Medical College’s efforts to develop handoff “best practices,” making use of both conventional methods as well as more novel methods such as faculty oversight of house staff sign-out. This system relies on an integrated desktop/mobile application network which generates prioritized patient handoff and assigned task lists (according to severity of illness), incorporates a physician events reporting module that permits real time monitoring “sick patients” and notifies covering physicians of any clinically significant events. The system is integrated into a patient safety multidisciplinary rounding process which focuses on patients at risk of clinical deterioration. Experiences with these processes have been published as above and have led to several awards including

- Outstanding research award, 2010 Spring meeting of the Associate of Program Directors in Internal Medicine.
- The 2010 Northern Metropolitan Hospital Association award for quality improvement – large hospital category

2. Co-investigator for the “Administrative Internship,” a systems based practice, quality improvement and patient safety related curriculum for internal medicine residents.

- The curriculum provides for a series of rotations (ranging in length from 4 hours to 20 hours) that take place as a subcomponent of the annual month-long ambulatory care block. Each involves close interaction with the (largely) non-physician staff whose training and expertise not only help our facility to function as a cohesive unit but represent a valuable educational resource.

3. Research Mentoring/Director of Educational Innovations Project Center for Quality Research

- Mentor for Quality Improvement and Patient Safety Masters level projects, New York Medical College School of Public Health
- Site Director for Educational Innovations Collaborative Projects on Continuity of Care and Quality of Care in the Outpatient setting and Educational Milestones in the Outpatient Setting
- Contributor to development of the First Large Scale Educational Milestones Based Evaluation System of Internal Medicine Residency Programs. Collaborators on Project include members of the American Board of Internal Medicine.
Leanne Forman, M.D.
Chief, General Internal Medicine
New York Medical College
Westchester Medical Center

Dr. Forman graduated from Albert Einstein Medical College in 1990 and did her residency training at Jacobi Medical Center in Internal Medicine. She was faculty in the primary care department prior to moving to Florida where she worked in private practice. She then returned to the New York area and worked in the North Central Bronx medical clinic and then became faculty at Cornell where she was part of the faculty internal medicine group and the director of a women’s and children’s center in Long Island City established to serve a diverse and needy population. There she was very active in developing outreach and education programs for the community.

She came to Westchester Medical Center in 2001 where she served as the Medical Director at Taylor Care Center for 2 ½ years prior to becoming the medicine clerkship director for New York Medical College. She served as the director of the Occupational Health Center at WMC for 3 years prior to becoming the director of the Adult Primary Care Center in July 2007 where she now works full time. Dr. Forman has been involved in a spectrum of medical educational activities throughout her career. She also became an Associate Program Director in July of 2007. In October of 2013, Dr. Forman was appointed as the Chief of the General Internal Medicine Division at Westchester Medical Center.
### Internal Medicine House Staff 2015-2016

#### Chief Residents

<table>
<thead>
<tr>
<th>Name</th>
<th>Position</th>
</tr>
</thead>
<tbody>
<tr>
<td>Roarke, Dennis</td>
<td>MD</td>
</tr>
<tr>
<td>Sao, Rahul</td>
<td>MD</td>
</tr>
<tr>
<td>Savooji, John</td>
<td>MD</td>
</tr>
</tbody>
</table>

#### PGY-I Categorical

<table>
<thead>
<tr>
<th>Name</th>
<th>Position</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blanco, Joanna</td>
<td>MD</td>
</tr>
<tr>
<td>Broker, Shikha</td>
<td>MBBS</td>
</tr>
<tr>
<td>Chakinala, Raja Chandra</td>
<td>MBBS</td>
</tr>
<tr>
<td>Chawla, Lavneet</td>
<td>MBBS</td>
</tr>
<tr>
<td>Griffiths, Jennifer</td>
<td>MD</td>
</tr>
<tr>
<td>Gupta, Shashvat</td>
<td>MBBS</td>
</tr>
</tbody>
</table>
Preliminary

Bergman, Alex - MD
Bhatnagar, Akash Kumar - MD
Blickstein, Adena - MD

Chen, Andrew - MD
de Gala, Virgilio - MD
Eisman, Daniel – MD

Hewitt, Kevin - MD
Hilmi, Kazi Md. Asif - MBBS
Jedrysiak, Daniel - MD

Kadosh, Daniel - MD
Kakkanatt, Ashley - MD
Kumar, Jessica - MD
McManis, Shannon - MD

Necola, Olivia - MD

Ptushko, Maksim - MD

PGY-II Categorical

Andries, Gabriela- MD

Bhugra, Priyanka- MBBS

Bradley, Jacqueline - DO

Farkas, Zahava- DO

Hanmantgad, Madhura - MBBS

Islam, Fateema - DO
Karass, Michael- MD
Karuthedom, Smitha- MBBS
Katchi, Tasleem- MBBS

Narurkar, Roshni-MBBS
Pandit, Amar-MBBS
Pawaskar, Aditya-MBBS

Raza, Anoshia-MBBS
Sabri, Ahlam-MD
Solanki, Shantanu-MBBS

Zaid, Syed-MBBS
PGY-III Categorical

Agarwal, Anup
Alli, Opeyemi
Gandhiraj, Deepthi

Gollapudi, Lakshmi Asritha
Giorgetti, Anna
Goyal, Abhishek

Haq, Khwaja
Jayakumar, Divya
Linder, Katherine
Overview of the Division of Internal Medicine

The Division of Internal Medicine provides the foundation upon which many of the other patient care services at Westchester Medical Center rely. Consistent leadership during the past 15 years has been responsible for the division’s expansion from four general internists to the current staff of 20 full- and part-time physicians. The hospitalist group is an integral part of the new computerized, handheld sign-out system recently implemented in the department, which provides a powerful tool for communication of key patient information from one clinician to another.

Members are very active in clinical research and coordinate many research projects. Areas of research interest include technological solutions to patient care, quality improvement and patient safety, epidemiology, decision analysis, healthcare research, screening for and early detection of disease, ethics and innovative methods of clinical teaching.

The division also operates a group practice providing outpatient services in offices located at 19 Bradhurst Ave., Hawthorne, where physicians are able to provide patient services just a few minutes from Westchester Medical Center.
Internal Medicine Residency Goals and Objectives

To all the residents who are members of our residency program at the Westchester Medical Center, we congratulate you and wish you much success as you continue onward in your medical careers. You are following in a long tradition both in your chosen profession and with the many physicians over the years who have received training here at the University Hospital of New York Medical College.

The fundamental goals and objectives of our program are to train competent, qualified, caring and sensitive physicians who are mindful of the significance of their role in the diagnosis and treatment of disease, the alleviation of suffering, the prevention of ill-health and the empathetic support of those, directly or indirectly, afflicted with medical illness. The task is large, the responsibilities are great, but the satisfaction of being the consummate physician-professional are enormous. There is no nobler ideal to which one can aspire.

The American Board of Internal Medicine, which serves as the organization of official professional recognition of those who successfully complete our program, has clearly addressed specific goals and objectives which serve as the basis for clinical competence. These goals have been explicated in the educational milestones which now form the basis for the educational curriculum in the training program. When each of the milestones has been consistently met, the resident stands qualified for board acceptance. We at New York Medical College strongly ascribe to these standards. Our curriculum and teaching programs have been designed to meet those objectives.

Our program is fully accredited by the Residency Review Committee (RRC) in Internal Medicine of the Accreditation Council for Graduate Medical Education (ACGME) and these goals and objectives are commensurate with the standards mandated by them for continued accreditation. There is additionally a medical curriculum that is in keeping with the standards required by the RRC as necessary for the full and comprehensive educational process of the medical resident.

Notwithstanding the importance of clinical skills and knowledge of scientific principles, humanistic qualities must be integrated into all aspects of medical practice. The roots of Medicine are in science, but the practice of medicine is foremost an art. It is most meaningful when practiced with respect for the dignity and worth of all and with the utmost compassion, integrity and honesty.

We are here to help you, teach you, and guide you further along in your careers. You are our junior colleagues now, but you will someday be physicians in the active practice of medicine, adding yet another link to an unbroken chain. Learn well and strive hard and you will find deep satisfaction and lasting fulfillment in this wonderful profession.

The Faculty
Department of Medicine
Goals and Objectives PGY-1

By the end of the PGY1 year residents should:

| Patient Care | 1. be able to do a complete and accurate history and physical examination  
2. be able to *interpret* the history, physical examination and laboratory data  
3. be able to discuss a differential diagnosis and arrive at the correct diagnosis  
4. be able to prioritize the patients problems and a days worth of work  
5. have demonstrated compassion for patients and their relatives and treat them in a dignified manner  
6. be able to handle emergency situations  
7. be able to *perform* all of the following procedures skillfully and with the least discomfort to the patient: ACLS, drawing venous blood, drawing arterial blood, placing a peripheral venous line, pap smear and endocervical culture  
8. Perform in a satisfactory way on mini-CEX |

| Patient Care Milestones | PC - A1 1. Acquire accurate and relevant history from the patient in an efficiently customized, prioritized, and hypothesis driven fashion | 6 |
| | PC - A2 2. Seek and obtain appropriate, verified, and prioritized data from secondary sources (eg, family, records, pharmacy) | 9 |
| | PC - B1 1. Perform an accurate physical examination that is appropriately targeted to the patient’s complaints and medical conditions. Identify pertinent abnormalities using common maneuvers | 6 |
| | PC - B2 2. Accurately track important changes in the physical examination over time in the outpatient and inpatient settings | 12 |
| | PC - C1 1. Synthesize all available data, including interview, physical examination, and preliminary laboratory data, to define each patient’s central clinical problem | 12 |
| | PC - C2 2. Develop prioritized differential diagnoses, evidence based diagnostic and therapeutic plan for common inpatient and ambulatory conditions | 12 |
| | PC - E1 1. Make appropriate clinical decisions based on the results of common diagnostic testing, including but not limited to routine blood chemistries, hematologic studies, coagulation tests, arterial blood gases, ECG, chest radiographs, pulmonary function tests, urinalysis and other body fluids | 12 |
| | PC - F1 1. Recognize situations with a need for urgent or emergent medical care, including life-threatening conditions | 6 |
| | PC - F2 2. Recognize when to seek additional guidance | 6 |
| | PC - F3 3. Provide appropriate preventive care and teach patient regarding self-care | 6 |
| PC - F4 | 4. With supervision, manage patients with common clinical disorders seen in the practice of inpatient and ambulatory general internal medicine | 12 |
| PC - F5 | 5. With minimal supervision, manage patients with common and complex clinical disorders seen in the practice of inpatient and ambulatory general internal medicine | 12 |
| PC - F6 | 6. Initiate management and stabilize patients with emergent medical conditions | 12 |

**Medical Knowledge**

| MK - A1 | 1. have begun becoming familiar with current literature |
| MK - A2 | 2. be able to demonstrate adequate knowledge of pathophysiology and clinical medicine |
| MK - A2 | 3. know the indications, contraindications, complications, techniques, specimen handling, result interpretation, and how to get informed consent, for *most* of the following procedures: ACLS, drawing venous blood, drawing arterial blood, abdominal paracentesis, placing a peripheral venous line, pap smear and endocervical culture, arterial puncture/line placement, arthrocentesis, lumbar puncture, central line placement, thoracentesis, and nasogastric intubation. |

**Expected time frame (months)**

| MK - A1 | 6 |
| MK - A2 | 12 |

**Practice Based Learning and Improvement**

| MK - B1 | 1. understand his or her own limitations of knowledge |
| MK - B1 | 2. ask peers and faculty for help when needed |
| MK - B1 | 3. accept feedback and develop self-improvement plans |
| MK - B1 | 4. be self-motivated to acquire knowledge |
| MK - B1 | 4. be able to use electronic references and literature to learn about patients diseases |

**Expected time frame (months)**

<p>| MK - B1 | 12 |</p>
<table>
<thead>
<tr>
<th>Milestones</th>
<th>Description</th>
<th>Expected time frame (months)</th>
</tr>
</thead>
<tbody>
<tr>
<td>PBLI - A1</td>
<td>1. Appreciate the responsibility to assess and improve care collectively for a panel of patients</td>
<td>12</td>
</tr>
<tr>
<td>PBLI - B1</td>
<td>1. Identify learning needs (clinical questions) as they emerge in patient care activities</td>
<td>12</td>
</tr>
<tr>
<td>PBLI - C1</td>
<td>1. Access medical information resources to answer clinical questions and support decision making</td>
<td>12</td>
</tr>
<tr>
<td>PBLI - C2</td>
<td>2. Effectively and efficiently search NLM database for original clinical research articles</td>
<td>12</td>
</tr>
<tr>
<td>PBLI - D1</td>
<td>1. With assistance, appraise study design, conduct, and statistical analysis in clinical research papers</td>
<td>12</td>
</tr>
<tr>
<td>PBLI - E1</td>
<td>1. Determine if clinical evidence can be generalized to an individual patient</td>
<td>12</td>
</tr>
<tr>
<td>PBLI - F1</td>
<td>1. Respond warmly and productively to action plans feedback from all members of the health care team including faculty, peer residents, students, nurses, allied health workers, patients, and their advocates</td>
<td>12</td>
</tr>
<tr>
<td>PBLI - H1</td>
<td>1. Actively participate in teaching conferences</td>
<td>12</td>
</tr>
<tr>
<td>PBLI - A1</td>
<td>1. Identify learning needs (clinical questions) as they emerge in patient care activities</td>
<td>12</td>
</tr>
<tr>
<td>PBLI - B1</td>
<td>1. Access medical information resources to answer clinical questions and support decision making</td>
<td>12</td>
</tr>
<tr>
<td>PBLI - C1</td>
<td>2. Effectively and efficiently search NLM database for original clinical research articles</td>
<td>12</td>
</tr>
<tr>
<td>PBLI - C2</td>
<td>1. With assistance, appraise study design, conduct, and statistical analysis in clinical research papers</td>
<td>12</td>
</tr>
<tr>
<td>PBLI - D1</td>
<td>1. Determine if clinical evidence can be generalized to an individual patient</td>
<td>12</td>
</tr>
<tr>
<td>PBLI - F1</td>
<td>1. Respond warmly and productively to action plans feedback from all members of the health care team including faculty, peer residents, students, nurses, allied health workers, patients, and their advocates</td>
<td>12</td>
</tr>
<tr>
<td>PBLI - H1</td>
<td>1. Actively participate in teaching conferences</td>
<td>12</td>
</tr>
</tbody>
</table>

**Interpersonal and Communication Skills**

1. Write clear, organized, legible notes and orders
2. Be able to use their verbal and non-verbal skills to competently and effectively interview a patient and/or family members
3. Interact with other members of the health care team in an effective, professional manner

<table>
<thead>
<tr>
<th>Interpersonal and Communication Skills Milestones</th>
<th>Description</th>
<th>Expected time frame (months)</th>
</tr>
</thead>
<tbody>
<tr>
<td>ICS - A1</td>
<td>1. Provide timely and comprehensive verbal and written communication to patients/advocates</td>
<td>12</td>
</tr>
<tr>
<td>ICS - A2</td>
<td>2. Effectively use verbal and nonverbal skills to create rapport with patients/families</td>
<td>12</td>
</tr>
<tr>
<td>ICS - A3</td>
<td>3. Use communication skills to build a therapeutic relationship</td>
<td>12</td>
</tr>
<tr>
<td>ICS - B1</td>
<td>1. Effectively use an interpreter to engage patients in the clinical setting, including patient education</td>
<td>6</td>
</tr>
</tbody>
</table>
2. Demonstrate sensitivity to differences in patients including but not limited to race, culture, gender, sexual orientation, socioeconomic status, literacy, and religious beliefs  

ICS - B2

1. Effectively communicate with other caregivers in order to maintain appropriate continuity during transitions of care  

ICS - C1

1. Deliver appropriate, succinct, hypothesis-driven oral presentations  

ICS - D1

2. Effectively communicate plan of care to all members of the health care team  

ICS - D2

1. Request consultative services in an effective manner  

ICS - E1

2. Clearly communicate the role of consultant to the patient, in support of the primary care relationship  

ICS - E2

1. Provide legible, accurate, complete, and timely written communication that is congruent with medical standards  

ICS - F1

Professionalism

1. be able to establish trust with the patients and staff  
2. be honest, reliable, cooperative and accepting of responsibility  
3. show regard for opinions and skills of colleagues  
4. demonstrate respect, compassion and integrity  
5. acknowledge errors and work to minimize them  
6. put the needs of the patient above self-interest

Professionalism Milestones

<table>
<thead>
<tr>
<th>Milestone</th>
<th>Description</th>
<th>Expected Time Frame (months)</th>
</tr>
</thead>
<tbody>
<tr>
<td>P - A1</td>
<td>1. Document and report clinical information truthfully</td>
<td>1</td>
</tr>
<tr>
<td>P - A2</td>
<td>2. Follow formal policies</td>
<td>1</td>
</tr>
<tr>
<td>P - A3</td>
<td>3. Accept personal errors and honestly acknowledge them</td>
<td>6</td>
</tr>
<tr>
<td>P - B1</td>
<td>1. Demonstrate empathy and compassion to all patients</td>
<td>3</td>
</tr>
<tr>
<td>P - B2</td>
<td>2. Demonstrate a commitment to relieve pain and suffering</td>
<td>3</td>
</tr>
<tr>
<td>P - C1</td>
<td>1. Communicate constructive feedback to other members of the health care team</td>
<td>12</td>
</tr>
<tr>
<td>P - D1</td>
<td>1. Respond promptly and appropriately to clinical responsibilities including but not limited to calls and pages</td>
<td>1</td>
</tr>
<tr>
<td>P - D2</td>
<td>2. Carry out timely interactions with colleagues, patients, and their designated caregivers</td>
<td>6</td>
</tr>
<tr>
<td>P - E1</td>
<td>1. Recognize and manage obvious conflicts of interest, such as caring for family members and professional associates as patients</td>
<td>6</td>
</tr>
<tr>
<td>P - F1</td>
<td>1. Dress and behave appropriately</td>
<td>1</td>
</tr>
<tr>
<td>P - F2</td>
<td>2. Maintain appropriate professional relationships with patients, families, and staff</td>
<td>1</td>
</tr>
<tr>
<td>P - F3</td>
<td>3. Ensure prompt completion of clinical, administrative, and curricular tasks</td>
<td>6</td>
</tr>
<tr>
<td>P - F4</td>
<td>4. Recognize and address personal, psychological, and physical limitations that may affect professional performance</td>
<td>12</td>
</tr>
<tr>
<td>P - F5</td>
<td>5. Recognize the scope of his/her abilities and ask for</td>
<td>12</td>
</tr>
<tr>
<td>Systems-Based Practice</td>
<td>Expected time frame (months)</td>
<td></td>
</tr>
<tr>
<td>------------------------</td>
<td>-----------------------------</td>
<td></td>
</tr>
<tr>
<td><strong>P - G1</strong></td>
<td>1. Recognize when it is necessary to advocate for individual patient needs</td>
<td>6</td>
</tr>
<tr>
<td><strong>P - I1</strong></td>
<td>1. Treat patients with dignity, civility and respect, regardless of race, culture, gender, ethnicity, age, or socioeconomic status</td>
<td>1</td>
</tr>
<tr>
<td><strong>P - J1</strong></td>
<td>1. Maintain patient confidentiality</td>
<td>1</td>
</tr>
<tr>
<td><strong>P - K1</strong></td>
<td>1. Recognize that disparities exist in health care among populations and that they may impact care of the patient</td>
<td>12</td>
</tr>
</tbody>
</table>

**Systems-Based Practice Milestones**

| SBP - A1 | 1. Understand unique roles and services provided by local health care delivery systems. | 12 |
| SBP - B1 | 1. Appreciate roles of a variety of health care providers, including but not limited to consultants, therapists, nurses, home care workers, pharmacists, and social workers. | 6 |
| SBP - B2 | 2. Work effectively as a member within the interprofessional team to ensure safe patient care. | 6 |
| SBP - B3 | 3. Consider alternative solutions provided by other teammates | 12 |
| SBP - C1 | 1. Recognize health system forces that increase the risk for error including barriers to optimal patient care | 12 |
| SBP - C2 | 2. Identify, reflect on, and learn from critical incidents such as near misses and preventable medical errors | 12 |
| SBP - D1 | 1. Reflect awareness of common socioeconomic barriers that impact patient care. | 12 |
| SBP - D2 | 2. Understand how cost-benefit analysis is applied to patient care (i.e., via principles of screening tests and the development of clinical guidelines) | 12 |
| SBP - E1 | 1. Identify costs for common diagnostic or therapeutic tests. | 6 |
| SBP - E2 | E2 - Minimize unnecessary care including tests, procedures, therapies, and ambulatory or hospital encounters | 6 |
Goals and Objectives PGY-2

By the end of the PGY2 year residents should (underlines are on material above the PGY1 goals):

During the second year of training, the resident will be expected to achieve the traditional goals and objectives defined below, but will additionally be required to consistently demonstrate the knowledge, skills and attitudes explicated by the milestones. The second year resident will also be required to continue to satisfy milestones set forth relative to months 1-12. These milestones will be periodically re-evaluated to ensure continuing competence.

<table>
<thead>
<tr>
<th>Patient Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. be able to do a complete and accurate history and physical examination</td>
</tr>
<tr>
<td>2. be able to interpret the history, physical examination and laboratory data</td>
</tr>
<tr>
<td>3. be able to discuss a differential diagnosis and arrive at the correct diagnosis</td>
</tr>
<tr>
<td>4. be able to prioritize the patients problems and a days worth of work</td>
</tr>
<tr>
<td>5. have demonstrated compassion for patients and their relatives and treat them in a dignified manner</td>
</tr>
<tr>
<td>6. be able to handle emergency situations</td>
</tr>
<tr>
<td>7. be able to perform all of the following procedures skillfully and with the least discomfort to the patient: ACLS, drawing venous blood, drawing arterial blood, placing a peripheral venous line, pap smear and endocervical culture, arterial line placement, central line placement, nasogastric intubation</td>
</tr>
<tr>
<td>8. be able to perform some of the following procedures skillfully and with the least discomfort to the patient depending on future practice interests: abdominal paracentesis, arthrocentesis, incision and drainage of abscess, lumbar puncture, pulmonary artery catheter placement, thoracentesis</td>
</tr>
<tr>
<td>9. perform in a satisfactory way on mini-CEX</td>
</tr>
<tr>
<td>10. be able to manage multiple problems at once</td>
</tr>
<tr>
<td>11. be showing ability to triage patients to appropriate level of care</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Patient Care Milestones</th>
<th>Expected time frame (months)</th>
</tr>
</thead>
<tbody>
<tr>
<td>PC - A3</td>
<td>3. Obtain relevant historical subtleties that inform and prioritize both differential diagnoses and diagnostic plans, including sensitive, complicated, and detailed information that may not often be volunteered by the patient</td>
</tr>
<tr>
<td>PC - B3</td>
<td>3. Demonstrate and teach how to elicit important physical findings for junior members of the health care team</td>
</tr>
<tr>
<td>PC - C3</td>
<td>3. Modify differential diagnosis and care plan based on clinical course and data as appropriate</td>
</tr>
<tr>
<td>PC - D1</td>
<td>1. Appropriately perform invasive procedures and</td>
</tr>
<tr>
<td>PC - E2</td>
<td>2. Make appropriate clinical decision based on the results of more advanced diagnostic tests</td>
</tr>
<tr>
<td>PC - G1</td>
<td>1. Provide specific, responsive consultation to other services</td>
</tr>
</tbody>
</table>

### Medical Knowledge

1. become familiar with current literature
2. be able to demonstrate adequate knowledge of pathophysiology and clinical medicine
3. know the indications, contraindications, complications, techniques, specimen handling, result interpretation, and how to get informed consent, for all of the following procedures: ACLS, drawing venous blood, drawing arterial blood, abdominal paracentesis, placing a peripheral venous line, pap smear and endocervical culture, arterial puncture/line placement, arthrocentesis, lumbar puncture, central line placement, thoracentesis, and nasogastric intubation.
4. have demonstrated knowledge of evidence based medicine and epidemiology principles, and be able to relate these to patient care

### Medical Knowledge Milestones

| MK - A3 | 3. Demonstrate sufficient knowledge to evaluate common ambulatory conditions | 18 |
| MK - A4 | 4. Demonstrate sufficient knowledge to diagnose and treat undifferentiated and emergent conditions | 18 |
| MK - A5 | 5. Demonstrate sufficient knowledge to provide preventive care | 18 |
| MK - A6 | 6. Demonstrate sufficient knowledge to identify and treat medical conditions that require intensive care | 24 |
| MK - B2 | 2. Understand indications for and has basic skills in interpreting more advanced diagnostic tests | 18 |
| MK - B3 | 3. Understand prior probability and test performance characteristics | 18 |

### Practice Based Learning and Improvement

1. understand his or her own limitations of knowledge
2. ask peers and faculty for help when needed
3. accept feedback and develop self-improvement plans
4. be self-motivated to acquire knowledge
5. facilitate the learning of interns and students by holding intelligent discussions regarding patient’s problems and management
<table>
<thead>
<tr>
<th>Practice Based Learning and Improvement Milestones</th>
<th>Expected time frame (months)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PBLI - A2</strong></td>
<td></td>
</tr>
<tr>
<td>2. Perform or review audit of a panel of patients using standardized, disease-specific, and evidence-based criteria</td>
<td>24</td>
</tr>
<tr>
<td><strong>PBLI - A3</strong></td>
<td></td>
</tr>
<tr>
<td>3. Reflect on audit compared with local or national benchmarks and explore possible explanations for deficiencies, including doctor related, system-related, and patient related factors</td>
<td>24</td>
</tr>
<tr>
<td><strong>PBLI - B2</strong></td>
<td></td>
</tr>
<tr>
<td>2. Classify and precisely articulate clinical questions</td>
<td>24</td>
</tr>
<tr>
<td><strong>PBLI - B3</strong></td>
<td></td>
</tr>
<tr>
<td>3. Develop a system to track, pursue, and reflect on clinical questions</td>
<td>24</td>
</tr>
<tr>
<td><strong>PBLI - C3</strong></td>
<td></td>
</tr>
<tr>
<td>3. Effectively and efficiently search evidence based summary medical information resources</td>
<td>24</td>
</tr>
<tr>
<td><strong>PBLI - D2</strong></td>
<td></td>
</tr>
<tr>
<td>2. With assistance, appraise clinical guidelines</td>
<td>24</td>
</tr>
<tr>
<td><strong>PBLI - E2</strong></td>
<td></td>
</tr>
<tr>
<td>2. Customize clinical evidence for an individual patient</td>
<td>24</td>
</tr>
<tr>
<td><strong>PBLI - F2</strong></td>
<td></td>
</tr>
<tr>
<td>2. Actively seek feedback from all members of the health care team</td>
<td>18</td>
</tr>
<tr>
<td><strong>PBLI - F3</strong></td>
<td></td>
</tr>
<tr>
<td>3. Calibrate self-assessment with feedback and other external data</td>
<td>24</td>
</tr>
<tr>
<td><strong>PBLI - F4</strong></td>
<td></td>
</tr>
<tr>
<td>4. Reflect on feedback in developing plans for improvement</td>
<td>24</td>
</tr>
<tr>
<td><strong>PBLI - G1</strong></td>
<td></td>
</tr>
<tr>
<td>1. Maintain awareness of the situation in the moment, and respond to meet situational needs</td>
<td>24</td>
</tr>
<tr>
<td><strong>PBLI - H2</strong></td>
<td></td>
</tr>
<tr>
<td>2. Integrate teaching, feedback, and evaluation with supervision of interns’ and students’ patient care</td>
<td>24</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Interpersonal and Communication Skills Milestones</th>
<th>Expected time frame (months)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ICS - A4</strong></td>
<td></td>
</tr>
<tr>
<td>4. Engage patients/advocates in shared decision making for uncomplicated diagnostic and therapeutic scenarios</td>
<td>24</td>
</tr>
<tr>
<td><strong>ICS - A5</strong></td>
<td></td>
</tr>
<tr>
<td>5. Use patient-centered education strategies</td>
<td>24</td>
</tr>
<tr>
<td><strong>ICS - C2</strong></td>
<td></td>
</tr>
<tr>
<td>2. Role model and teach effective communication with next caregivers during transitions of care</td>
<td>24</td>
</tr>
<tr>
<td><strong>ICS - F2</strong></td>
<td></td>
</tr>
<tr>
<td>2. Ensure succinct, relevant, and patient-specific written communication</td>
<td>24</td>
</tr>
<tr>
<td><strong>ICS - A4</strong></td>
<td></td>
</tr>
<tr>
<td>4. Engage patients/advocates in shared decision making for uncomplicated diagnostic and therapeutic scenarios</td>
<td>24</td>
</tr>
</tbody>
</table>
| Professionalism | 1. be able to establish trust with the patients and staff  
2. be honest, reliable, cooperative and accepting of responsibility  
3. show regard for opinions and skills of colleagues  
4. demonstrate respect, compassion and integrity  
5. acknowledge errors and work to minimize them  
6. put the needs of the patient above self-interest  
7. display initiative and leadership  
8. be able to delegate responsibility appropriately to others  
9. demonstrate sensitivity to patient culture, gender, age, preferences and disabilities |
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Professionalism Milestones</td>
<td>Expected time frame (months)</td>
</tr>
<tr>
<td>P - B3</td>
<td>3. Provide support (physical, psychological, social, and spiritual) for dying patients and their families</td>
</tr>
<tr>
<td>P - B4</td>
<td>4. Provide leadership for a team that respects patient dignity and autonomy</td>
</tr>
<tr>
<td>P - C2</td>
<td>2. Recognize, respond to, and report impairment in colleagues or substandard care via peer review process</td>
</tr>
<tr>
<td>P - H1</td>
<td>1. Recognize and take responsibility for situations where public health supersedes individual health (e.g., reportable infectious diseases)</td>
</tr>
<tr>
<td>P - J2</td>
<td>2. Educate and hold others accountable for patient confidentiality</td>
</tr>
</tbody>
</table>
| Systems-Based Practice | 1. be actively working with all health professionals to provide patient centered care  
2. have worked on several quality improvement projects that involve improving the systems in which they practice  
3. be a patient advocate  
4. be able to do the appropriate patient work-up in a cost effective way  
5. be able to supervise PGY1 residents and medical students |
| Systems-Based Practice Milestones | Expected time frame (months) |
| SBP - A2 | 2. Manage and coordinate care and care transitions across multiple delivery systems, including ambulatory, subacute, acute, rehabilitation, and skilled nursing. | 24 |
| SBP - C3 | 3. Dialogue with care team members to identify risk for and prevention of medical error | 24 |
| SBP - C4 | 4. Understand mechanisms for analysis and correction of systems errors | 24 |
| SBP - D3 | 3. Identify the role of various health care stakeholders including providers, suppliers, financiers, purchasers, and consumers and their varied impact on the cost of and access to health care. | 24 |
| SBP - D4 | 4. Understand coding and reimbursement principles. | 24 |
| SBP - E3 | 3. Demonstrate the incorporation of cost-awareness principles into standard clinical judgments and decision making | 18 |

**Goals and Objectives PGY-3**

**By the end of the PGY3 year residents should** (underlines are on material above the PGY2 goals):

During the third year of training, the resident will be expected to have achieved the traditional goals and objectives defined below, but will additionally be required to consistently demonstrate the knowledge, skills and attitudes explicated by the milestones applicable to months 24-36. The resident will also be required to continue to satisfy milestones set forth relative to months 1-24. The more basic milestones will be periodically re-evaluated to ensure continuing competence.

| Patient Care | 1. be able to do a complete and accurate history and physical examination  
2. be able to *interpret* the history, physical examination and laboratory data  
3. be able to discuss a differential diagnosis and arrive at the correct diagnosis  
4. be able to prioritize the patients problems and a day’s worth of work  
5. have demonstrated compassion for patients and their relatives and treat them in a dignified manner  
6. be able to handle emergency situations  
7. be able to *perform* all of the following procedures skillfully and with the least discomfort to the patient: ACLS, drawing venous blood, drawing arterial blood, abdominal paracentesis, placing a peripheral venous line, pap smear and endocervical culture, arterial puncture/line placement, arthrocentesis, lumbar puncture, central line placement, thoracentesis, and nasogastric intubation.  
8. perform in a satisfactory way on mini-CEX  
9. be able to manage multiple problems at once  
10. be showing ability to triage patients to appropriate level of care  
11. reason well in ambiguous situations  
12. spend time appropriate to the complexity of the problem  
13. be able to function and manage patient decision making independently | |

<table>
<thead>
<tr>
<th>Patient Care Milestones</th>
<th>Expected time frame (months)</th>
</tr>
</thead>
<tbody>
<tr>
<td>PC - A4</td>
<td>4. Role model gathering subtle and reliable information from the patient for junior members of the health care</td>
</tr>
<tr>
<td><strong>PC - B4</strong></td>
<td>4. Routinely identify subtle or unusual physical findings that may influence clinical decision making, using advanced maneuvers where applicable</td>
</tr>
<tr>
<td><strong>PC - C4</strong></td>
<td>4. Recognize disease presentations that deviate from common patterns and that require complex decision making</td>
</tr>
<tr>
<td><strong>PC - F7</strong></td>
<td>7. Manage patients with conditions that require intensive care</td>
</tr>
<tr>
<td><strong>PC - F8</strong></td>
<td>8. Independently manage patients with a broad spectrum of clinical disorders seen in the practice of general internal medicine</td>
</tr>
<tr>
<td><strong>PC - F9</strong></td>
<td>9. Manage complex or rare medical conditions</td>
</tr>
<tr>
<td><strong>PC - F10</strong></td>
<td>10. Customize care in the context of the patient’s preferences and overall health</td>
</tr>
<tr>
<td><strong>PC - G2</strong></td>
<td>2. Provide internal medicine consultation for patients with more complex clinical problems requiring detailed risk assessment</td>
</tr>
</tbody>
</table>

### Medical Knowledge

1. have become familiar with current literature
2. be able to demonstrate adequate knowledge of pathophysiology and clinical medicine
3. know the indications, contraindications, complications, techniques, specimen handling, result interpretation, and how to get informed consent, for all of the following procedures: ACLS, drawing venous blood, drawing arterial blood, abdominal paracentesis, placing a peripheral venous line, pap smear and endocervical culture, arterial puncture/line placement, arthrocentesis, lumbar puncture, central line placement, thoracentesis, and nasogastric intubation.
4. have demonstrated knowledge of evidence based medicine and epidemiology principles, and be able to relate these to patient care
5. be ready to take and pass the ABIM board certification examination

### Medical Knowledge Milestones

<p>| <strong>MK - A7</strong> | 7. Demonstrate sufficient knowledge to evaluate complex or rare medical conditions and multiple coexistent conditions | 36 |
| <strong>MK - A8</strong> | 8. Understand the relevant pathophysiology and basic science for uncommon or complex medical conditions | 36 |
| <strong>MK - A9</strong> | 9. Demonstrate sufficient knowledge of sociobehavioral sciences including but not limited to health care economics, medical ethics, and medical education | 36 |</p>
<table>
<thead>
<tr>
<th>Practice Based Learning and Improvement</th>
<th>Expected time frame (months)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. understand his or her own limitations of knowledge</td>
<td></td>
</tr>
<tr>
<td>2. ask peers and faculty for help when needed</td>
<td></td>
</tr>
<tr>
<td>3. accept feedback and develop self-improvement plans</td>
<td></td>
</tr>
<tr>
<td>3. be self-motivated to acquire knowledge</td>
<td></td>
</tr>
<tr>
<td>4. be able to use electronic references and literature to learn about patients diseases</td>
<td></td>
</tr>
<tr>
<td>5. facilitate the learning of interns and students by holding intelligent discussions regarding patient’s problems and management</td>
<td></td>
</tr>
<tr>
<td>6. analyze personal practice patterns to self-improve</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Practice Based Learning and Improvement Milestones</th>
</tr>
</thead>
<tbody>
<tr>
<td>PBLI - A4</td>
</tr>
<tr>
<td>36</td>
</tr>
<tr>
<td>PBLI - A5</td>
</tr>
<tr>
<td>36</td>
</tr>
<tr>
<td>PBLI - C4</td>
</tr>
<tr>
<td>36</td>
</tr>
<tr>
<td>PBLI - D3</td>
</tr>
<tr>
<td>36</td>
</tr>
<tr>
<td>PBLI - D4</td>
</tr>
<tr>
<td>36</td>
</tr>
<tr>
<td>PBLI - E3</td>
</tr>
<tr>
<td>36</td>
</tr>
<tr>
<td>PBLI - E4</td>
</tr>
<tr>
<td>36</td>
</tr>
<tr>
<td>PBLI - G2</td>
</tr>
<tr>
<td>36</td>
</tr>
<tr>
<td>PBLI - H3</td>
</tr>
<tr>
<td>36</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Interpersonal and Communication Skills</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. write clear, organized, legible notes and orders</td>
</tr>
<tr>
<td>2. be able to use their verbal and non-verbal skills to competently and effectively interview a patient and/or family members</td>
</tr>
<tr>
<td>3. interact with other members of the health</td>
</tr>
<tr>
<td><strong>Care Team</strong></td>
</tr>
<tr>
<td>---</td>
</tr>
<tr>
<td>care team in an effective, professional manner in a leadership role</td>
</tr>
<tr>
<td>4. provide education and counseling to the patients and their families</td>
</tr>
<tr>
<td>5. be able to discuss end of life decisions and care with patients and their families</td>
</tr>
<tr>
<td>6. have developed expertise in communicating with difficult patients</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Interpersonal and Communication Skills Milestones</strong></th>
<th><strong>Professionalism Milestones</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ICS - A6</strong></td>
<td></td>
</tr>
<tr>
<td>6. Engage patients/advocates in shared decision making for difficult, ambiguous, or controversial scenarios</td>
<td></td>
</tr>
<tr>
<td><strong>ICS - A7</strong></td>
<td></td>
</tr>
<tr>
<td>7. Appropriately counsel patients about the risks and benefits of tests and procedures, highlighting cost awareness and resource allocation</td>
<td></td>
</tr>
<tr>
<td><strong>ICS - A8</strong></td>
<td></td>
</tr>
<tr>
<td>8. Role model effective communication skills in challenging situations</td>
<td></td>
</tr>
<tr>
<td><strong>ICS - B3</strong></td>
<td></td>
</tr>
<tr>
<td>3. Actively seek to understand patient differences and views and reflects this in respectful communication and shared decision-making with the patient and the healthcare team</td>
<td></td>
</tr>
<tr>
<td><strong>ICS - D3</strong></td>
<td></td>
</tr>
<tr>
<td>3. Engage in collaborative communication with all members of the health care team</td>
<td></td>
</tr>
<tr>
<td><strong>ICS - E3</strong></td>
<td></td>
</tr>
<tr>
<td>3. Communicate consultative recommendations to the referring team in an effective manner</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Expected time frame (months)</strong></th>
<th><strong>Expected time frame (months)</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>36</td>
<td>30</td>
</tr>
<tr>
<td>36</td>
<td>30</td>
</tr>
<tr>
<td>36</td>
<td>36</td>
</tr>
<tr>
<td>30</td>
<td>36</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Professionalism</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. be able to establish trust with the patients and staff</td>
<td></td>
</tr>
<tr>
<td>2. be honest, reliable, cooperative and accepting of responsibility</td>
<td></td>
</tr>
<tr>
<td>3. show regard for opinions and skills of colleagues</td>
<td></td>
</tr>
<tr>
<td>4. demonstrate respect, compassion and integrity</td>
<td></td>
</tr>
<tr>
<td>5. acknowledge errors and work to minimize them</td>
<td></td>
</tr>
<tr>
<td>6. put the needs of the patient above self-interest</td>
<td></td>
</tr>
<tr>
<td>7. display initiative and leadership</td>
<td></td>
</tr>
<tr>
<td>8. be able to delegate responsibility appropriately to others</td>
<td></td>
</tr>
<tr>
<td>9. demonstrate sensitivity to patient culture, gender, age, preferences and disabilities</td>
<td></td>
</tr>
<tr>
<td>10. be an effective consultant to other specialties</td>
<td></td>
</tr>
<tr>
<td>P - A4</td>
<td>4. Uphold ethical expectations of research and scholarly activity</td>
</tr>
<tr>
<td>P - E2</td>
<td>2. Maintain ethical relationships with industry</td>
</tr>
<tr>
<td>P - E3</td>
<td>3. Recognize and manage subtler conflicts of interest</td>
</tr>
<tr>
<td>P - F6</td>
<td>6. Serve as a professional role model for more junior colleagues (eg, medical students, interns)</td>
</tr>
<tr>
<td>P - F7</td>
<td>7. Recognize the need to assist colleagues in the provision of duties</td>
</tr>
<tr>
<td>P - G2</td>
<td>2. Effectively advocate for individual patient needs</td>
</tr>
<tr>
<td>P - I2</td>
<td>2. Recognize and manage conflict when patient values differ from their own</td>
</tr>
<tr>
<td>P - K2</td>
<td>2. Embrace physicians’ role in assisting the public and policy makers in understanding and addressing causes of disparity in disease and suffering</td>
</tr>
<tr>
<td>P - K3</td>
<td>3. Advocates for appropriate allocation of limited health care resources.</td>
</tr>
<tr>
<td>P - A4</td>
<td>4. Uphold ethical expectations of research and scholarly activity</td>
</tr>
<tr>
<td>P - E2</td>
<td>2. Maintain ethical relationships with industry</td>
</tr>
<tr>
<td>P - E3</td>
<td>3. Recognize and manage subtler conflicts of interest</td>
</tr>
<tr>
<td>P - F6</td>
<td>6. Serve as a professional role model for more junior colleagues (eg, medical students, interns)</td>
</tr>
<tr>
<td>P - F7</td>
<td>7. Recognize the need to assist colleagues in the provision of duties</td>
</tr>
<tr>
<td>P - G2</td>
<td>2. Effectively advocate for individual patient needs</td>
</tr>
<tr>
<td>P - I2</td>
<td>2. Recognize and manage conflict when patient values differ from their own</td>
</tr>
<tr>
<td>P - K2</td>
<td>2. Embrace physicians’ role in assisting the public and policy makers in understanding and addressing causes of disparity in disease and suffering</td>
</tr>
<tr>
<td>P - K3</td>
<td>3. Advocates for appropriate allocation of limited health care resources.</td>
</tr>
</tbody>
</table>

**Systems-Based Practice**

1. have begun working with all health professionals to provide patient centered care
2. have worked on several quality improvement projects that involve improving the systems in which they practice
3. be a patient advocate
4. be able to do the appropriate patient work-up in a cost effective way
5. be able to supervise PGY1 residents and medical students
6. understand different types of medical practice and how they function and integrate with society

**Systems-Based Practice Milestones**

| SBP - A3 | 3. Negotiate patient-centered care among multiple care providers. | 36 |
| SBP - B4 | 4. Demonstrate how to manage the team by using the skills and coordinating the activities of interprofessional team members. | 36 |
5. Demonstrate ability to understand and engage in a system-level quality improvement intervention.

6. Partner with other health care professionals to identify, propose improvement opportunities within the system.

4. Demonstrate the incorporation of cost-awareness principles into complex clinical scenarios

Internal Medicine Residency Resident Selection, Promotion, Dismissal and Leave Policies

Criteria for Resident Selection

1. USMLE scores for both steps 1, 2ck, 2cs
2. Strong motivation and commitment to Medicine as evidenced by background education, personal statement, research and letters of recommendation
3. Personality traits such as emotional maturity, warmth and compassion
4. Strong interpersonal and communications skills and organizational skills

Process of Resident Selection

Each year, the internal medicine residency receive thousands of applications for positions in the 3 year Categorical and 1 year Preliminary positions. All applications are personally screened by the Program leadership and about 250 are chosen who meet the above criteria. These candidates are invited for a personal interview. They are interviewed and graded by attendings from all sections of the Department of Medicine. Prior to finalizing a rank list the program directorship meets to discuss the candidates and then the final list is submitted for the match.

Criteria for Promotion in the Program

Residents need to have fulfilled all goals and objectives for their PGY which are listed previously in this manual. All residents must pass their Step 3 exam before the end of their PGY-2 year in order to move up to the next training level.

They must also have:
1. Acceptable standard of clinical competence as judged by the faculty
   a. Consistent display of milestones based performance
   b. Successful display of emergency management skills
   c. Successful display of handoff communications skills
   d. Evidence of commitment to patient safety and quality of care improvement activities
2. Consistent evidence of hard work and dedication to patient care
3. Evidence of eagerness and motivation to learn; documented progression in clinical competence during the year
4. Outstanding professional and ethical conduct
5. Capacity to work as a team member
6. Regular participation in all educational conferences and punctuality
7. Active participation in scholarly activities, seminars and conferences
8. Documented acceptable performance in all six core competencies and applicable milestones

**Process of Promotion**

In general, promotion to the next year of training is formal and will proceed assuming that the resident performs satisfactorily according to the above criteria as judged by the Clinical Competence Committee and the Program Leadership. During clinical competency meetings, the house officer’s performance will be evaluated in light of the educational milestones. Emphasis on direct observation of clinical competence is of paramount importance to the clinical competency committee. Minor deficiencies in resident performance will be identified using milestones based criteria and will serve as the basis for individualized remediation plans, as appropriate. Any major deficiencies identified by the committee will be communicated to the resident by the Program Director in persona and will result in a robust remediation plan. Collaborative recommendations will be made for correcting the deficiencies. Such recommendations will be less formal in instances of minor problems with house officer performance, followed by formal written documentation if the problem persists. In case of persistent serious performance deficiencies in one or more areas, the faculty will decide whether the resident will be held back in the same year and not be promoted, or dismissed from the program.

**Criteria for Successful completion of preliminary training year, Internal Medicine**

In order to be certified for completion of a preliminary training year in internal medicine, the intern: 1) must have completed 12 months of supervised clinical training; 2) must meet all standards set by the Clinical Competency Committee (including the ability to consistently display the knowledge, skills and attitudes described in the ACGME/ABIM milestones-based narratives applicable to the first year of training); 3) must be deemed by the program director and clinical competency committee capable of safely practicing medicine in a supervised capacity as a second year resident upon preliminary training year completion; 4) must have demonstrated exemplary professionalism during the preliminary training year; and 5) there must be no other known factors which would preclude the intern from providing excellent patient care to the public while continuing in the subsequent training years.

**Graduation, Internal Medicine**

In order to be certified for graduation, PGY-3 resident must: 1) have completed 36 months of supervised clinical training; 2) must meet all standards set by the Clinical Competency Committee (including the ability to consistently display the knowledge, skills and attitudes described in the ACGME/ABIM milestones-based narratives); 3) must be deemed by the program director and clinical competency committee capable of safely practicing medicine in an independent fashion; 4) must have demonstrated exemplary professionalism during residency; and 5) there must be no other known factors which would preclude the graduating resident from providing excellent patient care to the public as an independent practitioner.

**Criteria for Dismissal from the Program**

1. Unacceptable performance in patient care or clinical incompetence
2. Indifference, lack of motivation to learn
3. Professional misconduct or unethical behavior
4. Personality traits that seriously interfere with the resident’s effective functioning
5. Poor performance in clinical rotations or in-training examination
6. Poor participation in scholarly activities
7. Poor or disorganized documentation, failure to comply with medical record keeping requirements
8. Persistent inability to satisfy the goals and objectives for their PGY as delineated above

**Process of Dismissal**

Major conduct or performance deficiencies are causes for dismissal from the program. The Program Director may decide not to renew the resident’s contract for the following year because of unsatisfactory performance based on above criteria. The decision not to renew the contract will be conveyed to the resident by the Program Director.

**Taking Leave From the Program**

Housestaff may request to take leave from the program. This must be done in writing to the Program Director. The residents training will be prolonged by the same amount of time as the leave taken and the resident is then considered off-cycle. This is true regardless of the reason for leave, including childbirth. This policy is in compliance with the ABIM and RRC both of which require 36 months of training with at most 3 months for vacation during that time.
Supervision and Delineation of Privileges House Staff and Attending Staff

Policy

As required by the New York State Code, Rules and Regulations, Part 405, the Medical Staff shall monitor and supervise postgraduate trainees assigned patient care responsibilities as part of an approved medical training program. This shall include written documentation of privileges granted to such individuals, and the continuous monitoring of patient care services provided by such individuals to assure the provision of quality patient care services within the scope of privileges granted.

The following represents a general outline of the process to be used by clinical departments for direct and indirect supervision of house staff:

1. **General Responsibilities of the Department Director**
   a. **Orientation** – The Department Director will ensure that each new house officer receives an orientation to the Department and the Hospital. This would include but not be limited to:
      i. Rules, Regulations and Policies of the Department
      ii. Rules and Regulations of the Medical Staff
      iii. Material contained in the House Staff manual
      iv. Relevant policies and procedures of the Medical Board
   b. **Delineation of Privileges** – The Department Director will ensure that criteria based delineation of privileges system is in place for each resident training level of the program.
      Each resident must be made aware of his privileges as granted and that he may not exceed the scope of these privileges. At Westchester Medical Center, residents may not be granted privileges under general supervision in procedure areas. These include, but are not limited to:
      i. Operating Room
      ii. Ambulatory Surgery
      iii. Cardiac Catheterization
      iv. Angiography
      v. Chemotherapeutic or antineoplastic agents
         1. any agent designated as a chemotherapeutic agent or antineoplastic drug must be ordered only by an attending physician approved for prescribing the agent or by an Oncology Fellow or Nurse Practitioner who is functioning under the guidance/training of the Attending. The Fellow or Nurse Practitioner must sign the “Written by” section. The Attending must review the orders, modify if needed and sign.
         2. The definition of these agents is: Antineoplastic drugs - A chemotherapeutic or biologic agent that controls or kills cancer cells. A chemotherapeutic agent may be used for a reason other than to treat cancer. An example would be methotrexate to treat rheumatoid arthritis.
      vi. See attached Appendix A for complete listing of WMC chemotherapeutic or antineoplastic agents
   c. Resident physicians may perform any procedure under the direct visual supervision of an appropriately privileged house officer or attending physician.
   d. In life-threatening situations, a resident physician may perform any life-sustaining procedure. This emergency action must be documented in the patient’s medical record and the supervising attending physician notified.
e. The Director of the Department must ensure that a system of clinical competence in place to ensure that each resident is proficient in his practice of individual skills and procedures before being permitted to progress. Such a system would be utilized to validate and modify privileges for each resident and to evaluate and document each resident’s performance.
   i. Records of credentialing will be maintained in the New Innovations Software program and will be periodically transmitted to the Westchester Hospital Administration as required by policy.

f. The Director of the Department, together with the Quality Assurance Department, will ensure that appropriate indicators are established to monitor house staff performance and the level of supervision provided by the supervisory attending staff. The program will be reviewed and/or revised by the Quality Assurance Department as needed, but not less than annually.

g. The Director of the Department will ensure that written policies are in place and known to the residents which detail circumstances under which supervisory attending physicians or their fellows must be contacted. Such circumstances will include, but not be limited to:
   i. Significant change in patient’s condition or change in the treatment plan
   ii. Admission to the hospital
   iii. Transfer of the patient to the ICU
   iv. Need for new intubation, or if an unplanned extubation occurs and re-intubation is not immediately performed
   v. Patient demise, Cardiac arrest, or other significant changes in hemodynamic status
   vi. Development of significant neurological changes
   vii. Development of major wound complications
   viii. Errors requiring a change in clinical care
   ix. Any significant clinical problem that will require a procedure or operation
   x. Critical test results as defined by Department/Division, which require urgent clinical intervention
   xi. Patient elopement or other unplanned discharge

2. **Specific Responsibilities of Supervisory Attending Staff**
   a. Resident Status – Each supervisory attending physician must know the status of each resident rotating onto his service. This would include:
      i. Previous evaluations
      ii. Current delineation of privileges, any modifications to these privileges and the reasons for the modifications
      iii. Status of clinical competence process. The supervisory attending physicians will use this data in making assignments and determining the level of direct supervision required.

   b. The supervisory attendings physician will ensure that all residents rotating on their service are knowledgeable of and understand specific policies and procedures pertaining to the service.

   c. The supervisory attending physician will ensure that each resident rotating onto the service understand the organization of patient care on the service. This would include the specific role of the particular resident in relation to the senior resident and supervisory attending staff. Also included would be:
      i. Patient information which must be transmitted to higher levels immediately
      ii. Documentation requirements
      iii. Procedures for signing patients off to residents on other shifts
      iv. Procedures for recording near miss, adverse events and clinically significant events through the electronic handoff system
d. The supervisory attending physician will ensure that there is an organized treatment plan for each patient. It is the responsibility of the supervisory attending physician to ensure that the resident understands the plan and the level of latitude afforded to him in managing the plan.

e. The supervisory attending physician should make rounds frequently to discuss the patient’s progress with the resident and ensure that the treatment plan is being followed.

f. During the course of rounds the supervisory attending physician will evaluate the resident’s skills and understanding of cases assigned to them as a basis on an overall evaluation of performance.

g. It is the responsibility of the supervisory attending physician to document his supervision of house staff on the medical record. As a minimum this shall include:

   i. A minimum of one supervisory attending note every other day showing concurrence with the course of the treatment plan.
   
   ii. All approvals of change in the treatment plan

   iii. Approval of procedures and treatment

   iv. Documentation of mandatory hospital consults

h. In accordance with New York’s Codes, Rules and Regulations, Part 405, whenever on-site supervision is provided by an individual in his final year of training, the supervising attending physician must be readily available, defined as within 30 minutes.

   i. The supervising attending physician shall ensure that each house officer complies with applicable hospital and regulatory policies regarding sleep and fatigue
Residency Supervision

Interns (On Floors and Units & Ambulatory Clinic)- Always Direct Supervision
- are responsible for the day to day care of the patient and insure that all necessary tests and orders are completed
- should communicate with the resident about every aspect of the patient's care
- should perform procedures under the direct supervision of previously credentialed housestaff or attending physicians
- participate in the admission process with the resident to formulate a differential diagnosis and treatment plan which is then discussed with the patient’s attending
- are also responsible for teaching students how to care for patients and how to apply basic science to clinical situations
- obtain attending review of handoff information while on floor duty
- Report clinically significant events using appropriate means including direct verbal communication, and/or phone

Residents (Team or Unit Leaders & Ambulatory Clinic) Direct or Indirect Supervision with Direct Supervision immediately available
- are responsible for the direct supervision of the interns in all aspects of patient care
- are responsible for teaching patient management skills, formulating differential diagnoses and providing references to the interns on up-to-date medical information
- are responsible for teaching procedural skills to Interns and other residents who lack the skill and directly supervise them as they learn
- interact with all attendings on all patients, at the time of their admission and throughout their hospital stay
- call upon the attending if there is any change in the patient’s condition or if a diagnostic or therapeutic dilemma arise
- are responsible for the care provided by his/her interns to their patients
- supervise floor and MICU handoffs; obtain attending review of handoff information while on floor duty
- Report (or cause to be reported by interns) clinically significant events using appropriate means including direct verbal communication and/or phone.

Attendants
Responsible for admission of all hospitalized patients and are ultimately responsible for their patient’s care, whether that be on the floors or units. They generally do not write orders, but instead communicate with the house staff on a daily basis to provide insight into the patient’s disease and discuss treatment options. They educate the house staff and supply articles and reference material on up-to-date medical information as it applies to their patients. They, or their designee (a fellow or covering attending) are always available to discuss problems or care issues. Fellows work in conjunction with an attending in the Internal Medicine subspecialty areas. Sub-specialty attendings in the units conduct daily teaching rounds and go over each case in detail to insure proper care is being provided. They are available should any problems arise in the units. Emergency Department (ED) attendings are fully responsible for patient care and the ultimate disposition of all patients. ED attendings can admit patients to any service as they see fit. They are responsible for teaching the house staff ED skills as well as ED medical approach to patients.
Division Chiefs

Division chiefs are responsible for the practice of medicine by their attendings and the educational program of the residents and fellows on their service. They dictate the professional conduct of their division and take ultimate responsibility for that conduct.

Chief Medical Resident (CMR)

Is responsible for the well-being (both educational and emotional) of the entire medical house staff. They set the standard for moral, ethical and professional behavior to be exhibited by the house staff. The CMR is responsible for the educational training of the house staff, and is responsible for insuring good communication between house staff. The CMR is the house staff advocate and should support the residents as physicians as well as individuals. Also, there is a clear teaching responsibility with the residents and students. The CMR is available at all times for any problems, consistent with duty hour regulations and policy. The monthly resident schedules, clinic schedule and conference schedules are set up by the chief resident. The Program Director supplies advice and support on a continuing basis to insure a high quality educational setting.

Program Director

The program Director is ultimately responsible for the residency training program and maintaining adherence to the educational requirements established by the Residency Review Committee of the ACGME. He/she works closely with the CMRs on all the above issues to promote a healthy academic milieu. The program director works with the departmental leadership closely to develop new training goals and teaching endeavors.
### Department of Medicine Division Leadership

<table>
<thead>
<tr>
<th>Divisions</th>
<th>Chiefs</th>
<th>Residency/Fellowship Directors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiology</td>
<td>Julio Panza, MD</td>
<td>Howard Cooper</td>
</tr>
<tr>
<td>Endocrinology</td>
<td>Irene Weiss, MD</td>
<td>Irene Weiss, MD</td>
</tr>
<tr>
<td>Gastroenterology</td>
<td>Edward Lebovics, MD</td>
<td>Edward Lebovics, MD</td>
</tr>
<tr>
<td>General Internal Medicine</td>
<td>Arif Mumtaz, MD</td>
<td>Sachin Sule, MD</td>
</tr>
<tr>
<td>Endocrinology</td>
<td>Irene Weiss, MD</td>
<td>Irene Weiss, MD</td>
</tr>
<tr>
<td>Gastroenterology</td>
<td>Edward Lebovics, MD</td>
<td>Edward Lebovics, MD</td>
</tr>
<tr>
<td>General Internal Medicine</td>
<td>Arif Mumtaz, MD</td>
<td>Sachin Sule, MD</td>
</tr>
<tr>
<td>Endocrinology</td>
<td>Irene Weiss, MD</td>
<td>Irene Weiss, MD</td>
</tr>
<tr>
<td>Gastroenterology</td>
<td>Edward Lebovics, MD</td>
<td>Edward Lebovics, MD</td>
</tr>
<tr>
<td>Residency Program</td>
<td>William Frishman, MD, MACP</td>
<td>Sachin Sule, MD</td>
</tr>
<tr>
<td>Infectious Diseases</td>
<td>Gary Wormser, MD</td>
<td>Gary Wormser, MD</td>
</tr>
<tr>
<td>Nephrology</td>
<td>Renee Garrick, MD</td>
<td>Maureen Brogan, MD</td>
</tr>
<tr>
<td>Oncology</td>
<td>Tauseef Ahmed, MD</td>
<td>Robert G. Lerner, MD (Hematology/Oncology)</td>
</tr>
<tr>
<td>Hematology</td>
<td>Robert G. Lerner, MD</td>
<td></td>
</tr>
<tr>
<td>Pulmonary/Critical Care</td>
<td>George Maguire, MD</td>
<td>Dipak Chandy, MBBS</td>
</tr>
<tr>
<td>Allergy/Immunology/Rheumatology</td>
<td>Raymond Dattwyler, MD, PhD</td>
<td>Julia Ash, MD (Rheumatology)</td>
</tr>
</tbody>
</table>
Order Writing, Charting, Medical Records

Order Writing
Although the legal right for attending physicians to write orders on their patients can never be taken away, it is asked that all patient orders are to be written by the house staff. The only exception would be if the attending physician has prior communication with the appropriate house officer for a particular order and the house officer is accepting of that contingent arrangement. Medical students rotating through the floors as subinterns can also write orders, but they have to be countersigned and must have had prior resident discussion and approval. The house staff are responsible for discussing the patient’s problems with attending physicians and coming to a consensus with that physician regarding the treatment of the patient and then writing the appropriate orders. Should a dispute occur between the resident and the responsible attending physician, the problem is brought to the attention of the Program Director or the Chief of Service for adjudication.

Electronic Health Record (EHR)
Westchester Medical Center has implemented a fully functional EHR across it’s inpatient and outpatient facilities. All residents will be trained in the use of EHR and appropriate documentation prior to the start of their residency training.

Medical Records
All medical residents are responsible for maintaining current records, including diagnosis, and discharge summaries. Medical records must be completed promptly. House officers should take pride in satisfactory completion of their record responsibilities without the need for follow-up communication by the Medical Records Department.

House officers are reminded that medical records are legal documents that should clearly, succinctly and in grammatically appropriate English state the relevant clinical issues at hand and the proposed responses to them. Ancillary issues related to the total healthcare needs of the patient are also appropriate for the medical record.
Department of Medicine Discharge Summary Policy

- Complete discharge summaries on the day of discharge.
- Bolded words should be used as headings for sections of the summary.
- Utilize Approved Discharge summary template (See Appendix B)
- Discharge summary template must be pasted into the discharge management tab on A2K and updated on a daily basis.

Be as concise as possible. The purpose of the summary is to allow the next physician who cares for the patient to easily and quickly have an overview of this hospital stay. It is not necessary to include specific ventilator settings or day to day variation in Hgb levels, etc. This is not the place to justify treatment; that should have been done in the progress notes. It is not necessary to explain why studies were ordered, just give results.
Procedural Skills

It is important that residents become skilled in the performance of medical procedures and understand the indications, contraindications, complications, sterile technique, specimen handling, interpretation of results and informed consent. There must also be understanding of the cost of performance as well as the underlying ethical issues such as relevance to the underlying medical state of the patient and the need to educate the patient regarding potential gain versus detriment and ultimately, respect and support for the patient’s decisions.

<table>
<thead>
<tr>
<th>Know, Understand, and Explain</th>
<th>Indications; Contraindications; Recognition &amp; Management of Complications; Pain Management; Sterile Techniques</th>
<th>Specimen Handling</th>
<th>Interpretation of Results</th>
<th>Requirements &amp; Knowledge to Obtain Informed Consent</th>
<th>Perform Safely and Competently</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abdominal paracentesis</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td><strong>Advanced cardiac life support</strong></td>
<td>X</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>X</td>
</tr>
<tr>
<td>Arterial line placement</td>
<td>X</td>
<td>N/A</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Arthrocentesis</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Central venous line placement</td>
<td>X</td>
<td>N/A</td>
<td>N/A</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td><strong>Drawing venous blood</strong></td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>N/A</td>
<td>X</td>
</tr>
<tr>
<td><strong>Drawing arterial blood</strong></td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Incision and drainage of an abscess</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Lumbar puncture</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Nasogastric intubation</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Pap smear and endocervical culture</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td><strong>Placing a peripheral venous line</strong></td>
<td>X</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>X</td>
</tr>
<tr>
<td>Pulmonary artery catheter placement</td>
<td>X</td>
<td>N/A</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Thoracentesis</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
</tbody>
</table>

In addition to those listed above, at WMC required procedures also include: central line placement in the IJ and femoral locations (by the end of PGY2)

Residents are responsible for maintaining, in good standing their electronic procedural log books. Attestations of procedural proficiency and interpretative skill competency must be documented in this book. No resident will successfully fulfill his/her program responsibilities without such documentation. A resident can not perform a procedure independently until the required number of procedures from the procedure log have been submitted to the residency coordinator and entered into the residents official file.
Central Venous Access Device Policy

The Department of Medicine is committed to reducing complications related to central venous access, including catheter related infections. As such, the supervising resident of each clinical area will complete documentation using the stamp provided below for any patient having a central venous access device to ensure that each device is evaluated daily for a continuing need for use and for findings that would suggest a complication or need for line maintenance and/or removal.

<table>
<thead>
<tr>
<th>DAILY CVC ASSESSMENT, Department of Medicine</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Central Venous Catheter has been evaluated and the following is noted:</td>
</tr>
<tr>
<td>• Location: Right ( ), Left ( ): Internal Jugular ( ), Subclavian ( ), Axillary ( ), Femoral ( )</td>
</tr>
<tr>
<td>• Type of central venous access: ___________________________________________</td>
</tr>
<tr>
<td>• Continuing indication for use: ____________________________________________</td>
</tr>
<tr>
<td>• Status of Dressing: clean, dry and intact, labeled properly: Yes ( ) No ( )</td>
</tr>
<tr>
<td>(if answer is “no,” dressing change must be completed as soon as possible)</td>
</tr>
<tr>
<td>• Known or reported breach of aseptic access to line: Yes ( ) No ( )</td>
</tr>
<tr>
<td>• Complication related to line: None ( ); Other ( ) (circle or describe findings below)</td>
</tr>
<tr>
<td>- Adverse findings:</td>
</tr>
<tr>
<td>• Bleeding ( )</td>
</tr>
<tr>
<td>• Obstruction: sluggish or absent blood flow ( ), resistance to flushing ( )</td>
</tr>
<tr>
<td>• Potential Exit site infection: pain ( ), redness ( ), swelling ( ), drainage ( )</td>
</tr>
<tr>
<td>• PICC line specific findings: extremity discoloration ( ), warmth ( ), erythema along vein ( )</td>
</tr>
<tr>
<td>• Catheter displacement: ( ) externalization of cuff, lengthening of catheter from exit site ( )</td>
</tr>
<tr>
<td>(Please note: for PICCs, approximately one cm is externalized)</td>
</tr>
<tr>
<td>• Possible Deep vein thrombosis: face and neck swelling ( ), engorged neck veins ( )</td>
</tr>
<tr>
<td>( ) Other abnormal findings: ______________________________________________</td>
</tr>
</tbody>
</table>

Printed or stamped name: ____________________________________________
Practitioner Status: ________________________________________________
Date and time of examination: ________________________________________

Interpretive Skills
Interpretative skill competency is required in the reading of electrocardiograms, chest x-ray, spirometry, peripheral blood smears, gram stain of sputum, microscopic examination of urine, and KOH and wet prep of vaginal discharge.

Educational Opportunities

Residents have the opportunity to gain exposure to Allergy/Immunology, Psychiatry, Dermatology, Ophthalmology, Gynecology, ENT, Orthopedics, Palliative Medicine, Sleep Medicine, and Rehab Medicine during clinic month or electives. Dermatology training is a required experience at WMC.

Admissions Caps and Limits

All patients, private or hospitalist service, are treated in exactly the same manner. On Inpatient rotations:
   a. A first-year resident must not be assigned more than five new patients per admitting day; an additional 2 patients may be assigned if they are in-house transfers from the medical services.
   b. A first-year resident must not be assigned more than eight new patients in a 48-hour period.
   c. A first-year resident must not be responsible for the ongoing care of more than 10 patients.
   d. When supervising more than one first-year resident, the supervising resident must not be responsible for the supervision or admission of more than 10 new patients and 4 transfer patients per admitting day or more than 16 new patients in a 48-hour period.
   e. When supervising one first-year resident, the supervising resident must not be responsible for the ongoing care of more than 14 patients.
   f. When supervising more than one first-year resident, the supervising resident must not be responsible for the ongoing care of more than 20 patients.

Absences

If you are sick and can not come in to work, you must inform the chief medical resident (long range beeper: 914-952-1796), your senior resident/fellow that morning. Please check to see if you are in clinic and notify the chief medical resident. If you don't show up for a call, fail to notify the chief medical resident that you will not be present, or fail to answer the sick call beeper if you are on sick call, you will be assigned extra calls and possibly suffer academic remediation or probation for lack of professionalism and endangering patient care. You will not be covered on the floors and units when sick, the burden will fall on your co-
intern and PGY2/3 resident with whom you are working so please only call in sick if you absolutely must. All sick days will be made up later. The RRC for medicine requires 33 months of training regardless of the CIR contract allowing sick days. Academic credit is needed for the full 33 months to be graduated on time.

### Swaps

Changes made to the master schedule must be made more than three months in advance so that the clinic schedule will not be affected. All switches must be approved by the Chief Residents and, if affecting clinic in any way, the Medical Director of the APCC. If there is a swap, the Chief Residents must be informed via email in advance. CMR email: cmrwmc@gmail.com

The Swaps are prohibited during floor months and ICU months. You are allowed to exchange a night float shift or ER shift since these will not interfere with the continuity of patient care. The post-swap schedule must still comply with work-hour regulations.

### Medical intensive care unit consults

Based upon the guidelines of Society of Critical Care Medicine, May 1998
Guidelines for ICU Admission, Discharge, and Triage


The following organ system specific conditions and/or the following objective signs, when present, should guide the clinician to consider medical intensive care unit consultation.

#### Guidelines by Organ System:

**A. Cardiac System**
1. Acute myocardial infarction with complications
2. Cardiogenic shock
3. Complex arrhythmias requiring close monitoring and intervention
4. Acute congestive heart failure with respiratory failure and/or requiring hemodynamic support
5. Hypertensive emergencies
6. Unstable angina, particularly with dysrhythmias, hemodynamic instability, or persistent chest pain
7. S/P cardiac arrest
8. Cardiac tamponade or constriction with hemodynamic instability
9. Dissecting aortic aneurysms
10. Complete heart block

**B. Pulmonary System**
1. Acute respiratory failure requiring ventilatory support
2. Pulmonary emboli with hemodynamic instability
3. Patients in an intermediate care unit who are demonstrating respiratory deterioration
4. Need for nursing/respiratory care not available in lesser care areas such as floor or intermediate care unit
5. Massive hemoptysis
6. Respiratory failure with imminent intubation

C. Neurologic Disorders
1. Acute stroke with altered mental status
2. Coma: metabolic, toxic, or anoxic
3. Intracranial hemorrhage with potential for herniation
4. Acute subarachnoid hemorrhage
5. Meningitis with altered mental status or respiratory compromise
6. Central nervous system or neuromuscular disorders with deteriorating neurologic or pulmonary function
7. Status epilepticus
8. Brain dead or potentially brain dead patients who are being aggressively managed while determining organ donation status
9. Vasospasm
10. Severe head injured patients

D. Drug Ingestion and Drug Overdose
1. Hemodynamically unstable drug ingestion
2. Drug ingestion with significantly altered mental status with inadequate airway protection
3. Seizures following drug ingestion

E. Gastrointestinal Disorders
1. Life threatening gastrointestinal bleeding including hypotension, angina, continued bleeding, or with comorbid conditions
2. Fulminant hepatic failure
3. Severe pancreatitis
4. Esophageal perforation with or without mediastinitis

F. Endocrine
1. Diabetic ketoacidosis complicated by hemodynamic instability, altered mental status, respiratory insufficiency, or severe acidosis
2. Thyroid storm or myxedema coma with hemodynamic instability
3. Hyperosmolar state with coma and/or hemodynamic instability
4. Other endocrine problems such as adrenal crises with hemodynamic instability
5. Severe hypercalcemia with altered mental status, requiring hemodynamic monitoring
6. Hypo or hypernatremia with seizures, altered mental status
7. Hypo or hypermagnesemia with hemodynamic compromise or dysrhythmias
8. Hypo or hyperkalemia with dysrhythmias or muscular weakness
9. Hypophosphatemia with muscular weakness

G. Surgical
1. Post-operative patients requiring hemodynamic monitoring/ventilatory support or extensive nursing Care

H. Miscellaneous
1. Septic shock with hemodynamic instability
2. Hemodynamic monitoring
3. Clinical conditions requiring ICU level nursing care
4. Environmental injuries (lightning, near drowning, hypo/hyperthermia)
5. New/experimental therapies with potential for complications

**Objective Guidelines**

* Pulse < 40 or > 150 beats/minute
* Systolic arterial pressure < 80 mm Hg or 20 mm Hg below the patient's usual pressure
* Mean arterial pressure < 60 mm Hg
* Diastolic arterial pressure > 120 mm Hg
* Respiratory rate > 35 breaths/minute

**Laboratory Values (newly discovered)**

* Serum sodium < 110 mEq/L or > 170 mEq/L
* Serum potassium < 2.0 mEq/L or > 7.0 mEq/L
* PaO2 < 50 mm Hg
* pH < 7.1 or > 7.7
* Serum glucose > 800 mg/dl
* Serum calcium > 15 mg/dl
* Toxic level of drug or other chemical substance in a hemodynamically or neurologically compromised patient

**Radiography/Ultrasoundography/Tomography (newly discovered)**

* Cerebral vascular hemorrhage, contusion or subarachnoid hemorrhage with altered mental status or focal neurological signs
* Ruptured viscera, bladder, liver, esophageal varices or uterus with hemodynamic instability
* Dissecting aortic aneurysm

**Electrocardiogram**

* Myocardial infarction with complex arrhythmias, hemodynamic instability or congestive heart failure
* Sustained ventricular tachycardia or ventricular fibrillation
* Complete heart block with hemodynamic instability

**Physical Findings (acute onset)**

* Unequal pupils in an unconscious patient
* Burns covering > 10% BSA
* Anuria
* Airway obstruction
* Coma
* Continuous seizures
* Cyanosis
* Cardiac tamponade

**Dress Code**
Men must where a button-down shirt every day. Women similarly must wear professional attire. You can wear scrubs only on MICU/CCU rotation, night float, ED shifts and on VIR/Anesthesia (procedures) elective. Scrubs are never to be worn to clinic. Jeans, open toe shoes, bare belly buttons are all unacceptable. Dress like a professional!

**Meals**

The chief residents give out meal cards at the beginning of each month for those with on-call and off hour shifts.

**HIPAA**

While it has always been important to protect a patients’ confidential medical information, HIPAA regulations have now brought this topic to the forefront. We must all be careful when speaking in public areas (not a closed door conference room) such as an elevator. We should all be careful not to leave sheets of paper (labs or otherwise) with patient information lying around where other patients or doctors can see them. Put simply, consider carefully what you say and do, and where you say and do it.

**Autopsies**

As part of the educational process, it is important that autopsies be obtained and performed whenever possible. Residents are urged to obtain autopsies. Residents are also strongly urged to be physically present when the post-mortem examination is performed.

**Proper Autopsy Protocol**

Upon the death of a patient, the following steps must be taken:

- The intern must call the resident, who is then responsible for notifying the family and asking permission for an autopsy on all patients. Consent for autopsy can only be given by the legal next of kin, which is as follows in order:
  a. spouse
  b. father or mother (or legal guardian)
  c. son or daughter of legal age
  d. brother or sister of legal age
  e. uncle or aunt
  f. cousin

**Special Situations**

- Separated, not legally divorced – the surviving spouse is the legal next of kin.
- Common law marriage – no legal basis
- In case of no living relatives – consent by a friend should have concurrence by the
administrator of the hospital
- In case of no living relatives and the body is not claimed for 48 hours – autopsy consent should be referred to the administrator
- When several persons have equal rights
  - Obtain consent of all or as many as possible, or
  - Obtain a statement “other relatives of the same degree of kinship to the deceased do not object to this procedure”

Special consent (written out specifically) is required for an autopsy to be done on the following: brain, extremities, artificial grafts, shunts or other devices (even for culture)

- Medical residents cannot sign the death certificate in the event of an autopsy. They will be signed by the pathologist and only then can the body be released from the hospital.
- Medical residents on call must notify the pathology resident on call if any autopsy consent has been obtained or if one has been cancelled. If you are unable to contact the Pathology resident, then the Pathology attending on call or the hospital administrator should be called.
- An autopsy sheet must be filled out on all deaths (on the floor and in the units), whether or not an autopsy consent was obtained, and given to the chief resident.

Consent

Must be obtained from a patient with capacity or the Health Care Proxy, for central IV access (TLC, PICC lines), IV contrast dye, other invasive procedures (usually done by the physician performing these), and transfusion of blood products. If you know a patient will be requiring blood over night or on the weekend…call the Blood Bank (ext. 7610) and confirm they have a valid Type and Cross and obtain consent before you leave for the day. If you know that a patient will be getting a CT scan with contrast…obtain consent before you leave that day.

Email

You must check your email daily. Your personal electronic device must be set up to receive exchange server information from the WCMC.COM system. While on floors and MICU, you are required to check your email for important notices regarding changes in your patients’ condition(s). This is sent via daily report from the handoff system. There is also often important information disseminated by email by the chief residents, program directorship, residency coordinator etc. You will be held responsible if things are not done that were sent by email. Microsoft outlook meeting invitations are utilized by the program for key meetings such as house staff meetings and meetings with the program director. You should promptly respond to these notices. The official email of the medicine residency is that of the Westchester Medical Center information systems – wcmc.com.

Step 3
It is now policy that Internal Medicine categorical housestaff must take Step 3 during PGY-1 year. The test must be passed by the end of PGY-2 or housestaff member is at risk of not being promoted to PGY-3.

For those house-officers who need to take either the USMLE 3 or COMLEX 3 examinations, these examinations should be scheduled on weekends (now available) and on elective rotations (when not scheduled in clinic) or during vacation periods. Do not schedule your test in June or July unless you have vacation time during these months. If you decide on a date early (at least 3 months in advance, inform the chiefs and a schedule change can be attempted (but NOT guaranteed) to try and help you out. When you schedule these tests, try do it three months in advance if possible so that it can be built right into the clinic schedule that you are not there those two days. Inform the Chief Residents/Program Director as soon as you know your dates.

**Housestaff Evaluation**

The manner in which the 6 core competencies are evaluated for each house officer during each rotation are listed in the curriculum (separate document). The educational milestones, which define for the trainee and program the knowledge, skills and attitudes that should consistently be displayed during particular stages of training are set out above. The housestaff also meet with the Program Director or his/her designee in the middle of the year for formative feedback and at the end of the year for summative feedback. The In-Training examination of Medical Knowledge is given to categorical housestaff in October.

**Patient Age Cut-Off**

If a patient is 18 years of age or older, we can take the patient on the medicine service and/or see the patient on the consult service. Pediatrics generally considers a patient to be a child until 21, so they may wish to keep the patient until they reach that age. With respect to pregnant females, medicine considers the patient to be an adult when pregnant, even if the patient is 14 years of age, for example. So, we can take such patients to our MICU for admission or see the patient as a consult if desired by OB/GYN.
6 Core Competencies

I. Patient care
Residents must be able to provide patient care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health. Residents are expected to:
- Communicate effectively and demonstrate caring and respectful behaviors when interacting with patients and their families
- Gather essential and accurate information about their patients
- Make informed decisions about diagnostic and therapeutic interventions on the basis of patient information and preferences, up-to-date scientific evidence, and clinical judgment
- Develop and carry out patient management plans
- Counsel and educate patients and their families
- Use information technology to support patient care decisions and patient education
- Perform competently all medical and invasive procedures considered essential for the area of practice
- Provide health care services aimed at preventing health problems or maintaining health
- Work with health care professionals, including those from other disciplines, to provide patient-focused care

II. Medical knowledge
Residents must demonstrate knowledge about established and evolving biomedical, clinical, and cognitive (e.g., epidemiologic and social-behavioral) sciences and the application of this knowledge to patient care. Residents are expected to:
- Demonstrate an investigatory and analytic thinking approach to clinical situations
- Know and apply the basic and clinically supportive sciences that are appropriate to their discipline

III. Practice-based learning and improvement
Residents must be able to investigate and evaluate their patient care practices, appraise and assimilate scientific evidence, and improve their patient care practices. Residents are expected to:
- Analyze practice experience and perform practice-based improvement activities using a systematic methodology
- Locate, appraise, and assimilate evidence from scientific studies related to their patients' health problems
- Obtain and use information about their own population of patients and the larger population from which their patients are drawn
- Apply knowledge of study designs and statistical methods to the appraisal of clinical studies and other information on diagnostic and therapeutic effectiveness
- Use information technology to manage information, access online medical information, and support their own education
- Facilitate the learning of students and other health care professionals

IV. Interpersonal and communication skills
Residents must be able to demonstrate interpersonal and communication skills that result in effective information exchange and teaming with patients, their patients’ families, and professional associates. Residents are expected to:
- Create and sustain a therapeutic and ethically sound relationship with patients
- Use effective listening skills and elicit and provide information using effective nonverbal, explanatory, questioning, and writing skills
- Work effectively with others as a member or leader of a health care team or other professional group

V. Professionalism
Residents must demonstrate a commitment to carrying out professional responsibilities, adhering to ethical principles, and being sensitive to a diverse patient population. Residents are expected to demonstrate:
- Respect, compassion, and integrity; a responsiveness to the needs of patients and society that supersedes self-interest; accountability to patients, society, and the profession; and a commitment to excellence and on-going professional development
- A commitment to ethical principles pertaining to provision or withholding of clinical care, confidentiality of patient information, informed consent, and business practices
- Sensitivity and responsiveness to patients' culture, age, sex, and disabilities

VI. Systems-based practice
Residents must demonstrate an awareness of and responsiveness to the larger context and system of health care and the ability to effectively call on system resources to provide care that is of optimal value. Residents are expected to:
- Understand how their patient care and other professional practices affect other health care professionals, the health care organization, and the larger society and how these elements of the system affect their own practice
- Know how types of medical practice and delivery systems differ from one another, including methods of controlling health care costs and allocating resources
- Practice cost-effective health care and resource allocation that does not compromise quality of care
- Advocate for quality patient care and assist patients in dealing with system complexities
- Know how to partner with health care managers and health care providers to assess, coordinate, and improve health care and know how these activities can affect system performance
These are graded on 1 through 9. 1-3 are failing and the resident may not move on to the next PGY. 4 is marginal and means that with remediation the resident may move on to the next PGY at the end of the year. Evaluations informed by the educational milestones are aggregated by the program to arrive at scores relative to the six core competencies.

**Study Guides and References**

You should all consider the Medstudy and MKSAP as key reading for the three years of residency and it is well worth your money to invest in one or both. Do not try to read a textbook in order to gain a base of medical knowledge. Use textbooks as references.

**New York Medical College Library** – In the BSB is a large library with journals and textbooks. Even more important is to get access to the online library. Stop in and fill out the form to get this access so you can look up topics and articles through their website by remote access from wherever you are.

**Internal Medicine CD’s** – The CD’s are available in the 5th floor housestaff lounge to be signed out for at most 14 days at a time.

**APCC Library** – The APCC has many texts for reference in its’ conference room.

**Useful Websites**

[www.nymc.edu](http://www.nymc.edu) - to use the medical schools resources click on library and then databases – login from remote site. This includes full text linked pubmed, mdconsult, etc.


[www.acponline.org](http://www.acponline.org) – For ACP members and limited access to non-members. Contains useful information for residents and Internists alike. Look for PIER as a resource for reference. Links to *Annals of Internal Medicine*.


[www.medscape.com](http://www.medscape.com) – Free site with online texts and medical news

**Sleep and Fatigue**
It is an RRC requirement to educate housestaff on sleep and fatigue. We accomplish this by having the housestaff go to the SAFER website http://www.vcu-cme.com/safer/safercontent.html and go through the presentation, complete the quiz and hand in the certificate of completion.
Opioid Protocol – Internal Medicine Housestaff

**Admissions** – PGY 2&3 residents doing an admission where an opioid is required, must discuss the opioid use with the attending to whom they are presenting.

**Patient’s already admitted** – PGY1 housestaff covering an already admitted patient that has new or escalating pain which they think requires an opioid, must have their supervising PGY 2 or 3 resident come to the bedside to personally review the situation, examine the patient and agree with the need for the opioid. A housestaff member should then call the attending covering that patient to present the situation and discuss the opioid to be used.

Housestaff should consider non-opioid medications (NSAIDs, acetaminophen etc.) and other non-medication measures (hot/cold packs, PT, etc.) when evaluating and treating pain. Housestaff should always be considering the underlying cause of pain and trying to look for and address the underlying issue rather than just prescribing an opioid alone. Generally, when choosing an opioid, hydromorphone (Dilaudid) is not first line, especially in an opioid naïve patient.
WMC Holidays

Independence Day
Labor Day
Columbus Day
Election Day
Veteran’s Day
Thanksgiving Day
Christmas Day
New Year’s Day
Martin Luther King’s Birthday
Lincoln’s Birthday
President’s Day
Memorial Day

You can check the dates these fall on on the WMC icare intranet website.

Note: This does not mean you are automatically free! Check the schedule to see if you are on call!

July 4th is not considered a holiday for the housestaff on the floors/ units/ admitting team and consults, since we have just begun on July 1st.

Moonlighting Policy

Moonlighting is not allowed by Internal Medicine residents.
405 Regulations (work hour regulations specific to New York)

The New York State Department of Health requires that all New York State teaching hospitals operate their graduate medical education programs in strict conformance with Part 405 of the New York State Public Health Law which governs house staff work hours and supervision. In addition, the ACGME also sets strict requirements relative to duty hours. The Medical Center and New York Medical College, which sponsor all residency programs, are intent on ensuring that we adhere to all of these regulations strictly. We have, for your information, included the Westchester Medical Center policies related to these regulations.

In order to monitor compliance, you are required to complete duty hours logs in the New Innovations program. When on call or shift work, you must complete your duty hours log at the completion of each work shift. On elective and other rotations not involving call, you are permitted to complete duty hours logs on a weekly basis. Duty hours compliance is analyzed on a daily basis by program leadership and the results are be forwarded to the hospital Quality Assurance Department and the New York Medical College Office of Graduate Medical Education. Should you experience any problems with compliance, you are obligated to report this confidentially to Westchester Medical Center’s Office of Corporate Compliance at 493-2080. It must be understood that the consequences of any violation are of such a serious nature to the hospital and to the medical school, that willful violations will become the subject of disciplinary action and may in fact result in non-renewal of your contract.

SUMMARY OF REQUIREMENTS 10NYCRR, SECTION 405.4 (B)(6) & (F)(3)

- A limit of 80 hours for the scheduled workweek of residents averaged over a four week period. On-call duty in the hospital for surgical residents is not included in the 80-hour limit when evidence of adequate rest time is available and the number of interruptions are infrequent.
- Assigned work periods should not exceed 24 consecutive hours. The on-call duty of surgical residents in hospitals is not included in the 24 hour limit with evidence that rest time is adequate and interruptions infrequent.
- For hospital emergency departments with more than 15,000 unscheduled visits per year, the on-duty assignment of residents should not exceed 12 consecutive hours.
- Dual employment or “moonlighting” by residents must be monitored by hospitals and any such hours worked must be considered as part of the working hour limitations.
- Non-working periods following scheduled on-duty or on-call periods, and one 24 hour period of scheduled non-working time per week must be provided.
- Onsite, 24 hours per day seven days per week, supervision of residents by physicians in their respective specialties is required.
- Direct in-person supervision by an attending surgeon is required for all surgical procedures involving general anesthesia.
- On-call duty must be limited to no more than every third night

DUTY HOUR REQUIREMENTS OF THE ACGME

- VI.G.1. Maximum Hours of Work per Week
  Duty hours must be limited to 80 hours per week, averaged over a four week period, inclusive of all in-house call activities and all moonlighting.
- VI.G.3. Mandatory Time Free of Duty
Residents must be scheduled for a minimum of one day free of duty every week (when averaged over four weeks). At-home call cannot be assigned on these free days.

- **VI.G.4. Maximum Duty Period Length**
- **VI.G.4.a) Duty periods of PGY-1 residents must not exceed 16 hours in duration.**
- **VI.G.4.b) Duty periods of PGY-2 residents and above may be scheduled to a maximum of 24 hours of continuous duty in the hospital.**

*Programs must encourage residents to use alertness management strategies in the context of patient care responsibilities. Strategic napping, especially after 16 hours of continuous duty and between the hours of 10:00 p.m. and 8:00 a.m., is strongly suggested.*

- **VI.G.4.b)(1) It is essential for patient safety and resident education that effective transitions in care occur. Residents may be allowed to remain on-site in order to accomplish these tasks; however, this period of time must be no longer than an additional four hours.**
- **VI.G.4.b)(2) Residents must not be assigned additional clinical responsibilities after 24 hours of continuous in-house duty.**
- **VI.G.4.b)(3) In unusual circumstances, residents, on their own initiative, may remain beyond their scheduled period of duty to continue to provide care to a single patient. Justifications for such extensions of duty are limited to reasons of required continuity for a severely ill or unstable patient, academic importance of the events transpiring, or humanistic attention to the needs of a patient or family.**
- **VI.G.4.b)(3).(a) Under those circumstances, the resident must:**
  - **VI.G.4.b)(3).(a).(i) appropriately hand over the care of all other patients to the team responsible for their continuing care; and,**
  - **VI.G.4.b)(3).(a).(ii) document the reasons for remaining to care for the patient in question and submit that documentation in every circumstance to the program director.**
- **VI.G.4.b)(3).(b) The program director must review each submission of additional service, and track both individual resident and program-wide episodes of additional duty.**
- **VI.G.5. Minimum Time Off between Scheduled Duty Periods**
- **VI.G.5.a) PGY-1 residents should have 10 hours, and must have eight hours, free of duty between scheduled duty periods.**
- **VI.G.5.b) Intermediate-level residents should have 10 hours free of duty, and must have eight hours between scheduled duty periods. They must have at least 14 hours free of duty after 24 hours of in-house duty.**
- **VI.G.5.c) Residents in the final years of education must be prepared to enter the unsupervised practice of medicine and care for patients over irregular or extended periods.**
- **VI.G.5.c).(1) This preparation must occur within the context of the 80-hour, maximum duty period length, and one-day-off-in seven standards. While it is desirable that residents in their final years of education have eight hours free of duty between scheduled duty periods, there may be circumstances when these residents must stay on duty to care for their patients or return to the hospital with fewer than eight hours free of duty.**
- **VI.G.5.c).(1).(a) Circumstances of return-to-hospital activities with fewer than eight hours away from the hospital by residents in their final years of education must be monitored by the program director.**

- **VI.G.6. Maximum Frequency of In-House Night Float**
- **Residents must not be scheduled for more than six consecutive nights of night float.**

- **VI.G.7. Maximum In-House On-Call Frequency**
PGY-2 residents and above must be scheduled for in-house call no more frequently than every-third-night (when averaged over a four-week period).

- VI.G.8. At-Home Call
- VI.G.8.a) Time spent in the hospital by residents on at-home call must count towards the 80-hour maximum weekly hour limit. The frequency of at-home call is not subject to the every-third-night limitation, but must satisfy the requirement for one-day-in-seven free of duty, when averaged over four weeks.
- VI.G.8.a).(1) At-home call must not be so frequent or taxing as to preclude rest or reasonable personal time for each resident.

Common Program Requirements 19
- VI.G.8.b) Residents are permitted to return to the hospital while on at-home call to care for new or established patients. Each episode of this type of care, while it must be included in the 80-hour weekly maximum, will not initiate a new “off-duty period”.

52
PURPOSE
In order to ensure that entries, errors, additions, and countersignatures are entered into a medical record in a standardized way, the following procedures, governed by a written policy, are to be utilized by all health practitioners at the Westchester Medical Center (WMC).

SCOPE
Practitioners Responsible for Documentation in the Medical Record

POLICY
Each entry in the medical record must be dated and authenticated (signed) by the practitioner within the established time frames. The practitioner who treats a patient shall have the responsibility for documenting and authenticating the care rendered. Authentication by definition means that the author has reviewed it. If a report is typed, the practitioner can authenticate by signing it. If the report is on the computer, the practitioner can authenticate it by affixing an electronic signature to the document. Such documentation shall be in accordance with:

- Generally accepted professional standards of documentation;
- Documentation guidelines developed in concert with this policy statement and approved by the medical staff; and
- Medical record content policy of the facility.

The policy of WMC is to ensure that the medical record is complete, accurate and timely.

There are legally acceptable/recognized ways to make corrections and/or additional notations without jeopardizing the integrity of the medical record as a legal document. It is important to note that only the author should make a change(s) to his/her own entry. Corrections, addendum and late entries can be made on the progress note or medical record form.

Procedure for Countersignatures
1. The following specific entries must be authenticated by the appropriate physician:
   a. Physician Orders
   b. History and Physical
   c. Operative Report
   d. Consultations
   e. Discharge Summaries
It is the responsibility of the supervising Attending physician to document his/her supervision of the Resident physician in the medical record. At a minimum, this should include:

- An Attending’s **countersignature** of the Resident’s note
- Consultation notes written by the Resident physician must be **countersigned** by the supervising Attending physician.
Professional Behavior

The Faculty and Student Body of the New York Medical College regard the following as essentials of professional behavior. Professional behavior is expected of residents with or in front of patients, members of the health care team, and others in the professional environment (school, hospital, clinic, office) such as faculty member, standardized patients, staff, and administration members. Faculty members and administrators are expected to observe the same standards of professional behavior in their interactions with students, patients, members of the health care team, and others in the professional environment.

Relationship to Others

Response to Supervision
- Accepts and incorporates criticism in a non-resistant and non-defensive manner
- Accepts responsibility for failure or errors

Dependability / Initiative
- Completes tasks in a timely fashion (papers, reports, examinations, appointments, patient notes, patient care tasks)
- Does not need reminders about academic responsibilities, responsibilities to patients or to other health care professionals in order to complete them
- Appropriately available for professional responsibilities (i.e. required activities, available on clinical service, responds to pager)
- Takes on appropriate responsibilities willingly (not resistant or defensive)
- Takes on appropriate patient care activities (does not “turf” patients or responsibilities)

Cooperation with Other Members of the Team (peers, nursing staff, support staff, administrators, faculty members)
- Communicates with other members of the health care team in a timely manner
- Shows sensitivity to the needs, feelings, wishes of health care team members
- Relates and cooperates well with members of the health care team

Professional Attributes
Maintaining a Professional Demeanor
- Appearance, dress, professional behavior follow generally accepted professional norms
- Is not arrogant or insolent
- Maintains professional demeanor even when stressed; not verbally hostile, abusive, dismissive or inappropriately angry
- Does not express anger physically
- Accepts professionally accepted boundaries for patient relationships
- Does not use his/her professional position to engage in romantic or sexual relationships with patients or members of their families.
- Conforms to policies governing behavior such as sexual harassment policy, policy regarding consensual amorous relationship, hazing, use of alcohol, etc.

Recognizing Limits and When to Seek Help
- Appears aware of own inadequacies / correctly estimates own abilities or knowledge with supervision
- Recognizes own limits / when to seek help
Showing Respect for Patient’s Dignity and Rights

- Makes appropriate attempts to establish rapport with patients or families
- Shows sensitivity to the patients’ or families’ feelings, needs, or wishes
- Demonstrates appropriate empathy
- Shows respect for patient autonomy
- Maintains confidentiality of patient information

Displaying Honesty and Integrity

- Does not misrepresent or falsify information and/or actions (i.e. cheating)

Does not engage in other unethical behavior
Drug and Substance Abuse Policy

Impairment of performance by resident/fellow physicians can put patients at risk. Impairment will be managed as a medical/behavioral illness. Implicit in this concept is the existence of criteria permitting diagnosis, opportunity for treatment, and with successful progress toward recovery, the possibility of returning to training in an appropriate capacity. Impairment may result from depression or other behavioral problems, from physical impairment, from medical illness, and from substance abuse and consequent chemical dependency. Untreated or relapsing impairment is not compatible with safe clinical performance. The goals of this policy are:

- To prevent or minimize the occurrence of impairment, including substance abuse, among residents/fellows at the Westchester Medical Center.

- To protect patients from risks associated with care given by an impaired resident/fellow physician.

- To compassionately confront problems of impairment to effect diagnosis, relief from patient care responsibilities if necessary, treatment as indicated, and appropriate rehabilitation.

In achieving these goals, several principles are involved:

- The safety of both the impaired individual and of patients is of prime importance.

- The privacy and dignity of the affected individual should be maintained to the extent possible.

- To the extent that its resources allow, the WMC will help facilitate education, intervention, preliminary assessment, diagnostic evaluation, treatment, and post treatment monitoring.

Diagnosis Of Impairment

The following are signs and symptoms of impairment. Isolated instances of any of these signs and symptoms may not impair ability to perform adequately, but if they are noted on a continued basis or if multiple signs are observed in an individual action may be indicated. Warning signs and symptoms, although certainly not specific to problems of substance abuse, may include:

- Physical signs such as fatigue, deterioration in personal hygiene and appearance, multiple physical complaints, accidents, eating disorders.

- Disturbances in family stability.

- Social changes such as withdrawal from outside activities, isolation from peers, embarrassing or inappropriate behavior at professional and social gatherings/events, adverse interactions with police, driving while intoxicated, undependability and unpredictability, aggressive behavior, and argumentativeness.
• Professional behavior patterns such as unexplained absences, spending excessive time at the hospital, tardiness, decreasing quality or interest in work, inappropriate orders, behavioral changes, altered interaction with other staff, and inadequate professional performance.

• Behavioral signs such as mood changes, depression, slowness, lapses of attention, chronic exhaustion, risk taking behavior, excessive cheerfulness, and flat affect.

• Drug use indicators such as excessive agitation or edginess, dilated or pinpoint pupils, self-medication with psychotropic drugs, stereotypical behavior, alcohol on breath at work, uncontrolled drinking at social events, blackouts, binge drinking, and changes in attire (e.g. wearing of long sleeve garments by parenteral drug users).

Policy Implementation

**Education:** To try to minimize the incidence of impairment a program will be developed to educate residents/fellows about physician impairment, including problems of substance abuse, its incidence and nature and risks both to the involved individuals and patients. Education will include knowledge concerning signs and symptoms of impairment, emphasizing detection of abnormal behavior associated with use of psychoactive drugs and alcohol abuse.

**Counseling:** To the extent that its resources allow, the Westchester Medical Center Program will provide individual counseling both to supervisors and to individuals in need. Confidentiality will be preserved to the extent possible.

**Assessment:** Evaluation of impairment status: For both new residents/fellows with a history of impairment and current residents/fellows who experience impairment and/or for whom evidence of substance abuse exists, evaluation will be performed under the auspices of the Physicians' Assistance Committee on an ad-hoc basis by the Chairman of Medicine and in consultation with the appropriate Division Chiefs.

**Management:** Each residency/fellowship Program Director, after consultation with appropriate resources, will be responsible for certifying the functional status of all residents/fellows and for judging whether functional impairment exists in an individual. When an individual with impairment is identified, the residency/fellowship Program Director will report this information immediately to the Department Chair.

Each resident/fellow, as a condition of appointment, agrees to accept the residency/fellowship Program Director's and Department Chair's decision regarding his/her impairment status and practice/training privileges. Should the residency/fellowship Program Director and/or the Medical Director conclude, after consultation with the Physicians Assistance Committee at WMC or other appropriate individuals, that a member of the residency and/or fellowship training program is suffering from impairment, including substance abuse, he/she may immediately take appropriate action, which may include placing that person on a medical leave of absence with or without suspension from the training program. Suspension from the training program is to be considered if impairment may adversely affect patient care.

Return from leave for impairment shall be based upon written re-entry policies that include understandings with the residency/fellowship training program and the Department of Medicine. Any return from leave shall be based on a complete review of the individual's medical history from all sources, including, but not limited to records of any impairment treatment program and may include an evaluation performed by a person selected by the School of Medicine.
A decision regarding the return of an impaired resident/fellow will be based on paramount concerns for patient safety, potential for relapse, nature of the specialty and any other factors as determined by the School.

**Reporting Process:** All medical personnel possess a duty, in part by ethical concern for the well being of patients and one's fellow professionals and in part as mandated by state law, to report in confidence, concerns about possible impairment both in themselves and in others, to an appropriate supervisor.

If a resident/fellow physician is observed to be impaired/disabled while engaged in the performance of this or her duties, the course of action shall be as follows:

The observer shall report his/her concern immediately to a responsible supervisor, ultimately the residency/fellowship Program Director.

When substance abuse is suspected, the residency/fellowship Program Director shall notify and seek help from the Office of the Dean of Medicine and appropriate Department Chair. The Department of Medicine can ascertain the need for help, facilitate an intervention leading to further professional evaluation and possible inpatient or outpatient treatment.

In consultation, a decision will be made regarding any leave of absence, and suspension from the training program. If a leave of absence is indicated, the resident/fellow will be informed of the effects of that leave of absence upon training. The need for reporting to the State of New York Medical Disciplinary Board the impairment status of the resident/fellow will be evaluated.

Should a resident/fellow about whom concern has been expressed, be determined not to be impaired, mention of the concern shall be removed from his/her records and the individual may be allowed to return to their residency/fellowship program without prejudice.

Appropriate and complete documentation of the events shall be performed.

**Policy Regarding The Use Of Psychoactive Drugs By Physicians**

Use of controlled substances must be by prescription of a physician. Non-medicinal use of controlled substances is illegal. Non-medicinal use of other mind-altering drugs are inappropriate. Discovery of such use will result in evaluation for possible treatment and may be grounds for immediate suspension and ultimate termination.

For the purposes of this policy, use of alcohol during routine working hours, and particularly when one is engaged in patient care, is regarded as inappropriate. When one is "on call," any use of alcohol that either produces or appears to produce (e.g. odor of alcohol on breath) evidence of behavioral impairment is also regarded as inappropriate.

**Sexual Harassment Policy**
Westchester Medical Center is committed to fostering a work environment free of sexual harassment and intimidation where every individual is treated with respect and dignity. In fostering such a work environment, WMC wishes to maintain all of its job sites free of inappropriate or unwelcome conduct of a sexual nature by and/or toward employees, supervisors, patients, visitors, vendors, contractors, volunteers, temporary agency employees, students, interns, physicians, or any other persons. Therefore, WMC will not tolerate or condone any form of sexual harassment or any other abusive conduct or treatment of a sexual nature either at WMC or at outside WMC-sponsored events.

**Definition of Harassment**

Sexual harassment is a form of unlawful discrimination which violates WMC policy. In accordance with the Equal Employment Opportunity Commission’s definition, sexual harassment is defined under this policy as unwelcome sexual advances, request for sexual favors, and other verbal or physical conduct of a sexual nature when:

1. submission to such conduct is made either explicitly or implicitly a term or condition of an individual’s employment;
2. submission to or rejection of such conduct by an individual is used as the basis for an employment decision affecting such individual; or
3. such conduct has the purpose or effect of unreasonably interfering with an individual’s work performance or creating an intimidating, hostile or offensive working environment.

Harassment does not refer to behavior or occasional compliments of a socially acceptable nature. It refers to unwelcome conduct that is offensive, especially where that conduct interferes with effectiveness at work. Sexual harassment may take the form of a demand for sexual favors, but there are other forms of harassment, including but not limited to, unwelcome:

- **Verbal**: sexual advances or propositions, repeated social invitation despite invitee’s expressed lack of interest, sexual innuendoes, suggestive comments, jokes of a sexual nature, sexually vulgar language, derogatory or sexually suggestive epithets, graphic, degrading or condescending comments about an individual’s appearance, dress or anatomy; and
- **Non-verbal**: sexually suggestive objectives or pictures (including, for example, calendars, cartoons, photographs, emails, screen savers, posters or drawings), or obscene gestures; this includes the use of Internet or email to display, and/or transmit any sexually explicit images, messages, slurs, epithets or anything that could be construed as sexually harassing or disparaging to another; leering; and
- **Physical**: unwanted physical conduct such as touching, pinching, kissing, embracing or blocking of normal movement.

Sexual harassment includes harassment between members of the opposite as well as between members of the same sex.

**Obligations Under the Policy**

Every manager/supervisor is responsible for creating and maintaining a work environment that is free from sexual harassment and for taking immediate and appropriate action when necessary. It is the obligation of every employee, volunteer, student, intern and physician who works at WMC to understand this policy and refrain from engaging in any conduct that may constitute sexual harassment. All of these individuals are expected to demonstrate a strong commitment to maintaining a workplace that is free of sexual harassment.

**Who is this Policy Applicable To?**

This policy applies to all employees, members of the medical staff, including but not limited to interns and physicians, students, and volunteers. Appropriate disciplinary actions up to and including termination of
employment or termination of the working or contractual relationship shall be taken against any person found to have violated this policy.

**Procedure**

**Notification**
WMC encourages reports of all perceived incidents of sexual harassment, regardless of who the potential offender might be. Any employee, member of the medical staff, student, volunteer or temporary agency employee who feels he or she has been subject to or witness of any kind of sexual harassment described in this policy should immediately notify his or her supervisor or the Assistant Director of Human Resources in the Department of Human Resources. The Supervisor then shall immediately notify the Assistant Director of Human Resources of the complaint. In the event that the complaint involves the individual’s supervisor, or the individual does not feel comfortable notifying his or her supervisor, he or she should notify the person to whom the individual’s immediate supervisor reports (such as the Department Head) or the Assistant Director of Human Resources.

**Timeliness**
Prompt reporting of perceived incidents of sexual harassment is important to ensure that corrective action may be taken in a timely manner. We urge every individual to act promptly.

**Investigation**
All reports of alleged sexual harassment will be promptly reported to and investigated by the Human Resources Department in a sensitive and discrete manner and will be kept confidential to the extent consistent with the need to fairly investigate and resolve the complaint. An investigation which will include interviews with the individual making the complaint, the accused individual, any witnesses and any other relevant persons, will be conducted promptly. Any individual who fails to cooperate in any such investigation may be subject to disciplinary action. The complainant and the person alleged to have violated the sexual harassment policy will be informed of the results of the investigation.

**Disciplinary Action**
If the investigation reveals that this policy has been violated, prompt disciplinary action designed to immediately stop the harassment and to prevent its recurrence, will be taken, up to and including.

**Harassment by Third Parties**
WMC will not tolerate harassment of its employees, medical staff, students, volunteers or temporary agency employees by visitors, patients, or outside vendors or contractors. In the event a WMC employee, member of medical staff, student, volunteer or temporary employee is subjected to harassment by a visitor, patient or outside vendor or contractor, the individual should immediately report such harassment to his or her supervisor or to the Assistant Director of Human Resources. To the extent of its authority, WMC will take all reasonable steps to ensure that such conduct is not repeated.

**Harassment of Third Parties**
Any temporary agency employee, volunteer, outside vendor, contractor or member of the medical staff, including but not limited to, physicians, interns and students, who work at WMC who believes he or she has been subject to or witnessed any kind of sexual harassment described in this policy should immediately notify the Assistant Director of Human Resources. To the extent of its authority, WMC shall then take prompt, appropriate action in response to the complaint.

**Non-Retaliation**
There will be no adverse employment action taken against any individual for initiating, testifying, assisting or participating in good faith in any manner of proceeding under this policy. However, retaliation against complainants, witnesses or other parties is a serious violation of this policy and should be reported immediately using the above procedures. Any person who is found to have engaged in retaliation in violation of this policy is subject to disciplinary action up to and including termination of employment relationship or working or contractual relationship. WMC shall take all reasonable steps to prevent employees, members of medical staff, students, volunteers and temporary agency employees from retaliation or discrimination for filing a sexual harassment complaint or participating in a sexual harassment investigation. If, however, after investigating a complaint of harassment, WMC determines that the complaint is false or that an individual has knowingly provided false information regarding the complaint, disciplinary action may be taken against the individual who filed the false complaint or gave the false information.

Questions
Questions regarding this policy should be directed to the Assistant Director of Human Resources in the Department of Human Resources at 493-5072.
Remediation And Probation For House Staff Members: Manual Code R - 1

PURPOSE

The Remediation/Probationary process described herein is not intended to be disciplinary in nature, but instead designed to identify deficiencies to the House Staff member with the expectation that such deficiencies will be addressed and corrected. Depending on the circumstances involved, remediation and/or probation may also include a restriction or suspension of clinical privileges, including on a summary basis, or the involuntary non-renewal of a contract. Under such circumstances, this policy will be supplemented by the procedures contained in the Collective Bargaining Agreement between Westchester County Health Care Corporation and the Committee of Interns and Residents/SEIU.

POLICY

It shall be the policy of Westchester Medical Center that a course of remediation and probation should be implemented if, in the discretion of the Hospital’s President and CEO, Program Director or Department Chair, a House Staff member’s performance is below the expected academic level, or whenever the conduct, condition, professional or otherwise, of the House Staff member is considered to be inconsistent with the Hospital's standards of patient care, patient welfare or the objectives of the Hospital, if such conduct or condition reflects adversely on the Hospital or the character or competence of such House Staff member, or results in disruption of Hospital operations. It shall also be the policy of the Medical Center to comply with all ACGME and JCAHO requirements regarding process, including notice and, where appropriate, appeal of any such remediation or probation.

SCOPE

Residents and fellows enrolled in ACGME or ADA accredited or non - accredited graduate education training programs.
Program Directors
Program Coordinator

DEFINITIONS

The following definitions are applicable to this policy:

Remediation: Process followed to correct educational deficiency (ies)

Probation: Process followed when Remediation has not corrected deficiency (ies) or when warranted by circumstances.

House Staff: Residents and fellows enrolled in ACGME or ADA accredited or non - accredited graduate education training programs.

Westchester County Health Care Corporation: All inpatient services, rehabilitation medicine, skilled nursing services and ambulatory care services provided to patients at University Hospital, Maria Fareri Children’s Hospital, Taylor Care Center, Behavioral Health Center and the Department of Corrections.
Committee for Interns and Residents/SEIU: Union which represents Residents and fellows enrolled in ACGME or ADA accredited or non-accredited graduate education training programs at the Westchester County Health Care Corporation

PROCEDURE

As described in more detail below, the time, course and content of the remedial and probationary process must be prescribed in writing by the Program Director or Department Chair and provided to the House Staff member at the commencement of the process and forwarded to the Chair of the Graduate Medical Education (“GME”) Committee.

Remediation

1. Remediation should be considered once a deficiency is identified. Remediation is not reportable to any federal or state agency or to the ACGME. It is the intention of the Medical Center that remediation would not have to be disclosed by the House Staff member or Program Director on any subsequent applications or other requests for academic history. The Program Director, Department Director, or President of the Hospital may skip remediation and take other steps consistent with this policy and/or the Collective Bargaining Agreement should the circumstances warrant. Under such circumstances, the Program Director, Department Director, and/or President are urged to coordinate with the Vice President of Academic Affairs, the Chair of the Hospital’s GME Committee, and the Office of Legal Affairs.

2. Remediation is to be employed as soon as possible after a deficiency is identified. Prior to issuing a letter of remediation, however, the Program Director should investigate and document the reasons for the deficiencies through, when appropriate, chart review, discussions with attendings, peers, and/or nursing.

3. Once the reasons for the deficiencies are properly identified, the Program Director shall issue to the House Staff member a letter advising the House Staff member that he or she is being placed on remediation. The letter shall include: (i) notice that the House Staff member is being placed on non-disciplinary remediation; (ii) the reasons for the remediation; (iii) the expected duration of the remediation, including any interim timelines in which performance will be reviewed during remediation; (iv) a plan of correction for the House Staff member; and (v) the consequences should the House Staff member fail to fully address the deficiencies noted, including the possibility of probation, a requirement that rotations be repeated, delays in graduation, and/or termination from the Program.

4. A copy of this letter shall be placed in the House Staff member’s file and forwarded to the Chair of the Hospital’s GME Committee, the Hospital’s Chief Medical Officer, and Vice President for Academic Affairs.

Probation

1. Probation is to be employed should there be no satisfactory improvement by the House Staff member after receiving a letter of remediation, and/or when circumstances warrant skipping the initial remedial phase. While probation is considered by the Hospital to be non-disciplinary in nature and is therefore not reportable by the hospital to any state or federal licensure agency, certain other entities and/or organizations, including the ACGME may require a House Staff member to disclose the fact that he or she was placed on probation. Accordingly, in order to comply with notions of “due process,” certain enhanced notice and appeal rights are applicable once a House Staff member is placed on probation.
2. Like remediation, prior to issuing a letter of probation, the Program Director should investigate and document the reasons for the deficiencies through, when appropriate, chart review, discussions with attendings, peers, and/or nursing.

3. Once the reasons for the deficiencies are properly identified, the Program Director shall coordinate with the Office of Graduate Medical Education and the Office of Legal Affairs to draft a letter to the House Staff member, advising the House Staff member of that he or she is being placed on probation. The letter shall include: (i) notice that the House Staff member is being placed on non-disciplinary probation; (ii) the reasons for the probation; (iii) the expected duration of the probation (which may be much more abbreviated than the remediation, including any interim timelines in which performance will be reviewed during probation; (iv) a plan of correction for the House Staff member; and (v) the consequences should the House Staff member fail to fully address the deficiencies noted, including a requirement that rotations be repeated, delays in graduation, and/or termination from the Program.
4. Once drafted, the Program Director shall ensure that a copy of the letter of probation is mailed by certified mail to the House Staff member as soon as may be practicable under the circumstances and will also schedule a meeting to discuss the terms of probation with the House Staff member as soon as practical. At the same time, the affected House Staff member shall be advised of his or her right to request that a Graduate Medical Education Review Committee be formed to review the probation and the reasons therefore. Such request must be made in writing to the Chair of the Graduate Medical Education Committee within (5) days after the Graduate Staff member’s receipt of the notice. Upon such request, the Chair of the Graduate Medical Education Committee will appoint a Graduate Medical Education Review Committee to hear the House Staff member’s request for a review of the probation.

5. A copy of this letter shall be placed in the House Staff member’s file and forwarded to the Chair of the Hospital’s GME Committee, Vice President for Academic Affairs and DIO.

**Graduate Medical Education Review Committee**

1. If requested, a Graduate Medical Education Review Committee (GMERC) shall be appointed by the Chair of the Graduate Medical Education Committee to review the probation imposed on a House Staff member. The GMERC shall consist of (i) another Program Director, who shall Chair this Committee, (ii) an Attending physician not a member of the Department to which the House Staff member is assigned, and (iii) a member of the House Staff from another discipline. The failure of the House Staff member who was placed on probation to appear shall be deemed a waiver of any right to challenge the probation. A record of the Committee meeting shall be made by such method as shall be determined by the Chair of the GMERC. The meeting shall not be considered to be a formal hearing and therefore shall not be subject to any formal rules of evidence or procedure. The introduction of any relevant information shall be determined by the Chair. In order to reverse the decision to place the House Staff member on probation, the House Staff member shall have the obligation to persuade the Committee that probation lacks any factual basis or that is either arbitrary, unreasonable or not in compliance with applicable law.

2. Within ten (10) days after the meeting, the GMERC shall submit a written decision which may accept, reject or modify the terms of probation along with a statement of the reasons therefore to the Chair of the GME Committee. The Chair of GME will distribute copies of the GMERC’s decision to House Staff member, the Department Chair, Vice President for Academic Affairs and DIO.
Appeal

1. Should the GMERC uphold the terms of probation, the House Staff member may request an appeal of the matter before the Vice President of Academic Affairs. The request must be in writing and made within five (5) days of the House Staff member’s receipt of the decision of the GMERC. Upon receipt of the request for an appeal, the Vice President of Academic Affairs will review the House Staff member’s record, the basis of the probation, and the GMERC’s decision. The Vice President of Academic Affairs may request and consider any additional information he or she deems necessary. Upon completion of his or her review, the Vice President of Academic Affairs will notify the Chairman of Hospital’s GME Committee, House Staff member, the Program Director, the Department Chair and the DIO of his or her decision in writing.

2. The decision of the Vice President of Academic Affairs will be final and binding upon all parties. Failure by the House Staff member to make a request for an appeal within the time frame set forth in the above paragraph will be deemed to be a waiver by the House Staff member of any further appeal of this matter, and the decision of the GMERC shall be deemed conclusive and final.

Approved by:

__________________________  __________  
Chief Medical Officer                   Date

__________________________  __________  
Vice President                               Date
Clinical and Academic Affairs

__________________________  __________  
Chair            Date
WMC GME Committee
New York Medical College

Professional Conduct in the Student-Student and Teacher-Student Relationships Policy

New York Medical College is dedicated to high standards of education and a respect for the dignity and a respect for the dignity of the individual. The College is concerned about preventing faculty-student, resident-student or student-student relationships that are perceived as injurious to the mental or physical well-being or academic freedom of any of its students. The College is committed to the principle that students and teachers have a duty to respect each other and promote a professional environment in which the educational, research and clinical missions of the university are pursued. This policy has been developed to define the standards of conduct in teacher-student and student-student relationships at New York Medical College, specify mechanisms for the prompt handling of complaints, and provide for education methods aimed at preventing student mistreatment and abuse.

General Principles
• Treat others with the same respect and dignity you would with them to show you. This includes patients, colleagues, students, teachers and other health professionals.
• Do not harass others physically, sexually, verbally or psychologically.
• Do not discriminate on the basis of sex, race, religion, age, national origin, marital or veteran status, disability or sexual orientation.
• Be truthful and honest in all communication. Acknowledge errors of omission and commission with colleagues and patients. Do not take credit for or plagiarize others work.
• Do not use offensive language. Do not belittle patients, students or colleagues in any way, either in or out of their presence.
• Be aware of personal limitations and areas in which you lack knowledge. Know when to ask for and whom to go to for help. Know when and for whom appropriate supervision is necessary.
• Maintain a high level of confidentiality on matters relating to colleagues, students and patients. Know when, where and to whom such matters should be discussed.

Student Mistreatment
The following guidelines have been established to prevent student mistreatment:
• Treat others with the same respect and dignity you would with them to show you. This includes colleagues, students, teachers and other health professionals.
• Do not belittle students or colleagues in any way, either in or out of their presence.
• Students should not be required or asked to perform personal services for their supervisors. Examples of inappropriate requests include baby-sitting, shopping, providing transportation, and buying lunch/coffee.
• Students should not be threatened in any way or emotionally or physically harmed.

Sexual Harassment
Sexual harassment in any form is unacceptable.
• The New York Medical College Policy Statement on Sexual Harassment states “sexual harassment includes unwelcome sexual advances, requests for sexual favors and other physical, verbal or visual conduct based on sex. This would include explicit sexual propositions, sexual innuendoes, suggestive comments, sexually oriented practical jokes or obscene language or gestures.”
• Sexual relationships between teachers and students, even when consensual, are always inappropriate due to the disparity of power and control in the relationship. If both parties involved intend to continue their relationship, the supervisory role must be terminated immediately. This is important because such conduct may interfere with the academic environment.

**Other Forms of Harassment**
No student should be treated differently or discriminated against based on race, religion, age, national origin, marital or veteran status or sexual orientation.

**Reporting**
Any student who believes that he or she has been the victim of harassment or abuse is encouraged to avail him/herself to the procedures available for resolution of this issue. Every effort will be made to resolve the complaint using the informal procedures already in place.

**Procedures**
A student who believes he/she has been the victim of harassment or abuse should:

1. Contact either the Vice Dean for Academic Affairs of the School of Medicine and Vice Provost for University Affairs (914-594-4500), the Vice Dean of the Graduate School of Health Sciences (914-594-4531), the Dean of the Graduate School of Basic Medical Sciences (914-594-4109), or an associate dean for student affairs, to discuss in confidence, the occurrence of possible abusive behavior on campus or at an affiliated facility.

   If the complaint does not appear to involve harassment or abuse, and the student and the dean agree that the matter would be more appropriately handled through another process, this will be initiated. If there appears to be student abuse or harassment, an investigation will be initiated. Following a complete investigation by one of the representatives identified in the College’s Harassment Policy, the complaint will be reported to the Dean of the School in which the student is enrolled who will make every effort to resolve the matter in an informal, confidential and expeditious manner within 30 days. The resolution of the matter will be reported to the student. If the complaint is of a statutory nature (i.e. involves sexual harassment, discrimination or harassment based on race, religion, ethnicity, gender, sexual orientation, physical handicap or age), it will also be forwarded by the Dean’s Office to the Office of the General Counsel of the College.

2. In the event that the informal resolution cannot be achieved, the matter will be taken under consideration by an ad hoc Academic Committee on harassment. This Committee will meet with the parties involved to determine whether further action should be taken. The Committee will make its recommendations for resolution to the Office of the Dean who will make the final decision.

The fact, nature, or resolution of a student complaint will not be recorded in the student’s record, will not serve as a basis for grades or recommendations and will not be transmitted in the Dean’s letter or any other form of student evaluation.

**Committees**
1. The ad hoc Academic Committee on harassment will be composed of three members: a student member of the school involved selected by the Student Senate of the School of Medicine, the Student Advisory Council of the Graduate School of Health Sciences, or the Graduate Student Association of the Graduate School of Basic Medical Sciences; a faculty member selected by the Faculty Senate of the School of Medicine, the Graduate Faculty Council of the Graduate School of Basic Medical Sciences, or the
Academic Policy Committee of the Graduate School of Health Sciences; and a senior member of the Administration appointed by the President and not previously involved in the attempted resolution. This Committee looks into complaints brought by any of the involved parties who feel that resolution through informal method has been unsatisfactory and determines whether further action should be pursued.

2. In addition to the Academic Committee on Harassment, there is an oversight committee to monitor and recommend changes in the established harassment policy and procedures by reviewing complaint activity that occurred during the preceding year.

This oversight function is performed by a special subcommittee of the existing Student-Faculty Relations Committee. It is composed of a senior member of the College Administration, a faculty member, and a student member. This subcommittee meets annually; reports on complaint activity are forwarded to this subcommittee by the Dean’s Office on a quarterly basis.

**Education**

The College acknowledges that the most important component of this policy is education of the members of the university community concerning issues of student mistreatment and abuse. Therefore, it widely publicizes the policy and procedures for dealing with student harassment or abuse to all segments of the College community. The policy and procedures and presented to students at their orientations and are incorporated into the Student Handbook, the Faculty Handbook and is on the College website.

**Pearls**

**Case Presentation** – Know at least the history by heart, if not the whole case. Have a differential diagnosis and reasonable work up ready for the presentation to show you are not just gathering data, but that you are thinking. Also, be able to summarize the case in a few sentences as many attendings want you to do this before discussing the differential diagnosis and work up. You will only get good at this with much practice so push your resident and attending to let you present as frequently as possible.

**Daily Labs** – Labs on patients should be drawn or ordered before noon. Please note that not all patients need labs everyday, and even those that do, do not need every lab every day. This should be discussed with your Resident.

**Coordinating Care with Other Health Care Workers** – Speak to the social workers early on in the course of the hospitalization to start discharge planning early. If the patient was just admitted and you know they will be in house for 2-3 days and then need rehab or a nursing home etc. tell them that the first day so that the planning can already begin and by the time of discharge be ready. Keep the nurses informed of what is going on with your patients, often as you tell them your plans for the patient they will tell you several reasons you did not know about as to why there is a problem with it. Tell the attending when something major happens. Always sign out to on-call colleagues any active issues.

**Prioritizing Sign Out List** – Use the ‘box and fill in’ method every morning. The note is least important (except service cases), so pay attention to the sickest patients early on, not the patient that is most convenient to look after next. **Do not sign out stat tests, including ABGs.** If the patient needs a stat CBC, draw it, bring it to the lab and wait for the results. That is not a circumstance to sign out the CBC just because it is sign out time. **Do not sign out test results to be followed up whose results will not impact the care that**
night. If you are waiting for a bone scan but will be continuing the same management whether it shows osteomyelitis or not, then check it the next day don’t sign it out to night float. Remember, eventually you will be night float and won’t want to be given extra unnecessary work that night too. You should have a blurb on each patient written out for the night float intern even if there is nothing to do on the patient that night

**Identifying Adverse Drug Reactions/ Interactions** – Whenever a problem with a patient comes up in house consider what drugs have been started (ex: stopping amiodarone while on coumadin and the INR goes through the roof). Also call the pharmacy department (x7207) if you need to have something specific looked up, use them as a resource. Epocrates and other similar PDA applications are useful for drug information. Epocrates has a multi-check function where it will check for reactions between as many drugs as you enter. This works even if you have the free version. Epocrates also has a non-exhaustive list of adverse drug reactions – the most common ones and the most severe ones. If you do not know how to download this program and use it on your PDA, ask one of the attendings or housestaff as many know how. If you do not have a PDA yet, buy one. They are cheap and very worth it! CIR will refund up to $500 for medicine related materials.

**Ethics of Informed Consent** – You must review with the patient the risks, benefits and alternatives of any procedure (or even medications you will give them). Blood transfusion is the typical example. I tell patients that the benefits are things like less chance of MI, CVA etc. which can happen when the blood count goes too low. I tell them that one of the main two risks are adverse reactions to the blood itself and we minimize this by doing a T+C and by having the nurses check the blood carefully before administering it. The other is infections which are now staggeringly rare (I actually tell them the statistics: HIV 1 in 1million, Hep B about 1 in 100,000 – by now these are probably even less). I tell them the alternative is to not give blood and see what happens which in some cases is very risky. With this technique I have always gotten consent for a transfusion. **If you do not know the risks, benefits and alternatives of what you are suggesting then you should not be getting the informed consent. DO NOT sign out consents/HCP forms/DNR forms to be done. Do them yourself. You know the patient best.**

**Using Electronic Databases** – Learn to use a Personal Digital Assistant with a drug information program (ex: Epocrates). I commented on Epocrates more extensively two paragraphs above. The PDA is also useful as a tool for textbook style medical information. There are many textbooks available for 40-70$ for the PDA that are easy to search and can be downloaded from the web. The NYMC library has a PDA text called DynaMed available for free to us if you go there and sign up. The hospital is in the process of getting Up-To-Date at every computer terminal for the entire hospital. NYMC library is also available from any terminal with your password and it contains many excellent reference tools including many full text articles.

**Assessing Patient Decision Making Capacity** – Can the patient understand the severity of the illness and the risks, benefits and alternatives to the treatment being offered? If they can, even if they are demented in other ways, then they have capacity to make that decision. You can only decide this by taking the time to probe with questions aimed at ascertaining their understanding of what is going on.

**Pharmacokinetics of Common Medications** – Learn the basics of Coumadin loading (generally 5mg the first two nights then alter per INR) and other commonly used medicines. Consider all other medications you are using when you use coumadin as many interact and can increase or decrease its effect on the INR. Other commonly used drugs with subtlety to their pharmacokinetics include: Dillantin, Digoxin, Amiodarone, and Carbamazepine. For any drug listed in this paragraph consider running a multi-check on your Epocrates or other software before adding medication to a regimen to find interactions.
**Literature Appraisal Skills** – Learn by looking up articles on questions that come up in rounds and review the articles with housestaff and attendings. JAMA does have a series of articles on how to appraise the medical literature so if you are looking up an article on the usefulness of a diagnostic test for your patient you can look for the JAMA article on appraising an article on diagnostic tests and read that too. Most doctors read the abstract and nothing more, but to really know if the article has any quality or usefulness you should spend some time on the methods section seeing how the study was done and on what population etc.

**Grief Management/ Delivering Bad News** – Mostly you will be watching people more senior than yourself break bad news to patients or family members. You should try to find people with excellent interpersonal skills to learn from. This is best taught by observation. Bring the family to a quiet area (family lounge) and start by finding out how much they know or understand about what is going on. Then, without using doctor terms, explain very honestly what happened and what the outcome was in a sympathetic tone. Be prepared to stay for questions for a good ½ hour at times.

**Composing Discharge Summaries** – Discharge summaries should be written part by part each day in the discharge management part of A2K. This should be done as if you were presenting the case to the attending for the H&P. Then summarize the hospital course and outcome. Lastly, add the discharge disposition and medications. Discharge summaries must be reviewed and submitted on the day of discharge-this is not negotiable. Charts become delinquent if discharge summaries are not completed within 2 weeks of the patients discharge; there will be consequences if this happens.

**Communicating with Difficult Patients** – Learn to speak calmly with the difficult patient and find out what has upset them before trying to give or get other information. Sometimes just sympathizing with their past troubles that have made them mad, can get you the leeway you need to do your job effectively. This is also something learned best by watching someone with excellent interpersonal skills. Do not stand over them when they are in a chair or bed and are angry. Come down to meet their eyes by also sitting. Say straight out, “I can see that you’re angry.” This alone can go along way to validating their feelings and making them see you are on their side not against them. Be willing to sit with them for 10-20 minutes to fully hear them out if you want to get anywhere in the therapeutic relationship. (This stuff really works. I use this most weekends I’m on call with at least one patient.)

**Assessing Suicide Risk** – Always ask depressed patients if they are suicidal or homicidal. If they are, try to get some idea if they have a plan. Ask if they have what they need for the plan around the house/hospital (a pt that says they want to kill themselves with a gun but tells you they have no gun and do not even know where to get one is at less risk than the one that says they want to kill themselves by jumping from the roof when they live on the 33rd floor). Do not allow a patient who is genuinely suicidal or homicidal to leave the hospital even if they want to. You are allowed to forcibly keep them at the hospital. Call psychiatry for some help if it comes to this.

**Dealing with Emotional Abuse from Patients or Colleagues** – You should not have to. Don’t be afraid to tell the person that you feel their comments or actions are inappropriate and don’t be afraid to tell the Chief Residents or Program Director. If it is a patient verbally abusing you, resist the urge to “fire back” and remember that you are a professional. If you feel that a patient may assault you, bring a security guard in the room with you.

**Ethics of Withdrawal/ Withholding of Care and Interpreting Advance Directives** – A difficult topic for all physicians, not just interns. In general, make sure the Next-of-Kin or Health Care Proxy knows what the *patient* would have wanted not just what they think is best for the patient (or if there is a Living Will, though not a legal document in NY, it can be used to decide what the patient wanted). If you as the doctor deem a
treatment futile, you do not have to offer it or do it just because the patient or patients’ family request it. Please do not make these decisions without consulting with your resident and/or attending.

**Discussing Advance Directives with Patients** – You should at least learn how to initiate the conversation with a sick patient whom you do not believe will need to be coded but should have their DNR paper signed just in case. Tell them that you need to talk about a difficult topic that most patients do not like to discuss. Explain that while you do not think it will come to it, you would rather know what the patient wants if their heart should stop or their blood pressure should become undetectable. Ask specifically if they want intubation, shocking, IV pressors etc. Then explain that if they want what they have just told you to actually happen in that scenario, they need to sign the DNR/ DNI with those specifications. Most patients will be happy you cared enough about their opinions to ask.

**Requesting Autopsies** – After discussing what happened with the family and conveying your condolences gently bring up that doctors like to learn from what happened and that it is standard to request an autopsy from the family. Explain that the face is not touched so an open casket can still occur and if they do not agree they can also be told that a limited autopsy can be requested (whatever organs or areas the family will allow). If this is an ME case (medical examiner) tell the family that you have to let the ME decide first if the case will be accepted, and if they decline only then it is the family’s decision. Cases to report to the ME are patients that die within 1 day of coming into the hospital, patients that die in close proximity to a procedure, patients that are very young, patients that die of unknown causes etc.

**Scenario Pearls**

Material regarding management of various scenarios that you may want to read over can be found in handheld books such as: Washington Manual, Scut Monkey, Ferri etc.

**Respiratory Distress** – Get a Pulse oximetry and ABG early. Add O₂ NC or VentiMask rapidly as needed. It is better to intubate early and extubate if you overshot than intubate too late and the patient codes. Consider CXR, EKG and cardiac enzymes. Never forget PE as a possibility. Remember, oxygen is a support measure. You need to evaluate the patient for a cause of respiratory distress.

**Chest Pain** – Do the EKG stat yourself. Give the patient 325mg of non-coated ASA to chew stat if the pain is cardiac related. Inform your resident early on, not 20 minutes into the patient’s MI. Also consider aortic dissection, PE, esophageal spasm, pneumothorax, costochondritis, and GERD. Be careful with ASA or anticoagulants in liver/oncology patients with low platelets or abnormal coags.

**Altered Mental Status** – Many elderly patients get delirious when put in the hospital (and especially at night). Think about what drugs you gave them that could cause delirium. Consider whether the patient is now septic, hypoxic or hypoglycemic. Think about CVA…but not everyone needs a head CT. Consider an ABG.

**GI Bleed** – Check Hgb repeatedly (on a brisk bleeder even as quickly as q1hour if needed). Send a T+C early and put units on hold. Do not wait for a drop in hematocrit for a patient who is actively bleeding. If it’s pouring out, pour it in (even 2 units at once if needed with you squeezing them in with both hands). Keep way ahead with the rapid bleeder and call GI or interventional radiology early on with rapid GI bleeding. If it looks like a serious bleed, talk to your resident about getting the patient to the ICU.
Fever – Never forget drugs can cause fever. Keep acalculous cholecystitis in the back of your head in the unconscious pt with fever (ICU). If you are thinking of doing blood cultures, do 2 sets (one set of two bottles from each arm, at least 5cc per bottle). In the elderly a mild fever of hypothermia may be the only sign of cystitis, pyelonephritis, pancreatitis, pneumonia, endocarditis etc. Oncology patients must ALWAYS get blood cultures for a fever. In general, a fever work up must include, blood cultures, UA, CXR to start with, unless you already have a source.

Acute Pulmonary Edema – Besides treating with diuretics and nitro preparations, always check if it was precipitated by an ischemic event, dietary indiscretion, or medication lapse. Check an EKG and cardiac enzymes.

Hypokalemia/ Hyperkalemia – Besides replacing K or bringing K down with kayexalate/ Ca/ Glucose/ Insulin, consider why it changed in the first place so it won’t happen again. The most common cause of hypokalemia that I see on the floors is that IVF is given with no K in it and the patient gets diluted down. Unless contraindicated give your NS or 1/2NS etc. with 10-20meQ/L right from the get-go so you will not be playing catch up the whole admission. Do not forget to re-evaluate IVF on your patients daily.

Abdominal Pain – First decide if it is an acute abdomen by physical exam. CXR not AXR is used to rule out free air. LFT, amylase and lipase are useful. Impacted stool and simple gas distention can hurt!

Severe Hypertension – You can give the patient an extra dose of whatever meds they are already on (or give the next dose early), or give clonidine by mouth or patch, labetalol by mouth or IV. Consider a drip (cardizem, labetalol etc.) if it is hard to control at first and you can then transfer it over to PO later.

Shock – Think fluids and pressors quickly. Neo-sympathomimetics only acts peripherally to increase blood pressure while dopamine will also raise the HR. Levophed will have inotropic activity as well. Think NS not ½ NS, and give liters if needed. Vasopressors without adequate IVF can be very deleterious.

Inpatient Glycemic Control – Recent studies are showing that ICU patients do better when tight glycemic control is attempted, as opposed to the regular sliding scale that everyone writes and then pays no attention unless the FS is > 400. Pay some attention when writing your daily note in the ICU and floors and increase the insulin coverage or baseline dosage if the control is not tight enough.

ARF – Quickly check reversible causes with an US of the kidneys and bladder. Ask if the patient has taken any NSAID’s as these can cause interstitial nephritis. Check the BUN:Cr ratio to see if it is >=20:1 (pre-renal). Check the spot urine for sodium and osmolarity, and calculate the FeNa (Una x Pcr)/(Ucr x Pna) to see if it is pre-renal (<1). Check urine eosinophils to r/o drug induced AIN (not always reliable though). Monitor K levels. Get the renal team involved early as the pt may need dialysis.

Arrhythmias – If the patient is unstable, just shock them out of whatever they are in. If they are stable, even if it is VT you do not have to shock them. Do a rapid EKG. Get the cardiac fellow if you think they need a temporary pacemaker. Think adenosine 6mg (then 12mg) if you want to help define an SVT while the EKG machine is running. Check if the patient is on digoxin as it can cause many different arrhythmias. Remember, for sinus tachycardia, you must treat the cause.

Anaphylaxis – Epinephrine, Epinephrine, Epinephrine. 1:1000 0.3cc SQ then get IV and airway then epinephrine 1:10,000 3-5cc IV and repeat if needed then saline/plasma rapidly then norepinephrine if needed.
Alcohol Withdrawal – If the pt has no sx they do not have to be put on a benzodiazepine taper. If they are high risk or are starting to have sx then start the taper.

Seizure – If the seizure does not break on its own rapidly: 1. screen for low glucose, Na, O2, check anticonvulsant levels, drug/alcohol screen, 2. Give glucose load, 3. Lorazepam 0.1mg/kg load at up to 2mg/min. Intubate, 4. Fosphenytoin/ Phenytoin 20mg/kg at 150 or 50mg/min respectively, add 5-10mg/kg fosphenytoin if sz persist, watch for hypotension and cardiac conduction abnormalities, check lab results, 5. Phenobarbital 20mg/kg at 100mg/min add 10mg/kg if needed (or: midzolam 0.2mg/kg at 4mg/min., propofol 1-2mg/kg load, pentobarbital 10-15mg/kg at 50mg/kg.), 6. Isoflurane, Get Neurology help! (#0681)

Procedure Pearls

Venipuncture – The patient will have less pain with rapid motion through the skin (it takes practice not to break the vein with rapid motion though). Apply a tourniquet. Use the tap and rub with alcohol to pop up the veins while the patient clenches the fist. Only use as much blood as needed (1cc for CBC, full tube for PT/PTT, 4-5 cc for Chemistry) as we tend to over-phlebotomize in general (and then initiate unnecessary work-ups when we wonder why they are anemic!). DO NOT FORGET to remove the tourniquet when you are done with an attempt or a blood draw.

Arterial Puncture – Tape the thumb down in external rotation if the patient will not hold still (use this in difficult venipuncture situations as well). Visualize where the artery is running as you feel the pulse, then go right where you see it in your mind and feel it with your finger. Hold pressure for more than a minute after removing the needle.

IV Placement – Use a 20 gauge or lower unless you have a hard time with the veins as a 22 is small enough that flow is slow. Carry a “24 special” (24 gauge IV) for nighttime difficult spots as a temporizing measure. Try not to use the antecubital fossa as patients bend their arms back and forth during the day and occlude it frequently. Get everything ready before starting, including heplock, flush, tape, band-aid etc. Use gloves.

NGT Placement – Ice the NGT and put lubricant on it. Curve the tip of the NGT. Have the patient sit forward, chin to chest and swallow (you can have them use a cup with a straw) as you insert the NGT. Listen for the whoosh of air in the epigastrium after placement, and if uncertain get a CXR to check placement before using.
Appendix A - Instructions for WMC Dictation of Discharge Summary

Please complete in the following order and by entering the noted types of information in the appropriate areas:

GENERAL INFORMATION
- PATIENT FIRST AND LAST NAME, AND MR NUMBER
- DATES OF ADMISSION AND DISCHARGE
- NAME OF ATTENDING (of record)
- NAME & TITLE OF PERSON DICTATING
- NAME & TITLE OF SUPERVISING RESIDENT
- NAME, PHONE NUMBER, ADDRESS OF PRIMARY CARE PROVIDER
- NAME & PHONE NUMBER OF FAMILY/SURROGATE: (guardian, next of kin, HCP)
- PRIMARY DIAGNOSES (one or more reasons the patient required admission)

PRESENTATION AT THE TIME OF ADMISSION
- CHIEF COMPLAINT
- HISTORY OF PRESENT ILLNESS
- PAST MEDICAL HISTORY with Pertinent Review of Systems
- PAST SURGICAL HISTORY
- HOME MEDICATIONS (Name, dose, route, frequency with recent changes)
- ALLERGIES (include type of reaction)
- MEDICATION INTOLERANCE(S) (include type of reaction)
- SOCIAL HISTORY
- FAMILY HISTORY
- ADMISSION PHYSICAL EXAM (brief, focused, pertinent; note LINES, PORT, PEG, FOLEY, AICD/PACEMAKER, TRACH, DIALYSIS ACCESS, ULCERS)
  - VITAL SIGNS
  - GENERAL
  - HEAD/NECK
  - NODES
  - LUNGS: HEART
  - ABDOMEN
  - EXTREMITIES
  - NEURO
  - SKIN
- PERTINENT ADMISSION LABS & DIAGNOSTIC TESTS

HOSPITAL COURSE (ORGANIZED BY PRIMARY DIAGNOSES)
- CONSULTING SERVICES/MD's AND RECOMMENDATIONS (include ancillary: nutrition & therapies)
- TREATMENT RENDERED
- MEDICATION CHANGES
• PROCEDURES AND RESULTS (key surgical, invasive diagnostic, pathology)
• PERTINENT LAB & TEST RESULTS (changes since admission)
• CHANGE IN CODE STATUS
• COMPLICATIONS (eg - falls, med errors, adverse drug effect, pnx, new onset afib, CP arrest, cellulitis, delirium, DVT, ileus, UTI, hypotension, ATN, post op bleed)

DISCHARGE STATUS
• DISPOSITION: (Discharged to: home, long term care facility, short term rehab)
• CONDITION AT DISCHARGE (overall) (Stable, Guarded, Serious, Critical)
• COGNITIVE FUNCTION AT DISCHARGE (no cognitive deficits noted, confused, delirious, returned to cognitive baseline, cannot follow commands, aphasia, hemiparesis, apraxia)
• TRANSFER METHODS/MOBILITY AIDS (walks unassisted, ambulates with walker, bed bound)
• ACTIVITIES OF DAILY LIVING ABILITIES (ability to eat, bathe, dress, and use toilet on one’s own)
• FALL RISK (low fall risk, high fall risk, history of falls)
• CODE STATUS/ADVANCED DIRECTIVES (full code, DNR, DNI, comfort care only)
• COMMUNICATION OF PROGNOSIS (patient/family is aware of prognosis/diagnosis)

FUTURE PLAN OF CARE
• FOLLOW-UP POST DISCHARGE
  o MD follow-up’s (date and time frame, ph # for appt.)
  o COMMUNICATION WITH PCP (date and method of communication of patient information or handoff with PCP)
  o Pending studies & lab results (imaging, echo, cultures, pathology, cytology, samples sent to reference labs, etc)
• DISCHARGE MEDICATIONS (dose, route, frequency; Oxygen)
• ANTICOAGULATION
  o Agent(s) used, dose, indication
  o Target INR, Last 3 INR’s
  o Anticipated duration
  o Follow up plan (responsible MD or clinic and lab follow up)
• DISCHARGE INSTRUCTIONS
  o THERAPY ORDERS (no therapy orders, PT, OT, Nursing, Wound Care/Suture Removal)
  o DIET (general, ADA, renal, dysphagia, NCS)
  o ACTIVITY (as tolerated, bed rest)
  o PATIENT EDUCATION (Summarize all patient education given by MD, nursing, nutritional counseling service and others)
• ANTICIPATED PROBLEMS and suggested interventions; include consultants recommendations

• INFORMATION TO CONTACT WMC
  o MAIN HOSPITAL (914) 493-7000, MEDICAL RECORDS (914) 493-7600
  o NAME OF RESPONSIBLE INTERN, RESIDENT, ATTENDING OF RECORD
  o MEDICAL ATTENDING (914) 493-8370

DATE OF DICTATION:
DICTATION JOB #: 

77