



**The University of Tennessee College of Medicine Chattanooga  
Obstetrics and Gynecology Residency Program**

# **2011-2012 Residency Manual**





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**OB-GYN RESIDENCY TRAINING PROGRAM**  
**Resident Handbook**  
**2011-2012**

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## Overview

Our University of Tennessee College of Medicine Chattanooga Obstetrics and Gynecology Residency is a four-year program, beginning at the PGY-1 Level, with four positions at each level.

## Goals and Objectives

Our residency program in obstetrics-gynecology is a structured educational experience, planned in continuity with undergraduate and continuing medical education, in the health care area encompassed by the specialty of women's healthcare. Although our residency program contains a patient-service component as a necessary element of training, it is designed to provide education as its first priority and not to function primarily to provide hospital service.

The goal of our educational program in obstetrics-gynecology is to assist our resident physicians to achieve the knowledge, skills, and attitudes essential to the practice of obstetrics and gynecology and the development of competence in the provision of ambulatory primary health care for women. The program design includes increasing responsibility, appropriate supervision, formal instruction, critical evaluation, and counseling for our residents.

The educational objectives for our program and curriculum are based on the educational objectives established by the Council on Resident Education in Obstetrics and Gynecology (CREOG). This information is available via the ACOG website at [https://www.acog.org/member\\_access/misc/creogeducationalobjectives.pdf](https://www.acog.org/member_access/misc/creogeducationalobjectives.pdf).

## Address

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Erlanger Medical Mall  
979 E. Third Street; Suite C-720  
Chattanooga, TN 37403  
Phone: 423-778-7515  
Fax: 423-267-6244  
Website: [www.utcomchatt.org/obgyn](http://www.utcomchatt.org/obgyn)

## Administrative structure

Chair and Program Director	• Paul G Stumpf MD
Assistant Program Directors	• Jeanie Dassow MD
	• Stephen DePasquale MD
	• Garret Lam MD
	• Gary Mills MD
Residency Coordinator	• Donna Gibson
General Obstetrics and Gynecology	• William Gist MD
General Obstetrics and Gynecology	• Enrique Ordonez MD



- |                                       |                         |
|---------------------------------------|-------------------------|
| General Obstetrics and Gynecology     | • Shevonda Sherrow MD   |
| General Obstetrics and Gynecology     | • Michael Sprague MD    |
| Ambulatory Obstetrics and             | • Jeanie Dassow MD      |
| Gynecology and Clerkship Director     |                         |
| Director of Gynecologic Oncology      | • Stephen DePasquale MD |
| Gynecologic Oncologist                | • Donald Chamberlain MD |
| Director of Gynecology service        | • Michael Sprague MD    |
| Vice Chair and Director of Maternal-  | • David Adair MD        |
| Fetal Medicine                        |                         |
| Perinatologist                        | • Garret Lam MD         |
| Perinatologist                        | • Joseph Kipikasa MD    |
| Perinatologist                        | • William Roberts MD    |
| Perinatologist                        | • Sunanda Sadanandan DO |
| Perinatologist                        | • Carlos Torres, MD     |
| Director of Reproductive              | • Barry Donesky MD      |
| Endocrinology                         |                         |
| Reproductive Endocrinologist          | • Joseph Bird MD        |
| Director of Resident Research Project | • Michael Sprague MD    |
| Administrative Assistant to the Chair | • Marcella Westmoreland |

### **Facilities**

Our primary clinical training site is Erlanger Health System, particularly its Erlanger Baroness Campus (975 East Third Street, Chattanooga, TN 37403) in downtown Chattanooga where approximately 3,500 births and more than 5,000 gynecological procedures are performed each year. Erlanger is a non-profit, academic teaching hospital affiliated with the University of Tennessee College of Medicine Chattanooga (UTCOCM). Erlanger Baroness Campus is an adult Level-One Trauma Center and is the only provider of tertiary care services for the citizens within a four-state region, encompassing southeast Tennessee, north Georgia, north Alabama and western North Carolina. Each year, more than a quarter of a million people are treated at the various Erlanger Health System components, including Baroness Erlanger, Children's Hospital at Erlanger, Erlanger North, and Erlanger East. Erlanger facilities have up-to-date, advanced laboratory, surgical, imaging, and other support services and resources to provide excellent patient care. Further details about Erlanger can be found at [www.erlanger.org](http://www.erlanger.org).



Every year, approximately 170 physicians with UTCOMC receive training at Erlanger through accredited residency and fellowship programs, including the following:

- Emergency Medicine
- Family Medicine
- Internal Medicine
- Obstetrics and Gynecology
- Orthopedic Surgery
- Pediatrics
- Plastic Surgery
- Surgery
- Transitional Year Program

Accredited fellowships include:

- Colon and Rectal Surgery
- Surgical Critical Care
- Vascular Surgery
- Hospice and Palliative Care

Approximately 150 medical students from the University of Tennessee College of Medicine and other medical schools across the country participate in clinical rotations (hands-on experience with patients) at Erlanger every year.

The UTCOMC Continuing Medical Education office provides CME activities for practicing physicians throughout the year.

Hundreds of nursing students and other aspiring allied health professionals also train at Erlanger. During any given week, an average of 185 students at Erlanger, representing 114 different clinical training programs, participate in clinical training.

Our secondary facility is part of the Erlanger System: Erlanger East Women's Services (1751 Gunbarrel Road; Chattanooga, TN 37421; phone: 423-778-8700). Erlanger East Women's Services specializes in providing family-centered childbirth for deliveries and babies born at 35-weeks gestation or above in 25 single-room maternity suites for labor, delivery, and recovery. These birthing suites, considerably larger than traditional hospital rooms, allow families to experience their baby's birth together. Patients who give birth vaginally labor, deliver, recover and receive postpartum care in their own private birthing suites. Each suite is equipped with the latest technology in fetal monitoring, as well as special accommodations such as a TV/VCR/DVD player, refrigerator, rocking chair, sleeping accommodations for a member of the family and bathrooms with sit-down showers with a shower massage. Room service is available for the patient as well as her family. 24-hour hour anesthesia service is available for pain management, including labor epidurals and C-sections.



Recently added as participating sites for the OB/GYN Residency is HCA Parkridge Health System, including its main downtown Parkridge Medical Center and Parkridge East.

- Parkridge Medical Center, a 275-bed medical center, has served our local community for almost 40 years, and was the first hospital in the area to offer robotic surgery (in 2002), with a well-respected robotic surgery team, which has now performed well over 750 procedures, and a Pelvic Floor Center offering state-of-the-art diagnostic and treatment options for women with incontinence, or other pelvic support concerns.
- Parkridge East is a 128-bed acute care community hospital serving the Chattanooga, Tennessee and northwest Georgia area for over 30 years, specializing in high-risk obstetrics, women's healthcare, minimally-invasive gynecologic surgery, outpatient surgery and women's diagnostic services.



## Educational Leave

In order to safeguard an optimal educational environment and quality of life for all residents in our Program, a maximum of two (2) residents may be scheduled be away from the program at any one time, for any reason.

With the same goal, a maximum of one (1) resident from any one year of training may be scheduled be away from the program at any one time, for any reason.

Approval for time away is obtained by submitting a request in advance to the Chief Residents, who then submit their recommendation to the Program Director. Time away for educational leave cannot be approved without a conference brochure describing the educational activity. Examples of educational activities that may be approved include:

First year	<ul style="list-style-type: none"> <li>• Local meetings (for example in Atlanta, Nashville, Knoxville, or Memphis) sponsored by the American College of Obstetricians and Gynecologists (ACOG) or an accredited university.</li> </ul> <p>Maximum 3 days for the year.</p>
Second year	<ul style="list-style-type: none"> <li>• Regional meetings (for example in Tennessee, Georgia, Alabama, Mississippi, North Carolina, South Carolina, or Florida) sponsored by the American College of Obstetricians and Gynecologists (ACOG) or an accredited university.</li> </ul> <p>Maximum 4 days for the year.</p>
Third year	<ul style="list-style-type: none"> <li>• National meetings (any of the 48 contiguous United States) sponsored by the American College of Obstetricians and Gynecologists (ACOG) or an accredited university.</li> </ul> <p>Maximum 5 days for the year.</p>
Fourth year	<ul style="list-style-type: none"> <li>• National meetings (any of the 48 contiguous United States) sponsored by the American College of Obstetricians and Gynecologists (ACOG) or an accredited university; or</li> <li>• Board Review courses within the 48 contiguous United States.</li> </ul> <p>Maximum 7 days total for the year.</p>
Any year	<ul style="list-style-type: none"> <li>• Personally presenting a scientific paper submitted with prior approval from the Program Director; or</li> <li>• Participation on the program of, or as an elected representative to, a recognized institution of organized medicine, such as the American College of Obstetricians and Gynecologists (ACOG), or the American Society for Reproductive Medicine (ASRM); or</li> <li>• Participation in specific remedial training, with prior written authorization from the UTCOMC Office of Medical Education.</li> </ul> <p>No absolute maximum.</p>

Time away without advance written approval of the Program Director cannot be counted in the time required for residency as defined by the Accreditation Council for Graduate Medical Education (ACGME) and the American Board of Obstetrics and Gynecology (ABOG).



## **Residency Program Vacation and Educational Conference Policy**

It is the policy of the Obstetrics and Gynecology Residency Program to offer the resident at all four levels of post-graduate training three weeks of vacation and one week of Continuing Medical Education leave. It is the resident's responsibility to obtain permission from appropriate individuals impacted by leave (e.g., chief residents) and secure approval signatures on the leave request form. These forms are available in the Residency Program Office.

All leave must be requested at least two months in advance unless there is an emergency. If an emergency arises, it is the resident's responsibility to communicate the nature of the emergency and the need for leave with the Chair/Program Director. If leave is not requested two months in advance, requests will be denied. Leave can only be scheduled through this system. The chief of the service is responsible for ensuring adequate coverage for the duration of the requested time period. Once all signatures have been obtained, the chief will evaluate the request and compare it to the leave calendar maintained in his/her office and either approve or deny the request. Vacation is approved on a first-come, first-served basis with occasional changes made by order of seniority, need, or reason.

There can be no more than two residents on vacation at the same time, and no more than one resident gone from any service at the same time unless extenuating circumstances apply. There cannot be two senior residents (PGY-4 Chiefs) gone at the same time unless a specific need dictates.

Vacation and educational leave may not be carried over at the end of the academic year. Leave counts start over at the beginning of each academic year. No vacations are granted in the last three weeks of June or during July. Any exceptions to this policy may only be granted by the Chair/Program Director.



## **RESIDENCY PROGRAM BENEFITS**

### **Conference Leave**

The Program allows residents to attend outside conferences deemed appropriate by the Chair/Program Director. The primary clinical training hospital, Erlanger, provides Professional Development Funds for reimbursement of external conference registration and expenses as follows:

- \$500 annually for PGY-1 Residents
- \$1,000 annually for PGY-2 Residents
- \$1,500 annually for PGY-3 and PGY-4 Residents

Conference attendance must be approved in advance by the Chair/Program Director. Reimbursement is in accordance with the University of Tennessee and Erlanger Travel Policies and Guidelines (with original receipts).

### **Other Items covered from Professional Development Funds**

- The Program permits residents to be reimbursed up to \$250 annually, from the Professional Development Funds, for the purchase of medical books and journals with original receipts.
- The Program permits residents to be reimbursed up to \$250, from the annual Professional Development Funds, for the purchase of a PDA or smart phone device.
- The Program permits residents to be reimbursed one time, from the annual Professional Development Funds, for USMLE Step III registration fees.

### **Holidays**

Residents are granted nine holidays observed by the University; however, patient care responsibilities must be covered by some residents:

New Year's Day  
Martin Luther King's Birthday  
Good Friday  
Memorial Day  
Independence Day (July 4th)  
Labor Day  
Thanksgiving (2 days)  
Christmas Day



## **Vacation**

Each resident is offered three weeks vacation annually, including time off during the Christmas/New Years season.

Ideally a resident should a week's vacation from three different time periods. Residents MAY NOT schedule two consecutive weeks away from the program for vacation, conference, or any combination thereof, but may schedule time off within the same month given approval by the Chief Residents and Chair/Program Director.

Two residents assigned to the same rotation may not take vacation during the same week. This rule applies to conference leave as well.

The Program will attempt to include either a preceding weekend or a post vacation weekend as part of vacation time.

Any deviation from this policy must be approved by the Chair/Program Director.

## **Sick Leave**

Residents may be paid for up to 21 sick days within a year (four weeks and one day); however, these cannot be carried over from year to year. A Program Director may request a physician's statement for periods of sick leave. A resident may not be paid for unused sick leave at the end of the year. The determination as to whether or not the resident will be required to make up time missed due to Sick Leave will be made by the Program Director, in accordance with residency requirements and board certification requirements.

## **Maternity/Parental Leave**

The UT College of Medicine Chattanooga and its GME Office recognize the importance of the early development of a relationship between parent and child and supports the use of time off for Resident and Fellow leave related to the recent birth or adoption of a child. Except in case of emergency, all maternity, parental, or adoptive leave should be requested at least three months in advance of the expected date of birth or adoption in order to ensure adequate coverage in the program. The Program Directors and Residents and Fellows should verify whether the length of leave will require extending training in order to meet program or board eligibility criteria.

The Tennessee Maternity Leave Act allows up to four months (16 weeks) of paid and unpaid total leave. With advance notice, the Program Directors may grant unpaid leave after all available paid annual and sick leave has been taken as allowed under the following maternity, parental, or adoptive leaves. A copy of this approval must be sent to



the GME Office.

- **Maternity Leave**  
All available sick and annual leave days up to the maximum of six (6) paid weeks duration may be used by female Residents or Fellows for the birth of a child. With prior approval, additional unpaid maternity leave may be granted by the Program Director. Extended leave due to complications may be covered under the Resident's or Fellow's disability policy after the 90 day waiting period.
- **Parental Leave**  
A parent Resident or Fellow other than the birth mother may use paid sick leave to take seven (7) consecutive calendar days to assist with parental duties commencing with the birth of the child. Additional paid time may be taken using any available annual leave. With prior approval, additional unpaid parental leave may be granted by the Program Directors.
- **Adoption Leave**  
Adoptive parent Residents or Fellows may use paid sick leave to take seven (7) consecutive calendar days for leave commencing with the adoption of the child. Additional paid time may be taken using any available annual leave. With prior approval, additional unpaid adoptive leave may be granted by the Program Directors.

## **Meals**

Erlanger provides a meal allowance and snacks in call rooms to residents at no charge (seven days a week, 24 hours each day).

## **Moving Reimbursement**

Erlanger provides up to \$1000 in reimbursement to residents moving to Chattanooga to begin their residency. Original receipts must be provided to the Residency Coordinator within 30 days of relocating to Chattanooga.



## **USMLE Licensing Examination and DEA registration**

As previously stated, all residents are required to be fully licensed in order to matriculate the third year of residency. This policy is also in effect for DEA registration. Once the resident has passed STEP III and received their license, they should apply for their DEA registration number. This will be used in place of the institutional DEA registration that is received at the beginning of residency. The institutional DEA number is not to be used beyond the second year of residency.



## **Resident Selection and Eligibility Policy**

The Obstetrics and Gynecology Program has adopted the institutional policy of the Graduate Medical Education Program of the University of Tennessee College of Medicine Chattanooga. This policy states that all programs of the Chattanooga campus acknowledge and follow the eligibility and selection criteria for resident applicants stated in the ACGME institutional requirements as well as the rules of the National Resident Match Program (NRMP).

Specific minimum requirements for OB/GYN applicant consideration

1. Application to the Obstetrics and Gynecology Residency Program must be submitted solely through ERAS (Electronic Residency Application Service).
2. All applications are processed through the National Resident Match Program (NRMP).
3. Applicants must have passed the USMLE step I and II on the first attempt with a minimum score of 185.
4. Applicants who are graduates of an international medical school must speak fluent English and have passed the exam on the first attempt.
5. Applicants must provide two (2) letters of recommendation from physicians certified by the American Board of Obstetrics and Gynecology (ABOG).
6. Preference is given to graduates in the top 25% of their class.
7. As a courtesy, students rotating through UTCOM during their fourth year are granted an interview; however, they must meet the requirements as stated above to qualify for ranking in the Match.



## Policy and Guidelines for Evaluation and Promotion of Residents

The Obstetrics and Gynecology Program has adopted the UTCOM Chattanooga's institutional Guidelines for Evaluation and Promotion of Residents as appropriate for this program. The Program acknowledges that:

1. The *Institutional Requirements* require the assurance that policies exist and are implemented for evaluation and advancement of Residents according to the principles outlined in the *Requirements*. All residency programs of UTCOM Chattanooga are required to evaluate residents at least on a semi-annual basis. All programs should require that written evaluations be completed then reviewed by and discussed with the residents at the conclusion of each rotation. Timely evaluations should be discussed with residents by the Chair, Program Director or designated faculty member in order to inform the residents as to his/her progress/weakness. If any remedial work or extra study is required, the correction plan is outlined with the resident to allow ample time for the resident to meet the program requirements. A Chair/Program is required to notify the Designated Institutional Official (DIO) and Director of Graduate Medical Education of any problems with a resident's performance and anticipated disciplinary actions. A resident must receive written notification of formal probationary status. The Director of Graduate Medical Education would then work with the University's Office of the General Counsel to ensure that all legal procedures are followed to guarantee the resident's right to an academic appeal or legal due process.
2. Resident appointments to the UT College of Medicine Chattanooga Graduate Medical Education Program are made on an annual basis with the expectation that continuation within the one-year appointment and appointment annually throughout the duration of the program will be based on evidence of satisfactory process in scholarship and professional growth. Advancement to the next year is based upon satisfactory evaluation. *Residents must pass USMLE STEP III prior to progression to the PGY-3 level.* Residents must pass the USMLE Step III in order to receive a certificate of completion of residency training at UTCOM Chattanooga.
3. The Obstetrics and Gynecology Program requires that:

Resident evaluations are completed by the faculty at the completion of each service rotation. The evaluations are reviewed by the Program Director and are maintained in New Innovations. In addition, the Chair/Program Director and faculty communicate verbally with the residents in order to address the weakness/strengths during each rotation. The progress of the resident is evaluated and summarized in a written review by the Chair/Program Director at least semi-annually. This evaluation process is explained to residents



entering the program. The written evaluation is a major component of the decision for advancing residents.

4. At the end of the academic year, the Program Director reviews each of the resident's evaluations from the different faculty members, as well as his own semi-annual evaluations. Advancement or graduation from the Program are based upon satisfactory written evaluations, assessment of clinical goals and objectives, surgical competency, operative cases and research projects.



## **Policy for Evaluation of Faculty and Rotations by Residents**

The *Institutional Requirements* require the assurance that policies exist and are implemented to allow residents the opportunity to evaluate the faculty to whom they are assigned and the quality of the educational experiences. Evaluations will be completed via New Innovations for residents to evaluate their faculty, rotations and the program. By using New Innovations, the residents are guaranteed full anonymity. They complete faculty and rotation evaluations on a semi-annual basis for all rotations to which they have been assigned for the previous six months.

The system provides summarized reports that can be monitored by the Program and the institution at the conclusion of each resident's rotation.

Any problems will be brought to the attention of the Chair/Program Director immediately. The evaluations are a component of the yearly faculty evaluation and the institutional internal review conducted at midpoint between site visits.



## **Policy on the Evaluation of the Program by Residents, by Faculty, by Medical Students**

### **Evaluation of the program by Residents:**

The Obstetrics and Gynecology Residency Program utilizes a semi-annual evaluation by residents that is completed in the web-based New Innovations system. Evaluations are completely anonymous. De-identified summaries are reviewed by the Chair and faculty.

### **Evaluation of the program by Faculty:**

The Obstetrics and Gynecology Program utilizes an annual evaluation of the program by faculty that is completed in the web-based New Innovations system. Evaluations address areas of strength and weakness within the program, and allow faculty members to rate performance various staff within the Program from the Program Director to the Residency Coordinator. Summary reports are compiled and reviewed by the Chair.

### **Evaluation of the program by Medical Students:**

Medical Students in an OB/GYN clerkship are required to complete an evaluation of the eight-week rotation. Upon the completion of the M-3 medical student rotation, each student is required to complete an evaluation in the web-based New Innovations System. Feedback is passed from the Clerkship Director to the Chair and other faculty.



## **INSTITUTIONAL POLICY ON DISCIPLINARY ACTIONS AND DISMISSAL**

Disciplinary actions are typically utilized for serious acts requiring immediate actions. These actions include suspension, probation, and dismissal. The residency program, the University of Tennessee College of Medicine Chattanooga (UTCOCM), the Statewide University of Tennessee Graduate Medical Education Programs, and the University of Tennessee Health Science Center are under no obligation to pursue remediation actions prior to recommending a disciplinary action. All disciplinary actions are subject to the University of Tennessee Graduate Medical Education (GME) Academic Appeals process. All disciplinary actions will become a permanent part of the Resident/Fellow training record.

### **Suspension**

A Resident/Fellow may be suspended from all program activities and duties by his or her Program Director, Department Chair, the Director of GME, the Associate Dean for Academic Affairs/DIO, or the UTCOCM Dean. Program suspension may be imposed for program-related conduct that is deemed to be grossly unprofessional, incompetent, erratic, potentially criminal, noncompliant with the University of Tennessee policies, procedures, and Code of Conduct, federal health care program requirements, or conduct threatening to the well-being of patients, other Residents/Fellows, faculty, staff, or the Resident/Fellow.

A decision involving program suspension of a Resident/Fellow must be reviewed within three (3) working days by the Department Chair (or designee) to determine if the Resident/Fellow may return to some or all program activities and duties and/or whether further action is warranted (including, but not limited to counseling, fitness for duty evaluation, referral to the AIRS program, drug testing, probation, non-renewal of contract, or dismissal). Suspension may be with or without pay at the discretion of institutional officials.

### **Performance Alert, Remediation, and Probation**

Probation is a serious disciplinary action that constitutes notification to the Resident/Fellow that dismissal from the program can occur at any time during or at the conclusion of probationary period. In most cases the Resident/Fellow will first receive a Performance Alert which may be followed by a Performance Deficiency and Remediation (PDR) prior to being placed on probation. However, a Resident/Fellow may be placed on probation at any time consistent with individual program policies. Probation is typically the final step before dismissal occurs. However, dismissal prior to the conclusion of a probationary period will occur if there is further deterioration in performance or additional deficiencies are identified. Additionally, dismissal prior to the end of the probationary period may occur if grounds for suspension or dismissal exist.



Each residency program is responsible for establishing written criteria and thresholds for placing Resident/Fellows on probation. Examples include but are not limited to the following: failure to complete the requirements of the Performance Alert and/or the PDR, not performing at an adequate level of competence, unprofessional or unethical behavior, misconduct, disruptive behavior, or failure to fulfill the responsibilities of the program in which he/she is enrolled.

### **Dismissal**

Residents/Fellows may be dismissed for a variety of serious acts. The Resident/Fellow does not need to be on suspension or probation for this action to be taken. These acts include but are not limited to the following: serious acts of incompetence, impairment, unprofessional behavior, falsifying information or lying, or non-compliance.

Immediate dismissal will occur if the Resident/Fellow is listed as an excluded individual by any of the following:

- Department of Health and Human Services Office of the Inspector General's "List of Excluded Individuals/Entities", or
- General services Administration "List of Parties Excluded from Federal Procurement and Non-Procurement Programs"; or
- Convicted of a crime related to the provision of health care items or services for which one may be excluded under 42 USC 1320a-7(a)

**Reviewed and approved by the GMEC, 2/22/2011.**



## **Institutional Policy on Remediation Actions**

Remediation actions are designed to identify and correct areas of marginal and/or unsatisfactory performance by a resident. These actions include Performance Alert and Review (PAR), Academic Deficiency & Remediation (ADR), repeat rotation, repeat academic year, and denial of certificate of completion. Each of these remediation actions are not forms of discipline and therefore not subject to the Statewide University of Tennessee Graduate Medical Education (GME) Academic Appeal process.

### **Performance Alert and Review (PAR)**

The PAR is a tool for program directors to formally notify residents regarding areas of marginal/unsatisfactory performance noted by the faculty and or the program director. The PAR is designed to replace more traditional methods to document marginal performance such as letters of warning and/or counseling sessions. Performance alerts and reviews are not to be used as a substitute for the ongoing assessment and evaluation of residents during training. Instead, they should be used as the first notice to the resident that his or her current performance is marginal or unsatisfactory in any of the six ACGME competencies. To be most effective, a PAR should be initiated as soon as the faculty member identifies an area(s) of concern and the resident informed within 7-10 working days.

Any resident who receives an overall marginal or unsatisfactory evaluation for any rotation, semi-annual evaluation, or year of training should have one or more PARs on file documenting the performance concern(s).

### **Academic Deficiency and Remediation (ADR)**

ADR is a remediation action used in situations where a resident fails to comply with the academic requirements established by the residency training program, Statewide University of Tennessee GME Program, and/or participating institutions. Placement on ADR serves as an official notice to the resident of unsatisfactory performance. Typically the deficiencies are associated with one or more of the six ACGME competencies. However, this may also include disruptive physician behaviors not specifically addressed in the ACGME competencies.

Each residency program should establish written criteria and thresholds for placing residents on ADR. Examples include but are not limited to the following: poor academic performance as documented by unsatisfactory faculty evaluations, intramural examinations and /or written in-service examinations; failure to attend scheduled monthly departmental activities, clinical performance or surgical skills which are below those expected for the level of training as documented by written evaluations by the faculty, unprofessional or inappropriate actions, disruptive behavior, failure to complete



medical records in a timely manner, and failure to maintain procedure or surgical logs in a timely manner. Residency program requiring their residents to achieve a minimum score on an annual written in-service examination must publish this requirement at the beginning of each academic year.

The program director is required to provide the resident with a letter notifying him or her of ADR status and the area(s) of unsatisfactory performance, measures to improve performance, and time frame for completion.

### **Repeat Academic Year**

Repeating an academic year is a remediation action that may be used in limited situations such as: overall unsatisfactory performance during the entire academic year, overall unsatisfactory performance for at least 50% of rotations during the academic year, or failure to pass an annual written in-service examination. Each residency program is responsible for establishing specific written criteria for repeating an academic year. The resident will be notified of his/her requirement to repeat the academic year at least six weeks prior to the end of the academic year.

### **Denial of Certificate of Completion**

A resident may be denied a certificate of completion of training as a result of overall unsatisfactory performance during the final academic year of residency training. This may include the entire year or overall unsatisfactory performance for at least 50% of rotations during final academic year. Additionally, some programs may deny a certificate of completion to a resident who fails to pass the annual written in-service examination during the final year of training. Each residency program is responsible for establishing specific written criteria for denial of certificate of completion. Residents denied a certificate of completion must be notified in writing of unsatisfactory performance by the program director at least six weeks prior to scheduled completion of program. In most situations, the resident should be notified of this pending action as soon as possible. In certain situations, a resident denied a certificate of completion may be offered the option of repeating the academic year but only at the discretion of the program director.



**The OB/GYN Program abides by the ACGME Duty Hour requirements institutional policy approved by the UTCOMC GMEC.**

## **RESIDENT AND FELLOW DUTY HOURS POLICY Effective July 1, 2011**

### **Resident and Fellow Duty Hours in the Learning and Working Environment**

Duty hours are defined as all clinical and academic activities related to the Residency or Fellowship Program; *i.e.*, inpatient and outpatient care, administrative duties related to patient care, the provision for transfer of patient care, time spent in-house during call activities, internal and external moonlighting, and scheduled academic activities such as conferences. Duty hours do *not* include reading and preparation time spent away from the duty site. Graduate Medical Education (GME) duty hour standards incorporate the concept of graded and progressive Resident and Fellow responsibility leading to the unsupervised practice of medicine.

### **Duty Hour Oversight**

Duty hour compliance is a collective responsibility of GME leadership, Faculty, Residents, and Fellows. Each program is required to use the duty hour module in New Innovations to monitor compliance with institutional, common, and specialty/subspecialty-specific program requirements. Program Directors must monitor Resident and Fellow duty hours and adjust Resident and Fellow schedules as needed to mitigate excessive service demands and/or fatigue and to prevent negative effects of duty hours on learning and patient care. This includes monitoring the need for and ensuring the provision of back up support systems when patient care responsibilities are unusually difficult or prolonged. Residents, Fellows, and Faculty have a personal role and professional responsibility in the honest and accurate reporting of Resident and Fellow duty hours.

Duty hour reports will be submitted by all programs as requested by the GME office with a frequency to ensure compliance with requirements. Reports will be reviewed by the GME Committee and compliance issues addressed as needed.

### **Duty Hour Standards**

Each ACGME-accredited training program is required to establish a formal written policy governing Resident and Fellow duty hours consistent with institutional and program requirements. The policy at a minimum must document that the following institutional duty hour standards are met. These standards reflect the need for programs to design schedules and clinical assignments to match Resident and Fellow levels of training and competencies in order to improve education and patient safety. Individual program policies may have additional specialty specific duty hour restrictions. All programs will distribute their program policy and procedures to Residents, Fellows, and Faculty.



### **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.

**Exception Requests:** Some Residency Review Committees may grant exceptions to the 80-hour limit for up to 10% or a maximum of 88 hours per week based on a sound educational rationale. The University of Tennessee Graduate Medical Education Committee discourages any exceptions but will consider requests from individual programs. Any request for exception to the 80-hour limit must be reviewed and approved by the GMEC and DIO prior to submission to a program's RRC. In preparing a request for an exception the Program Director must follow the duty hour exception policy from the ACGME Manual on Policies and Procedures.

### **MANDATORY TIME FREE OF DUTY**

Resident and Fellows 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. One day is defined as one continuous 24-hour period free from all clinical, educational, and administrative activities.

### **MAXIMUM DUTY PERIOD LENGTH**

**PGY-1 Resident:** Duty periods of PGY-1 Residents must not exceed 16 hours in duration.

**PGY-2 and above:** Duty periods of PGY-2 Residents and above (including Fellows) may be scheduled to a maximum of 24 hours of continuous duty in the hospital. Programs must encourage Resident and Fellows to use alertness management strategies in the context of patient care responsibilities. Per the ACGME Common Program Requirements, 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.

It is essential for patient safety and Resident and Fellow education that effective transitions of care occur. Resident and Fellows 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*.

Resident and Fellows must not be assigned additional clinical responsibilities after 24 hours of continuous in-house duty.

In unusual circumstances, PGY-2 Residents and above (including Fellows), 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. Under those circumstances, *the Resident or Fellow must*.



- appropriately hand over the care of all other patients to the team responsible for their continuing care; and,
- document the reasons for remaining to care for the patient in question and submit that documentation in every circumstance to the Program Director in the New Innovations duty hour module.

The Program Director must then review each submission of additional service, and track both individual Resident and Fellow and program-wide episodes of additional duty.

#### ***MINIMUM TIME OFF BETWEEN SCHEDULED DUTY PERIODS***

**PGY-1 Residents** should have ten hours, and must have eight hours, free of duty between scheduled duty periods.

**Intermediate-level Residents** [as defined by the Review Committee] should have ten 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.

**Residents and Fellows in the final years of education** [as defined by the Review Committee] must be prepared to enter the unsupervised practice of medicine and care for patients over irregular or extended periods.

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 and Fellows in their final years of education have eight hours free of duty between scheduled duty periods, there may be circumstances [as defined by the Review Committee] when these Residents and Fellows must stay on duty to care for their patients or return to the hospital with fewer than eight hours free of duty.

Circumstances of return-to-hospital activities with fewer than eight hours away from the hospital by Residents and Fellows in their final years of education must be documented in the New Innovations duty hour module and monitored by the Program Director.

#### ***MAXIMUM FREQUENCY OF IN-HOUSE NIGHT FLOAT***

Residents and Fellows must not be scheduled for more than six consecutive nights of night float. [The maximum number of consecutive weeks of night float, and maximum number of months of night float per year may be further specified by the Review Committee.]

#### ***MAXIMUM IN-HOUSE ON-CALL FREQUENCY***

PGY-2 Residents and above (including Fellows) must be scheduled for in-house call no more frequently than every-third-night (when averaged over a four-week period). PGY-1



Residents are not allowed to take in-house call for more than 16 consecutive hours on duty.

***AT-HOME CALL***

Time spent in the hospital by Residents and Fellows on at-home call must count towards the 80-hour maximum weekly hour limit. PGY-1 Residents are not allowed to take at-home call.

The frequency of at-home call is not subject to the every-third-night limitation, but must satisfy the requirement of one 24-hour day free of duty every week (when averaged over four weeks).

Residents and Fellows 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”; however at-home call should not be associated with extensive returns to provide hospital service.

At-home call must not be so frequent or taxing as to preclude rest or reasonable personal time for each Resident, Fellow, and the Program Director must monitor the demands of at-home call and adjust schedules as necessary to mitigate excessive service demands and/or fatigue.

*Reviewed and Approved by the GMEC 5/24/2011*



## **POLICY ON MOONLIGHTING**

### Definition:

Moonlighting is defined as any professional activity outside the course and scope of a resident's approved training program.

### Policy:

UTCOMC OBGYN residents are not allowed to moonlight at any time while in our residency program.

### Rationale:

- Moonlighting has potential negative impact on educational growth.
- Moonlighting can jeopardize patient safety.
- Moonlighting presents challenges in complying with the ACGME 2011 approved Common Program Requirements related to duty hour standards, fatigue management, and fitness for duty.
- Moonlighting generates the need for professional liability for the moonlighting resident. The Tennessee State Claims Commission Act provides immunity for residents only when they are performing their job as a resident and employee of the State of Tennessee. This coverage does not cover residents who are moonlighting and working outside their regular resident duties and job.

### Penalties:

Violation of the UTKOMC OBGYN Residency Program moonlighting policy could result in disciplinary actions up to and including dismissal from the UTKOMC OBGYN Residency Program and the Statewide University of Tennessee Graduate Medical Education Program.



## **Faculty Involvement Protocol**

In addition to the circumstance listed below, OB/GYN residents should ask for faculty opinions, supervision or direct assistance if any questions or doubt exists regarding decisions or interventions as they pertain to patient care. We believe that communication is paramount for patient safety. Supervision will vary with resident experience per the Supervision Schedule.

### **Hospital Admissions**

All patients admitted to the hospital require notification of the admitting faculty in a timely manner. Junior level residents (PGY-1 and PGY-2) will notify senior level residents (PGY-3 and PGY-4) after initial evaluation of such patients. The senior level resident will then notify faculty members. If senior level residents are unavailable, the junior level resident should contact a faculty member prior to admission of the patient to the hospital. Patients with stable conditions will be evaluated directly by faculty members within 24 hours of admission. Patients with emergency conditions will be evaluated with direct faculty supervision as soon as possible.

### **Inpatient Hospital Transfers**

Acceptance of patients from another facility will be determined by faculty members only.

### **Outpatient Clinics**

Direct supervision of resident clinic encounters will occur by faculty members. Junior surgical residents (PGY-1 and PGY-2) will present patients to upper level residents (PGY-3 and PGY-4) or OB/GYN faculty during clinic evaluations. Senior residents may evaluate patients and present directly to the faculty covering the clinic. Surgical cases scheduled through an outpatient clinic by any resident will require discussion with faculty members and agreement on a plan of care.

### **ICU Patients**

All ICU patients with OB/GYN conditions will be evaluated by faculty members on a daily basis. Any patient transferred to the ICU requires faculty notification. Any deterioration in a patient's condition also requires immediate faculty notification. Junior residents (PGY-1 and PGY-2) will notify the senior residents (PGY-3 and PGY-4) immediately when the aforementioned situations are encountered.



## **DNR or End of Life Decisions**

All decisions for DNR or decisions regarding End of Life care require Faculty notification. Junior level residents (PGY-1 and PGY-2) will be supervised for formal discussions with patients or families. Senior level residents (PGY-3 and PGY-4) may discuss resuscitation directives and end of live decisions directly with patients or families at the discretion of the involved faculty member followed by a discussion with the faculty as to the family wishes.

## **POLICY ON SUPERVISION OF RESIDENTS**

### Definitions:

Medical staff physicians supervising residents in graduate medical education programs have the simultaneous purposes of enhancing the professional functioning of the resident while monitoring the quality of patient care delivered. Supervision is exercised through observation, consultation, directing the learning of the resident, and via role modeling. Documentation of supervision is the written or computer-generated medical record evidence of a patient encounter that reflects the level of supervision provided by a supervising medical staff physician.

### Policy:

- Policies of the UTCOMC OBGYN Residency Program comply with requirements of the Accreditation Council for Graduate Medical Education (ACGME), the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), and the University of Tennessee Health Science Center (see below).
- Supervising physicians will adhere to the ACGME requirements pertaining to the level of supervision for residents in a training program.
- To ensure patient safety and quality patient care while providing the opportunity to maximize the resident educational experience, at least one supervising physician will be available on-site 24 hours a day for the resident during resident's clinical duty.
- UTCOMC OBGYN Residency Program ensures that residents know which supervising medical staff physician is on call and how to reach this individual.
- Supervising physicians will be responsible for determining when a resident is unable to function at the level required to provide safe, high quality care to assigned patients, and have the authority to adjust duty hours downward to ensure that residents that are overly fatigued do not place patients at risk.
- Supervising physicians must demonstrate compliance with any residency review committee citations related to this supervisory function.
- UTCOMC OBGYN Residents only perform privileges and procedures for which their supervising physician has been appropriately credentialed.
- Supervising physicians are responsible for, and must be personally involved in, the care provided to individual patients in inpatient and outpatient settings where applicable. Whenever a resident is involved in the care of a patient, the responsible supervising physician must maintain personal involvement. The supervising physician oversees the care of the patient and provides the appropriate intensity of resident supervision based on the nature of the patient's condition, the likelihood of major changes in the management plan, the complexity of care, and the experience and judgment of the resident being supervised. All services must be rendered under the oversight of the responsible supervising physician or be personally furnished by the supervising physician.

- Individual UTCOCM OBGYN residents must be aware of their limitations and must not attempt to provide clinical services or do procedures for which they are not trained. They must know the graduated level of responsibility described for their level of training and must not practice outside of that scope of service. Each resident is responsible for communicating significant patient care issues to the supervising medical staff physician and such communication must be documented in the medical record. Failure to function within graduated levels of responsibility, communicate significant patient care issues to the supervising physician, or appropriately document the level of supervising physician oversight may result in the removal of the resident from patient care activities.
- As they advance in their training program, UTCOCM OBGYN residents are given progressive responsibility for care of patients. The determination of a resident's ability to provide care to patients without a supervising physician immediately present on-site is based on the resident's clinical experience, judgment, knowledge, and technical skill. The UTCOCM OBGYN Residency Program Director defines the levels of responsibilities for each year of residency training by preparing a description of the types of clinical activities residents may perform. Graduated levels of responsibility will be in accordance with ACGME and JCAHO guidelines. It is the decision of the supervising physician as to which activities the resident will be allowed to perform within the context of the assigned levels of responsibility. The level of supervision provided by supervising physicians to residents at various levels of training should be consistent with the requirement for progressively increasing resident responsibility during a residency program.
- Documentation of supervision must be entered into the medical record by the supervising physician or reflected within the resident progress note or other appropriate entries in the medical record (e.g., procedure reports, pathology reports, imaging reports, consultations, discharge summaries). The medical record must clearly demonstrate the involvement of the supervising medical staff physician in resident patient care, and all entries must be timed and dated. Examples of this documentation of supervision include: progress note or other entry into the medical record by the supervising physician; addendum to the resident progress note by the supervising physician; countersignature of the resident progress note or other medical record entry by the supervising physician (the supervising physician's countersignature signifies that the supervising practitioner has reviewed the resident note, and absent an addendum to the contrary, concurs with the content of the resident note or entry; resident progress note or other medical record entry documenting the name of the supervising physician with whom the case was discussed, a summary of the discussion, and a statement of the supervising physician's oversight responsibility with respect to the assessment or diagnosis and/or the plan for evaluation and/or treatment.
- Peer Review: Documentation of resident supervision will be monitored during the course of peer review. All cases reviewed by the peer review process including all screening will now be graded for quality of patient care, quality of documentation, and adequacy of resident supervision. Any case reviewed in which it appears there is inadequate resident supervision will be forwarded to the peer review committee. If over time it appears that there is lack of adequate supervision by a medical staff member, a letter will be sent to the departmental chair.

Rationale:

- Appropriate supervision of residents enhances educational growth.
- Appropriate supervision of residents helps to promote patient safety.
- Appropriate supervision of residents is necessary to comply with the ACGME 2011 approved Common Program Requirements.
- Appropriate supervision of residents is necessary to address professional liability for the supervising physician, the involved resident, and our institution.
- Resident supervision is an integral part of patient care. Documentation of that supervision is necessary to insure that it has occurred. The attending physician is ultimately responsible for all patients both medically and legally. This responsibility for supervision has nothing to do with teaching per se; it is required for patient care. Anyone reviewing the chart for whatever reason should be able to see that the attending physician is involved and aware of all aspects of the patient's care.
- Inpatient charts must have documentation in the daily progress notes of adequate level of attending involvement. ("Adequate" is defined as awareness by the supervising physician of the patient's plan of treatment and course and that this has been communicated to the patient. It is understood that some patients will have a longer hospital course, and may not require daily documentation so long as adequate supervision is maintained. Outpatient records should at a minimum indicate the supervising attending.

Implications:

Violation of the UTCOCM OBGYN residency program policy on supervision of residents could result in disciplinary actions up to and including dismissal for the faculty or resident of the UTCOCM OBGYN residency program and the University of Tennessee GME Programs.

Resident Activity	Resident Activity Description of Supervision		Documentation of Supervision Minimum Level (see page 2)
<b>INPATIENT CARE</b>	<b>New Admission</b>	Residents will notify departmental attending physician upon patient admission. The urgency of notification is based upon severity and acuity of patient. The departmental attending physician must see and evaluate the patient within one calendar day of admission.	<b>Level # 2, Co-signature not sufficient</b>
	<b>Continuing Care</b>	Departmental attending physician is personally involved in ongoing care.	<b>Level #4</b>
	<b>Intensive Care</b>	Because of the unstable nature of patients in ICUs, involvement of departmental attending physician is expected on admission and at least on a daily basis.	<b>Level #4</b>
	<b>Hospital Discharge /Transfer</b>	The departmental attending physician must be involved in decision to discharge or transfer patient.	<b>Level # 3 Discharge Summary Signature or Transfer Note co signature</b>
<b>OUTPATIENT CARE</b>	<b>New Patient Visit</b>	The departmental attending physician must be present in the clinic. Every new patient must be seen by and/or discussed with the departmental attending physician.	<b>Level # 2, Co-signature not sufficient</b>
	<b>Return Patient Visit</b>	The departmental attending physician must be present in the clinic.	<b>Level #4</b>
	<b>Clinic Discharge</b>	The departmental attending physician will assure clinic discharge is appropriate.	<b>Level #4</b>
<b>OPERATING / DELIVERY ROOM</b>	<b>The departmental</b>	<b>The departmental attending physician must physically</b>	<b>Level A: Attending performing the procedure, assisted by resident</b>

	attending physician must be notified prior to the scheduling of the procedure.	be present, within the facility where the procedure occurs, for the major components of the procedure and degree of involvement documented.	<p><b>Level B:</b> Resident performing the procedure and the departmental attending physician is scrubbed</p> <p><b>Level C:</b> Resident performing the procedure with the departmental attending physician not scrubbed, but present in Operating Room</p> <p><b>Level D:</b> Resident performing the procedure with the departmental attending physician not scrubbed, but present in suite or facility</p> <p><b>Level E:</b> Emergency Care - Immediate care is initiated to preserve life or prevent impairment. The procedure is initiated with the departmental attending physician contacted and in route</p>
Consultations(Inpatient, Outpatient and Emergency Department)	Departmental attending physician must supervise all consults.		Level #4 consistent with patient's condition and principles of graduated responsibility.
Radiology/Pathology			All reports verified by departmental attending physician prior to release
Emergency Department	Assigned Emergency Department Attending physician must be present in the emergency department and is the attending of record. Assigned Departmental attending physician must be involved in disposition of all patients. Patients to be admitted are then assigned to clinical Department Attending (see A.).		Level #4 consistent with patient's condition and principles of graduated responsibility.
Routine Bedside & Clinic Procedures			Level #4 consistent with patient's condition and principles of graduated responsibility as outlined on GME supervision web site <a href="http://www.uthsc.edu/GME/supervision.htm">http://www.uthsc.edu/GME/supervision.htm</a> .
Non-Routine, Non-Bedside, Non-OR Procedures	(e.g., Cardiac Cath, endoscopy, interventional radiology ,etc)	The departmental attending physician must physically be present, within the facility where the procedure occurs, for the major components of the procedure and degree of involvement documented.	<p><b>Level A:</b> Attending performing the procedure, assisted by resident</p> <p><b>Level B:</b> Resident performing the procedure and the departmental attending physician is assisting</p> <p><b>Level C:</b> Resident performing the procedure with the departmental attending physician not assisting, but present in suite.</p> <p><b>Level D:</b> Resident performing the procedure with the departmental attending physician not assisting, but present in suite or facility.</p>

			<p><b>Level E: Emergency Care - Immediate care is initiated to preserve life or prevent impairment. The procedure is initiated with the departmental attending physician contacted and in route.</b></p>
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**\*Level of Supervision Documentation**

1. Departmental attending physician Note
2. Departmental attending physician Addendum to the resident's note (not a co-signature)
3. Departmental attending physician Co-signature implies that the departmental attending physician has reviewed the resident's note, and absent an addendum to the contrary, concurs with the content of the resident's note.
4. Resident Documentation of departmental attending physician supervision. (e.g., "I have seen and/or discussed the patient with my departmental attending physician, Dr. \_\_\_\_\_, who agrees with my assessment and plan.")



## **General Information:**

### **Morning Report**

Morning report is held in the Erlanger Labor and Delivery Suite at 0630 during weekdays. It includes the off-going night call group as well as the oncoming clinical chiefs. Punctuality is mandatory.

The day shift is responsible for all rounds in the morning, to include; labor and delivery patients, high-risk antenatal patients, triage patients and post-partum patients. If the night team rounds on these patients before morning report, then a full checkout on all of these patients must be given to the oncoming crew.

At morning report, all admissions, deliveries and surgeries performed by the night-call team will be presented and discussed with the oncoming chiefs-of-service and faculty. Junior residents and medical students will be responsible for in-depth presentation of interesting cases to the chief resident. The chief resident will moderate morning report for cases which pertain to their services. In addition to new patients, the off-going group will update the chiefs on any new development with service patients or private patients which are being followed by the residents. All consults performed during the night will also be discussed with the clinical chiefs

### **Lectures and Educational Conferences**

Weekly didactic lectures are held on Fridays in the WW6 UTCOM conference room located off the "E" elevator on the 6<sup>th</sup> floor of the hospital. These lectures are given by faculty, residents and medical students. The majority of lectures are given by faculty and consist of didactic lectures, question and answer sessions, videos, presentations, journal review or other teaching methods. Residents will give three lectures per year on various topics taken directly from the CREOG examinations. Students are required to present a lecture as part of their clinical rotation.

Fetal Board sessions occur on the second Thursday of each month. These are held in the Erlanger Cancer Conference Center at noon. During Fetal Board sessions, special care babies and pregnancies are discussed in an interdisciplinary format with NICU, Perinatology, Neonatology, Pediatrics and Obstetrics. Additionally, follow-ups are given on previously presented special care babies. All residents are encouraged to attend.

Gynecologic Oncology Tumor Board occurs on alternating Tuesdays. Discuss with the chief resident on the service the location and time of tumor board. During Tumor Board sessions, gynecologic oncology patients are discussed in an interdisciplinary format including pathology, radiology, radiation oncology, medical oncology and gynecologic



oncology. Diagnosis, pathology, management and treatment plans are discussed. All residents are encouraged to attend.

Resident research meetings are held monthly headed by Drs. Sprague and DePasquale. These meetings occur during Friday morning lecture time. At research meetings, all resident and most faculty research will be discussed. The goal of these meetings is to assist the resident in selecting valid topics for research and developing a solid research plan and method. Each resident is required to complete and present an original research project prior to graduation.

### **Patient Care/Teaching Rounds**

1. Rounds on Service and private patients will be completed by 0630 Monday through Friday and by 0700 on weekends and holidays.
2. All Chief Residents are responsible for knowing all patients on their service, thus, if delegated rounding occurs, the Chief is responsible for receiving information about all patients from the junior-level residents.
3. All post-op patients will be rounded on within 4 hours of surgery and a note documenting the visit will be placed in the chart.
4. The clinical chief of the service is responsible for ensuring that all changes in patient status are presented to the faculty. The junior level residents should strive to present clear, concise pictures to the Chief Resident being specific about important changes.
5. All complications, changes in status or updates on patients should be presented to the Chief Resident BEFORE presentation to faculty.
6. All consults who are carried by a service will be included in daily rounds.

### **Checkout**

Weekdays (PM): The Chief Resident of each service is responsible for checkout to the Chief Resident on call. Labor and Delivery, antenatal, gynecology and oncology patients should be checked out to the first-call resident as well as the Chief Resident on-call. All services will be maintained by the respective teams until the call team is available. Reviewing management of antepartum, oncologic and complex gynecologic patients is mandatory. Scheduled surgical cases that cannot be finished by the time call handover occurs will be performed with the call-team as available.

Weekends: Written reports will be given to the oncoming call team by the respective off-going service teams. All rounds, circumcisions, consults, etc., should be completed prior to the off-going team's departure; unless arrangements have been made with the call team for coverage of such.



## **Call Assignments**

The call schedule will be made in advance by the administrative Chief Resident. Call will be scheduled according to the needs of the services. Weekends will include a 24 hour call period on Saturday 0600 to 0600 and two 12 hour shifts on Sunday.

Friday 1630 (Fri)-0700 (Sat)

Sat 0700 (Sat)-0700 (Sun)

Sun 0700 (Sun)-1800 (Sun) and 1800 (Sun)-0600 (Mon) –Night Float Team

Holiday calls will be 24 hours.

For extended weekends, the Chief Resident will attempt to distribute these evenly throughout the year.

## **Teaching Responsibilities**

Resident education is based on a steady advancement in ability, knowledge, ethics, and ability. This is developed in a gradual manner over the four years of residency. To continue to achieve this, the resident assumes increasing teaching responsibilities throughout the residency. A significant amount of teaching is performed as resident-to-resident with the upper level residents teaching the junior level residents and the junior level residents teaching the medical students. The faculty teaches at all levels, but especially help to develop the teaching skills, attention to detail and sense of urgency and triage of the upper level residents.



## **Resident Research Policy**

As a requirement for graduation from the OB/GYN Residency Program, all residents are required to develop, conduct and present a research project during their residency. Residents are encouraged to become involved in current research; however, to complete the requisites of the program, the resident must also develop and conduct an original research project. In addition, residents are required to write up a case report or case-series report by the end of their second year of training. All research projects and case reports involving human research, data or chart review must be submitted to and approved by the UTCOMC Scientific Review Committee and Institutional Review Board (IRB). All residents are required to complete an online course in human research (CITI).

The Program conducts research meetings each month or two months. The meetings are chaired by Dr. Sprague. During these meetings current research is discussed, guidance is given, and new projects are developed. Each resident should be assigned a faculty research mentor during their training. The resident should work closely with the faculty mentor in the developing and executing the project. The UTCOMC annually sponsors an institution-wide Research Week during which research projects and unique caswe reports are presented before an audience of peers and faculty. Presentations are judged, and outstanding research is rewarded. Additionally, exceptional research will be submitted for presentation at national meetings and/or for publication.

By the middle of the first year of training, the resident should have developed an area of interest for research and should discuss this with a mentor and at research meetings.

By the middle of the third year, research should be progressing. Failure to complete a project will constitute an incomplete residency and failure to graduate from the program unless the project is a multi-year project.



## SOCIAL NETWORKING GUIDELINES

The Office of Graduate Medical Education recommends that Residents and Fellows exercise caution in using social networking sites such as Facebook or MySpace. Items that represent unprofessional behavior posted by Residents and Fellows on such networking sites are not in the best interest of the University and may result in disciplinary action up to and including termination. All Residents and Fellows in the University of Tennessee Graduate Medical Education Program are student employees of the University of Tennessee. As such, they are responsible for adhering to all University policies, including the University's Code of Conduct as set forth in UT Policy No. HR0580.

This policy states that, "Each member of the university community is expected to exhibit a high degree of professionalism and personal integrity consistent with the pursuit of excellence in the conduct of his or her responsibilities."

The policy can be accessed in its entirety on the UTHSC and UT College of Medicine Chattanooga's GME websites and identifies certain commonly held values and associated behaviors by which the University as a community is measured and governed. Residents and Fellows must avoid identifying their connection to the University if their online activities are inconsistent with these values or could negatively impact the University's reputation. If using social networking sites, Residents and Fellows should use a personal email address as their primary means of identification. University and hospital email addresses should never be used for identification on these social networking sites or when expressing personal views.

Residents and Fellows who use these websites must be aware of the critical importance of privatizing their websites so that only trustworthy "friends" have access to the websites and applications.

In posting information on personal social networking sites, Residents and Fellows may not present themselves as an official representative or spokesperson for a Residency or Fellowship program, hospital, or the University.

Patient privacy must be maintained, and confidential or proprietary information about the University or hospitals must not be shared online. Patient information is protected under the Health Insurance Portability and Accountability Act (HIPAA). Residents and Fellows have an ethical and legal obligation to safeguard protected health information. **Posting or emailing patient photographs is a violation of the HIPAA statute.**

Each program should discuss with Residents, Fellows, and Faculty regarding how University and program policies apply to social media and professionalism.

*Reviewed and approved by the GMEC, 2/22/2011.*



## **Policy on Substance Abuse and Physician Impairment**

The Obstetrics and Gynecology Residency adopts the institutional policy on substance abuse and physician impairment:

### **AID FOR IMPAIRED RESIDENTS PROGRAM (AIRS)**

The Aid to Impaired Residents Program (AIRs) is a confidential program which functions in coordination with the nationally recognized Aid for Impaired Medical Students Program (AIMS) developed by the University of Tennessee. The program is a cooperative effort with the Tennessee Medical Foundation (TMF) Physician's Health Program (PHP) and is designed to assess and provide assistance for psychological or substance abuse problem that might affect a Resident's or Fellow's health or academic performance.

Entry into the AIRS Program is a formal process and requires that a Resident or Fellow follow a TMF PHP prescribed rehabilitation program. For individuals that admit and seek help prior to termination from the University of Tennessee Graduate Medical Education Programs, and who enter the AIRS Program, their positions may be protected until the individual receives advocacy of the TMF PHP and is ready to resume training or a determination is made that the individual will not be able to continue training. The residency position may be protected for a period not to exceed one year. If PHP treatment recommendations are followed, the GME Program will work with the resident or fellow to maintain financial support through payroll or disability benefits to determine what health insurance benefits are available to assist with treatment costs.

A resident or fellow who resumes training after completing TMF PHP treatment will be subject to immediate termination if there is a recurrence of distressed behavior or if the resident/fellow fails to maintain ongoing progress. Any exceptions to the policy, including requests for readmission to the TMF PHP due to recurrence of a resident's distressed behavior, will be considered on a case-by-case basis by GME administration.

Referrals may be made confidentially by a health care provider, a co-worker, family member, friend, or the Resident/Fellow. To make a referral or obtain more information, contact local AIRS Committee Chair, Dr. Robert Fore, at 423-778-6956. Residents and fellows may also contact Dr. Roland Gray, Medical Director for the TMF PHP, or another member of the AIRS Committee:



**UT College of Medicine Chattanooga AIRS Committee**

Robert Fore, EdD, Associate Dean/DIO and AIRS Committee Chair  
423-778-6956 [Robert.Fore@erlangers.org](mailto:Robert.Fore@erlangers.org)

Jonathan Cohen, MD, Psychiatry Division Chief and Faculty  
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Pamela Scott, Director of GME  
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## TRANSITION OF CARE

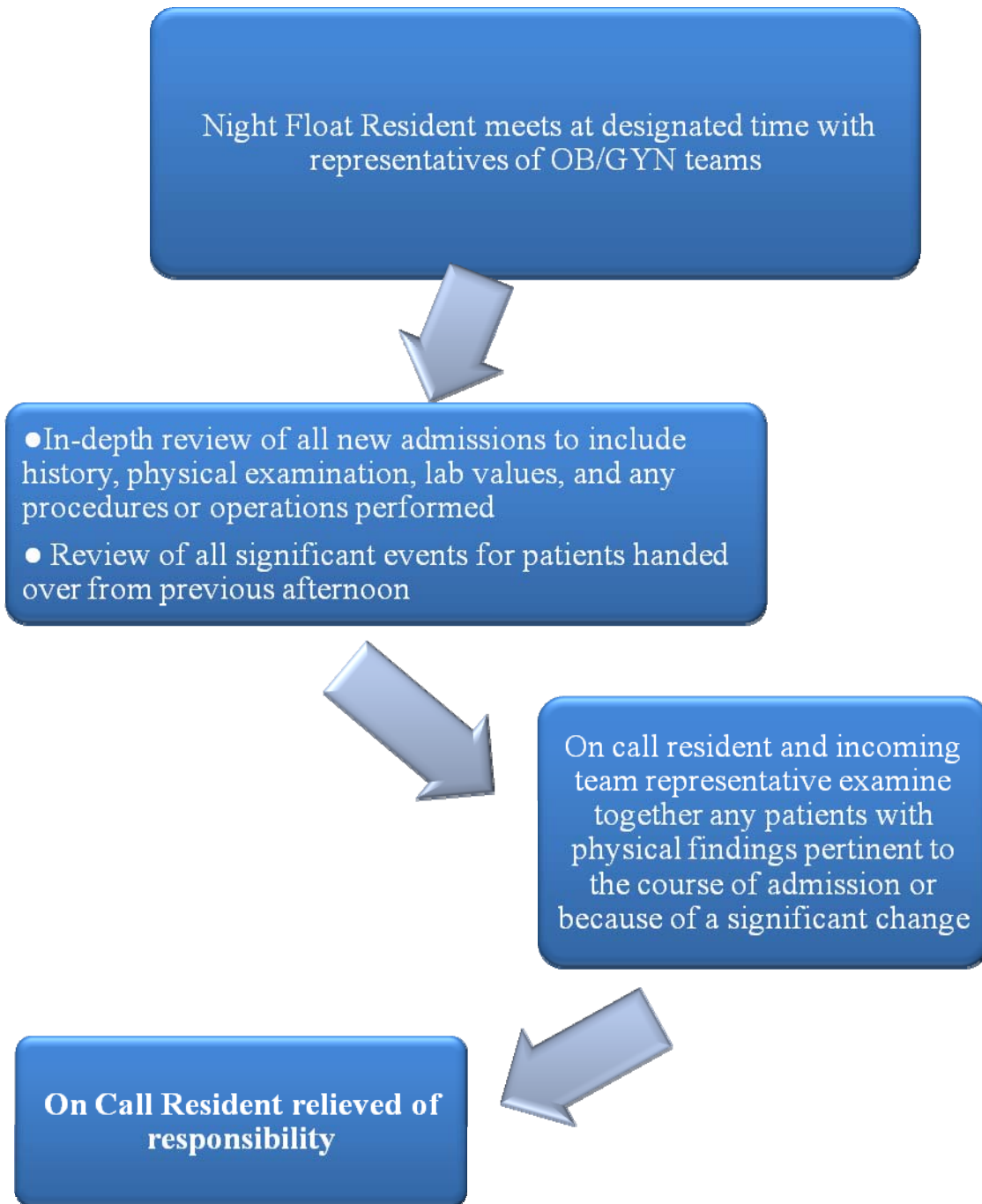
**Purpose:** To establish an orderly protocol for, and minimize the number of, transitions in patient care.

**Policy:**

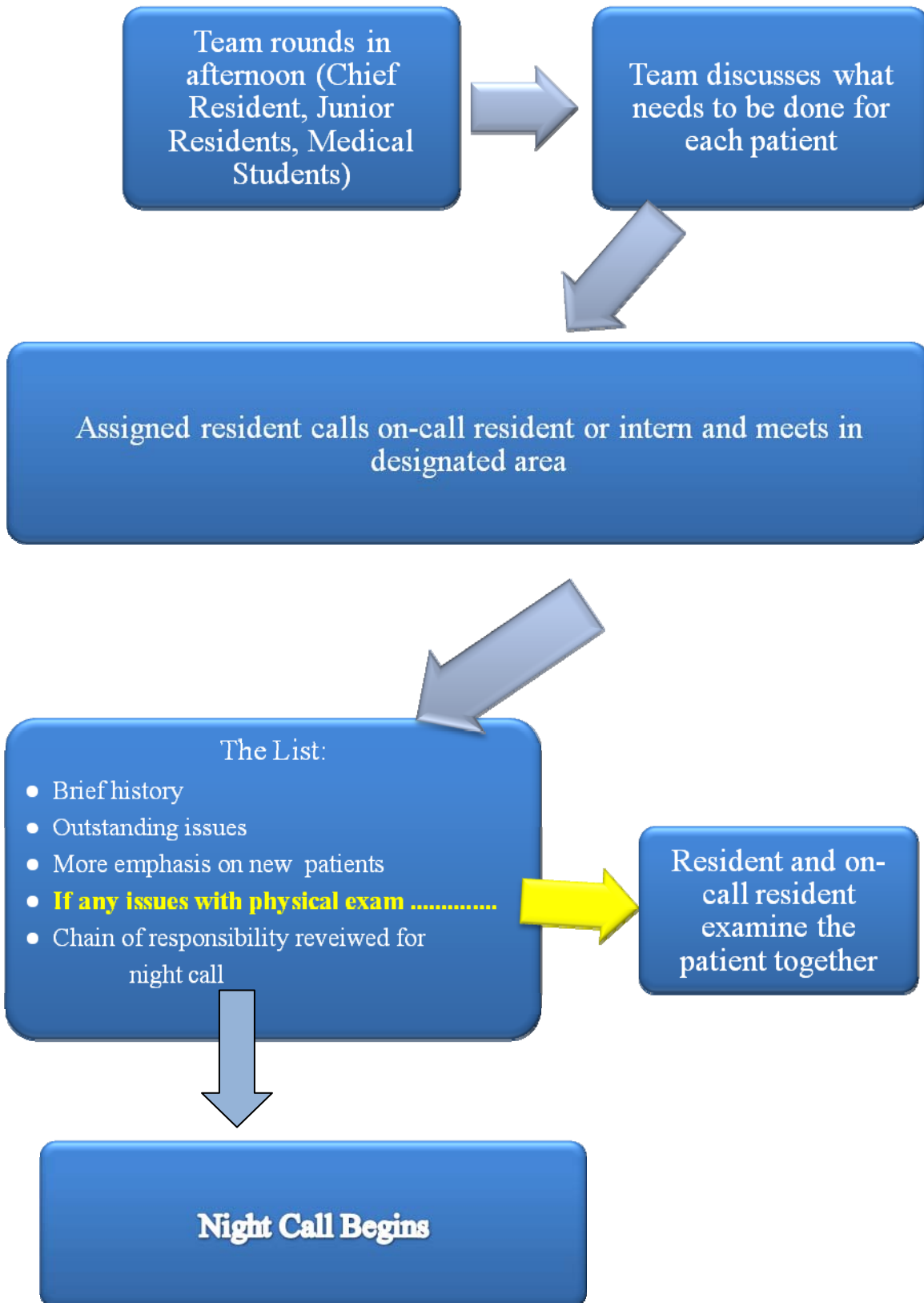
- All patient handovers will take place in a designated workplace, office, or conference room, to ensure patient confidentiality. (Handovers conducted in waiting rooms, cafeterias, elevators, and other public areas are prohibited).
- One-to-one communication must occur between the resident responsible for the patients being released and the resident that will be accepting responsibility for care. No third party communication is allowed.
- Handovers during the first month of residency will be conducted in the presence of a senior resident or attending surgeon to ensure that residents are competent in communication with team members.

**Process Map for transition of care on the next pages:**

AM:



PM:



## Template Patient Checklist for Handovers

- Patient name
- Age
- Room #
- ID number
- Name and contact number of responsible Resident, Fellow, and Attending Physician
- Pertinent diagnoses
- Allergies
- Pending laboratory and x-rays
- Overnight care issues with a “to do” list including follow-up on laboratory and x-rays
- Resuscitation status