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# Department Leadership and Administration

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<tr>
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<th>Name</th>
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<tbody>
<tr>
<td>Interim Chair, Department of Medicine</td>
<td>Louis Lambiase, MD</td>
</tr>
<tr>
<td>Program Director, Internal Medicine</td>
<td>Jennifer Dooley, MD</td>
</tr>
<tr>
<td>Associate Program Director</td>
<td>Rehan Qayyum, MD</td>
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<tr>
<td>Medical Student Clerkship Director</td>
<td>Gary Malakoff, MD</td>
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<tr>
<td>Assistant Clerkship Director</td>
<td>Shadi Ayyoub, MD</td>
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<tr>
<td>Clinical Competency and Quality Improvement Committee Chair</td>
<td>Jay Sizemore, MD</td>
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<tr>
<td>Program Director, Cardiology Fellowship</td>
<td>Charles Campbell, MD</td>
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<tr>
<td>Transitional Year Program Director</td>
<td>Mukta Panda, MD</td>
</tr>
<tr>
<td>Chief Resident</td>
<td>Orlando Turner, MD</td>
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<tr>
<td>Vice Chief Residents</td>
<td>Nathan Claydon, MD</td>
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<tr>
<td>Residency Program Coordinator and Department Manager</td>
<td>Ms. Deborah Fuller</td>
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<tr>
<td>Senior Administrative Assistant</td>
<td>Ms. Karen Sutberry</td>
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<tr>
<td>Clerkship and Transitional Year Coordinator</td>
<td>Ms. Joyce Poke</td>
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<tr>
<td>University Medical Associates, Manager</td>
<td>Ms. Debbie Downs</td>
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<tr>
<th>Division Chiefs</th>
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<tr>
<td>Allergy/Immunology</td>
<td>Hyman Kaplan, MD</td>
</tr>
<tr>
<td>Cardiology</td>
<td>Charles Campbell, MD</td>
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<tr>
<td>Critical Care</td>
<td>John Gunter, MD</td>
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<tr>
<td>Emergency Medicine</td>
<td>Jim Creel, MD</td>
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<tr>
<td>Endocrinology</td>
<td>Asma Khan, MD</td>
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<tr>
<td>Gastroenterology</td>
<td>Louis Lambiase, MD</td>
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<tr>
<td>Hematology/Oncology</td>
<td>Matt Graham, MD</td>
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<tr>
<td>Infectious Disease</td>
<td>Jay Sizemore, MD</td>
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<tr>
<td>Nephrology</td>
<td>Christopher Poole, MD</td>
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<td>Neurology</td>
<td>Tom Devlin, MD</td>
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<tr>
<td>Psychiatry</td>
<td>Jon Cohen, MD</td>
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<tr>
<td>Pulmonary</td>
<td>Suresh Enjeti, MD</td>
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<tr>
<td>Rheumatology</td>
<td>Michael Brit, MD</td>
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The administrative offices of the Department of Medicine are located on the 2nd of the Whitehall Building, Suite 200. The Whitehall Building is on Third Street across from Erlanger and is also accessible by the tunnel. University Medical Associates is also on the second floor of the Whitehall Building, Suite 208.

The Departmental Office extension is 2998. The departmental e-mail address is: UTintmed@erlanger.org.

Office Hours:
Weekdays, Monday- Friday
8:00 AM - 5:00 PM
Summary of the Program Graduation Requirements

1. **American Board of Internal Medicine (ABIM) requirements**
   www.abim.org/certification/policies/imss/im.aspx
   36 months of Medicine training must include the following:
   a. 30 months on internal medicine rotations
   b. 24 months of direct patient responsibility (patient care months)
   c. 6 months of direct patient responsibility in PGY1 year (i.e., medicine inpatient)
   d. Up to 3 months may be non-internal medicine primary care areas (i.e., pathology, radiology, pediatrics, surgery, OB/GYN, etc.)
   e. No more than 3 months of leave over 3 years (which includes vacations, CME)
   f. Patient Care Months (need a total of 24 months and may include)
      - Inpatient Medicine
      - Infectious Disease
      - Nephrology
      - Critical Care
      - Emergency Medicine
      - Neurology
      - Cardiology
      - Night Medicine
      - Hospitalist Elective
      - Gastroenterology
      - Pulmonary, Inpatient
      - Private Office

2. **ACGME Internal Medicine Residency Review Committee (RRC) requirements**
   www.acgme.org/acgmeweb/Portals/0/PFAssets/ProgramRequirements/140_internal_medicine_07012015.pdf
   a. At least 130 sessions of continuity clinics
   b. At least 1 month of ER
   c. At least 3 months of Critical Care and no more than 6
   d. At least 1/3 of residency experience ambulatory and 1/3 inpatient

3. Successful progress through the ACGME/ABIM Milestones
   www.acgme.org/acgmeweb/Portals/0/PDFs/Milestones/InternalMedicineMilestones.pdf
   as determined by the Clinical Competency and Quality Improvement Committee

4. Demonstration of competence in the core competencies on monthly & semi-annual evals

5. Mini-Clinical Evaluation Exercises (CEXs) completion-
   a. PGY1-4 must be completed by the first 6 months
   b. PGY2-2 required
   c. PGY3-2 required

6. Completion of the resident scholarly activity requirement
   a. 21 points total, minimum of 3 points each year

7. Education for Life requirement Statement submitted at final Semi-annual evaluation

8. Completion of ABIM and Departmental procedure requirements,
   (See Spreadsheet in Appendix)
9. Every resident must evaluate each rotation, each attending, peers and the program

10. A passing score on USMLE Step 3 is required before promotion to PGY3, per UT policy. Must register by February of PGY2 year to have results back in time. Failure to pass USMLE Step 3 before the end of the 2nd year may be grounds for non-reappointment or dismissal from the program.

11. Residents must maintain active ACLS certification all 3 years

12. Attendance at scheduled conferences is expected

13. Completion of program assignments (i.e., - minimum of 12 Hopkins modules/year)

14. Handover Evaluation is required each year

15. Successful completion and satisfactory evaluation of a Mega-code is required for promotion to PGY2

16. Timely Medical Record Completion

17. Adhere to UT Policies Regarding Professionalism, Dress Code, and Patient Privacy (see Appendix)

18. The following rotations must have been completed during the residency
   a. 12 months inpatient general medicine, with at least six months in the PGY-1 year
   b. 3 months critical care
   c. 2 months cardiology
   d. 1 month emergency medicine
   e. 1 month GI
   f. 1 month hematology-oncology
   g. 1 month ID
   h. 1 month nephrology
   i. 1 month neurology
   j. ½ month endocrinology
   k. ½ month geriatrics
   l. ½ month rheumatology
   m. ½ month psychiatry
Resident Duty Hours

ACGME Residency Review Committee Guidelines:
1. Resident may not work more than 80 hours a week, when averaged over 4 weeks (includes moonlighting hours)
2. Residents must have 1 day off in 7, when averaged over 4 weeks
3. Resident should have 10 hours off between duty assignments
4. Residents may not work more than 24 hours per shift
5. Interns cannot work more than 16 hours per shift

The department strictly adheres to and monitors duty hour compliance. Please enter duty hours in New Innovations daily. The GME requires residents update duty hours at a minimum weekly. Those who fail to update duty hours every 7 days are not in compliance with GME institutional policy which is monitored by the Dean’s office.

New Innovations
1. Hours you are in the hospital during most days should be logged as “Regular Duty”
2. Only 24 hours shifts should be designated as “Call”
   a. Our “Long call” team that admits 8am-8pm should be logged as “Regular duty” NOT “Call” which is defined by the ACGME as a 24 hours shift
3. Types of duty hours in New Innovation
   a. Regular Duty Hours- The majority of shifts will be entered as Regular duty
   b. Call- This is defined as a 24 hour in-house overnight shift.
      i. We currently do not have “Call” as defined by the ACGME
   c. Post Call- begins after 24 hour in-hospital overnight call, and is limited to 4 hours to complete handover and patient care. This must be logged separately from your regular overnight call hours.
   d. Night Float
   e. Moonlighting Duty
   f. Vacation/Leave- This is for Vacation, Personal Days, or Sick days. Regular Off days do not need to be logged.

If you stay late make sure you let your attending and senior know you require 10 hours off between shifts and do not report back to the hospital until 10 hours have occurred for required rest. To make sure this occurs please try to leave the hospital by 8pm and any pending duties should be signed over to night float.
Guidelines for Calling an Attending

Anytime a resident considers calling an attending, please do so. We always welcome discussion of any question or issues. Each attending physician bears medical, legal, and ethical responsibility for the quality of care received by each patient admitted to him or her and managed by a house staff team. Resident teams should understand clearly the need to inform their attending of the clinical status of patients sufficiently to allow appropriate attending physician oversight. Each attending physician must give appropriate oversight while allowing residents progressive opportunities for decision-making and responsibility.

Please always contact an attending during the following circumstances:

1. Any major change in a patient’s condition; including, but not limited to transfer to Intensive Care, Code Blue, Rapid Response, Need for emergent invasive procedure

2. If there is a suspicion the patient is hospitalized as a result of criminal activity (i.e., evidence of trauma/abuse)

3. Patients must be discussed with an attending prior to a patient being discharged

4. Interpersonal conflict with a patient or family member

5. Prior to any invasive procedure (unless emergent)

6. Patient death

7. Medical Error
Evaluation
A. House Staff will be evaluated by attending physicians and peers at mid-month and end of month in Medical Knowledge, Patient Care, Professionalism, System Based Practice, Problem Based Learning, Interpersonal Communication Skills
B. House staff will also have the opportunity to evaluate faculty and peers.
C. House staff will evaluate the program by both the UT GME survey and the ACGEM survey annually.
D. The Clinical Competency and Quality Improvement Committee (CCQIC) meets 3-4 times during the year to review resident evaluations and, as a committee, makes recommendations on feedback and promotion.
E. The CCQIC and Program Director review resident progress through the Milestones
F. Semi-Annual Evaluation
   i. The Program Director or Associate Program Director meets with each resident at least twice per year to review his/her individual evaluations and gives feedback as to how the resident is progressing through the residency.
   ii. Peer evaluations are not available to be reviewed by the resident. However, all peer evaluations will be reviewed by the program director and CCQIC on a regular basis
G. The Program Director ultimately is responsible for deciding if a resident has met the requirements for promotion to the next level and for graduation
H. Residents must achieve competence in each content area required by the ABIM and ACGME

In-Training Examination
The In-Training Examination is an exam administered to all Internal Medicine residents across the country each fall. All residents receive 2 scores, a total percentage correct and a percentile rank comparing the individual’s score to other PGY1s, 2s, and 3s across the country. The In-Training Exam is not used for promotion. All residents receive a score breakdown and list of objectives incorrectly answered. Residents should use the feedback to focus areas of study. Residents who score below the 25th percentile nationally will be placed on an individualized reading plan.
Reappointment, Promotion, Non-Renewal, and Appeals Policies

The Medicine Department follows the University of Tennessee College of Medicine Chattanooga Graduate Medical Education Programs Institutional Policy on Resident Re-Appointment, Promotion and Non-Renewal and Appeals

Please refer to the Appendix of this document to review all institutional policies referenced.
Internal Medicine Department Leave Policy

1. General Guidelines
   a. Effective July 1st a UT Resident Time Off Sheet must be submitted and signed each month to report all leave, regardless of whether or not the resident has taken time off for that period.
   b. The ABIM requires all internal medicine trainees to complete 33 months of training in order to be eligible for the medicine board exam; thus, cumulative leave of more than 3 months (thirteen weeks) for any reason will extend the period of training beyond the traditional 36 months.
   c. Internal Medicine residents are allowed:
      i. Three weeks (15 working days) vacation leave per academic year
      ii. Five personal days total over the 3 year training period
      iii. One week of Continuing Medical Education each academic year
      iv. Up to one week of holiday leave in late December or early January depending on patient care and scheduling demands
   d. No more than one week (5 weekdays) of leave may be scheduled during any rotation; if vacation time is scheduled during the same month, the resident may not be away for more than 5 weekdays during that month except in unusual circumstances that will be reviewed by the Program Director on an individual basis.
   e. Reminder for seniors: contracts end June 30th, if you plan to leave prior to June 30th (after graduation) please make sure you have sufficient vacation time.

2. Vacation Leave
   a. Must be scheduled and all signatures obtained on the leave approval form by the first day of the month prior to the month of the requested vacation
   b. Residents MAY NOT schedule vacations during Inpatient Medicine, Night Float, Critical Care (except interns), 2-week rotations, or Emergency Medicine. All vacation requested for the 1st week of a rotation month must have rotation Attending’s approval signature obtained by resident before request will be considered.
   c. Three weeks (15 working days)/academic year; unused vacation leave cannot be utilized in a subsequent academic year
   d. No more than 1 resident on the same rotation off unless special approval granted
   e. Granted on a first-come, first-approved policy
   f. No more than one week (5 working days) of scheduled leave during any month rotation
   g. No leave for travel outside of the US will be approved during the last 2 months of a currently valid non-resident visa or passport until renewal has been obtained. The resident must also adhere to 1(b) above.
   h. For overseas travel, residents must understand the risk of travel delays and the potential for lengthening the residency duration required to meet ABIM training requirements.
   i. If a resident is delayed by more than 60 days from returning to his/her residency assignments because of travel outside of the US, his/her status as a resident in the Internal Medicine Residency may be terminated. Resumption of residency will require reapplication for admission and is not guaranteed.
3. **Extended Vacation Leave- Only available for PGY2 and PGY3 residents**
   a. Maximum of 3 weeks consecutively but resident must have sufficient unused vacation time for that academic year
   b. If 2 weeks are scheduled consecutively, they must be scheduled for the first 2 weeks or last 2 weeks of a month. A 2-week rotation for the remainder of the month must be scheduled. (Endocrine, Psychiatry, Allergy, Dermatology, etc.)
   c. Must be scheduled by July 1 of the academic year for which the leave is being requested
   d. For overseas travel, residents must understand the risk of travel delays and the potential for lengthening the residency duration required to meet ABIM training requirements.

4. **Leave for Presentations at State and National Meetings**
   a. Approval contingent on ability to provide adequate patient care coverage as well as academic considerations.
   b. Arrangements for appropriate continuation of patient care duties in his/her absence is the responsibility of the presenting resident and must be approved by the program director.
   c. If approved, the Department of Medicine will provide residents with reimbursement according to departmental guidelines for presentations at state or national meetings.
   d. No more than one regional and one national meeting will be funded by the Department during each academic year for a resident to present accepted submissions; however, residents may apply their own unused CME (Continuing Medical Education) funds to attend additional meetings.
   e. Requests for funding the presentation of a completed resident Research project which has been accepted for presentation at a regional or national meeting after a resident has already received departmental funding for a regional and a national meeting during that academic year will be evaluated individually.
   f. Once accepted for a national meeting, the same submission must not be resubmitted to another regional or national meeting.

5. **Leave for Interview Dates**
   a. The Residency Program understands that invitations for fellowship interviews often occur with little advanced notice and offer only a single or limited number of days to interview. Employment interviewing typically offers more flexible scheduling.
   b. As soon as an invitation for an interview is received, the resident must contact the Program Coordinator, supervising attending, and UMA Clinic as continuity of patient care must be assured in order to be absent for interviewing.
   c. Residents must have sufficient vacation and/or personal days available for the expected dates of leave – no additional time away is granted for interviews; thus, residents anticipating the need for fellowship and/or job interviews should schedule their other leave periods accordingly.
   d. A signed leave form must be returned to the Program Coordinator prior to the absence
e. The resident is responsible for arranging coverage for patient care during his/her absence.

6. **Sick Leave**
   a. Residents are allowed up to 3 weeks (with one weekend for each sick week taken) paid sick leave days per year, if needed;
   b. Sick days are not carried over from year to year.
   c. The resident must provide a physician’s statement to return to residency duties for periods of sick leave of 3 consecutive work days or longer.
   d. A resident will not be paid for unused sick leave at the end of the year.
   e. The determination as to how 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.

7. **Personal Days**
   a. Five personal days will be granted over the 3 years.
   b. Personal Days cannot be taken on a clinic day.
   c. One week’s notice is necessary. If an emergency occurs which does not allow a one-week notice, call the Program Director to discuss the situation.
   d. A form requesting a personal day must be signed by the attending physician and by the Program Coordinator and then submitted to the Department of Medicine.

8. **Educational (CME) Leave**
   Each resident is provided funds via the Graduate Medical Education Office and Erlanger for reimbursement of expenses related to an external conference during each of the three years. The goal of the conference is to update the resident in general Internal Medicine. The following must be met:
   a. The conference must be approved by the Program Director.
   b. The program agenda must be submitted with the request.
   c. At least six hours per day must be devoted to the conference.
   d. The content must be devoted primarily to internal medicine or IM procedures.
   e. The conference must be in the United States “or be the national meeting of a US medical society. (Example: national meeting of the Society of General Internal Medicine held in Toronto, Canada in April 2007).”

   Educational leave should be requested **3 months** in advance of the trip. The same signatures are required as for vacation leave and must be obtained by the first day of the month prior to the month of the conference. The conference must be a full-day program and not one divided into two to four lectures in the course of a day with the remainder devoted to recreational activities. One-day additional travel time, either to or from the meeting, will be allowed. A total of five weekdays off will be granted for conferences, including travel time. Travel plans, which include completion of a University of Tennessee Authorization for Official Travel Form (T-18), should be coordinated with the Program Coordinator at least one month in advance to secure optimal travel rates. All travel is subject to the University of Tennessee and Erlanger hospital policy and procedures and original receipts are required within 30 days of the travel or expense.
9. **Leave of Absence, Family Medical Leave, Bereavement Leave**
   Please refer to GME Leave Policy in the Appendix of this document.

10. **Holidays**
    Due to the 24 hour nature of patient care, residents are not entitled to holiday leave unless the hospital or program service/clinic closes for that holiday. Time off for a holiday is based on a Resident’s or Fellow’s rotation assignment. A Program Director may approve time off on a holiday for a resident who is rotating on a clinic or service that closes due to the holiday.
Reimbursement
Regarding reimbursement of books, PDA’s or other non-travel related educational expenses, the resident must have already paid for the items prior to requesting reimbursement. Original receipts must be submitted to the Department of Medicine staff within 30 days of the expense. Residents should allow three weeks for processing from the time the request is received in the Graduate Medical Education Office. Any unused educational reimbursement at the end of June cannot be carried over to the next year. Reimbursement for educational conferences and materials is provided by the Graduate Medical Education (GME) office and not by the Department of Internal Medicine.

Approved expenses
Travel expenses to CME conferences approved by program director.

It is recommended that travel be arranged through the University of Tennessee recognized travel agency, World Travel, to ensure that all University policies are followed.

Electronic educational materials – including up to a maximum of $250 for an iPad or smart phones
Video course registration
Hard copy medical-related books
Board Reviews (hard copy, CD-ROM, online, etc.)
Membership fee for specialty organizations
USMLE Step 3 registration fee
Laptop computer
Small medical equipment such as stethoscope or neural reflex hammer

Non-approved expenses (may include but are not limited to)
Printers including palmtops
Digital cameras
Certification board exam fees
Medical license fees

For Travel Reimbursement from UT
A UT travel request (T18) must be submitted 1 month prior to travel
To be reimbursed for flights, must have original receipt with breakdown of taxes/fees and the receipt must denote Coach Fare.
To be reimbursed for hotel, must have original receipt from hotel with breakdown on nightly rate, taxes/fees.
Rental cars are NOT reimbursable
Receipts from travel sites such as Expedia, Travelocity, Orbitz, etc., generally will not be honored.
No package deals which include airfare, hotel, and car rental are permitted through these type travel sites – under any circumstances.
Again, the University recommends that you arrange travel through the UT recognized travel agency, World Travel, to ensure that all University policies are followed and receipts will meet requirements.

See GME Travel Policy in Appendix of this document.
Inpatient Medicine Teams and the Night Medicine System

1. All three Inpatient Medicine Teams are available for daytime admissions.
   i. All Teams are open for new admissions until 3:00 pm
   ii. The Long-Call team remains in-house until 8:00 pm

2. The Night Medicine Team covers all patients from 8:00pm-8:00am

3. A back-up resident is on-call each day and may be pulled for inpatient service in the event of unexpected illness, emergency, other. The back-up resident is also available for phone calls from interns when the senior is off. The backup resident is required to have his/her pager on at all times.

4. Handover occurs in WW2 after 8 am morning report Monday- Friday. Handover occurs in the Handover Room on WW7 every evening at 8pm and on weekends at 8 am. All teams must be present for morning handover.

5. Night float admissions will first fill the post-call team to the team limits per the team attending, then the other teams will accept remaining patients.

6. During each 24 hour period, there will be a limit of 10 new patients to the Medicine team (8 if single intern or no intern team). No more than 5 admissions per intern in 24 hours.

7. The total team census for a single intern team cannot exceed 14 and for double interns 20.

8. The night float intern and residents will be required to attend clinic for 2 sessions during the month. The intern will attend clinic on Friday morning and the senior will schedule clinic sessions prior to the month of night float with the patient service representatives in the clinic.

9. Admissions accepted after 6:30 PM can be held for the night float intern after the resident assures that the patients are adequately stabilized by the Emergency Department staff and that timely work-up has been initiated.

10. The Long-Call senior resident is responsible for directing all in-hospital “codes” (Code Blue) even if a private physician or faculty physician is present. Transfer of the direction of the code to the patient’s private physician is permitted, if requested; otherwise, the supervising medical resident directs codes. Internal Medicine residents are expected to respond to Code Blue in the operating rooms. Jump suits are available for the responding team to maintain sterile conditions. Critical Care Attendings and the Rapid Response Team will come to codes for supervision. Residents respond to 1st floor codes in the Medical Mall, but do not respond to private doctor offices located on the 2nd floor or above.
11. Orders must be written only by the house staff caring for the patient on teaching services except for procedural orders, chemotherapy orders, or emergency situations. Verbal orders should be avoided when possible, or must be signed within 24 hours.

12. If you feel a patient does not warrant admission, let the EM attending know you need to contact your attending. Residents may not refuse an admission, but there may be an attending to attending level discussion.

13. Residents may not accept transfer patients from the transfer center. If called by a private attending, please get their phone number and let them know an attending will return the call.

14. Backup for Team Seniors: Residents should call for backup for any acute or routine question anytime needed. The situation should dictate who to call first. However, the following are suggestions for assistance:
   1. Resident In-house or Attending on Call
   2. Back up senior resident
   3. Program Leadership (PD, APD, Core Faculty)
   4. Rapid Response Team

**Admissions from the Medicine Clinic**
Any patients admitted from UMA will be admitted by the resident evaluating the patient in the clinic. The clinic resident or intern will be responsible for notifying the on-call team, and will also be responsible for writing a comprehensive “holding note” and initial admitting orders. The receiving team will complete the admission History & Physical and dictate the H&P for the inpatient record.

**Admissions from the Tumor Clinic**
All patients admitted from the Oncology Clinic will be admitted by the resident assigned to Oncology Clinic. A comprehensive holding note and orders are to be written by the resident assigned to the Oncology clinic. If the patient is unstable, the Oncology clinic resident will assist with the patient’s care until the ER physician or inpatient team assumes care. The Oncology Clinic resident is responsible for notifying the on-call team about the patient being admitted. Patients being admitted for chemotherapy only are not to be admitted to medicine teams.

**Readmissions**
If a patient has been admitted in the past 30 days with a similar presenting problem, the pt is readmitted to that same service (i.e., Family Medicine, Hospitalists, Inpatient Internal Medicine). In the event of a disagreement about who should admit a patient, contact your attending physician to decide or follow the instructions of the ER physician who has evaluated the patient.

**Work Rounds & Attending Teaching Rounds**
1. Work rounds are to be conducted by the resident, intern(s), and medical student(s) on most days at a time separate from attending rounds.
2. The senior is responsible to provide oversight of the interns on all patients on the census prior to attending rounds.
3. Work rounds are primarily designed for the supervising resident to teach team members how to evaluate the clinical issues of the patient, plan the workup, and make appropriate treatment decisions.

4. Timing of teaching rounds will occur at the discretion of the attending and team members.

5. Management issues may be discussed in conjunction with didactics.

6. Teaching rounds is for the attending physician to be involved in the educational aspects of the cases and to appropriately supervise the clinical care of team patients. Teaching rounds are expected to total a minimum of 4.5 hours per week. Interns and Residents are expected to have read up to date literature on their patients.

Consultations

1. Consults should be called by the intern/resident and there should be completion of the consult forms.

2. Medical students should not call in consults

3. If there is a resident on the service that is being consulted, please communicate directly with the resident on the service.

4. Interns should speak with their senior prior to calling a consult

5. If an intern is called to accept a consult, please discuss with your senior and have them return the call to the attending requesting the consult.

6. When consulting other specialties, the consulting physician is expected to make recommendations and permit the primary resident to write orders unless the order is urgent or emergent.
**Academic Hospitalist Expectations of Inpatient Team**

- All team members should be active participants in rounds
- Please make sure all pts have been seen by the resident and intern prior to rounds *(Rounding times are flexible to make sure all pts are seen)*
- Residents are the team leaders and are responsible to have full knowledge of all patients
- Residents are responsible for preparing the team for attending rounds
- Residents please provide team calendar 2 weeks prior to 1st day of rotation to attendings and program coordinator *(include off days, clinic days, presentations)*
- Know when team presents Morning Report and review case with intern/attending prior to presentation
- Senior residents are responsible for rounding on 4th year medical student notes
- Interns are responsible for rounding on 3rd year medical student notes
- Discharge summaries should be completed at the time of discharge
  - *same day is the expectation, but should not be delayed over 24hours*
  - *Last line of discharge should include “Studies Pending” and/or “Issues to Address in Outpt Follow-up”*
  - Forward a copy of all discharge summaries to the patient’s primary care provider
- Dictate full and complete H&Ps with fully discussed differential diagnosis and plan
  - Full H&P components- see Resident Handbook
- Provide complete full presentation on initial day of visit and concise presentations in SOAP note format of follow-ups
- On call days senior page/text MR# of new admits to attendings *(do not text pt names for HIPPA compliance)*
  - Do not accept transfer patients. There must be attending to attending communication. Please be courteous and let the transferring MD know an attending will return the call
- If a pt cannot communicate or is in the ICU call the family daily & document
- E-mail checkouts to attending daily and forward to new attendings when there is a change of attendings
- Everyday ask yourself “What can I do today to get the pt one step closer to going home?” *(Can I stop IVF, remove lines, advance diet, change meds IV to PO, mobilize pt, etc.)*
- The phrase “It’s not my patient . . .” does not exist in your vocabulary
- The only 3 RULES in rounding with your hospitalist attending:

**1. If you consider calling an attending….CALL!**
   - Do not hesitate to call your attending.
   - While the resident is the team leader, the attending is ultimately medically and legally responsible for the patient.
   - Notify the attending of any major change in the patient’s condition/decompensation, pt/family conflict with care team, and/or death

**2. You will not be penalized for saying “I don’t know”**

**3. ENJOY ROUNDS 😊**
**Handover**

Studies have shown that lapses in care can occur if a physician is not fully aware of a patient’s clinical situation; thus careful handovers of care are essential.

**See Resident Handbook for template**

1. Always use the standard template for handover
2. Update the information daily
3. Handover must be written/electronic and verbal
4. Seniors should review intern handovers
   i. Always review the first week when working with a new intern and directly supervised the first few handover sessions to ensure the important information is conveyed accurately and concisely
5. Provide the receiving intern with two copies of your completed template for sign-out - one copy for them and one copy for their supervising resident. Always discuss new admissions, unstable patients, or anyone you anticipate may have a problem overnight with the receiving intern.
6. Provide your contact information, as well as contact information for your resident and attending on the header of the sign-out. The cross-covering team, may need to reach someone from your team.
7. Think carefully about tasks that you are handing over to the receiving team and be specific. If you want a lab value to be checked, indicate what time you ordered it to be drawn and what action should follow Tasks should follow “if, then” format. Example- Please follow-up 8pm H&H- If Hgb<7, then transfuse 1 Unit PRBC
8. Each morning at 8:30am handover, the night float intern must discuss with the inpatient teams any changes in the status of their patients as well as any new clinical problems which arose overnight
9. All handovers completed by medical students must be initialed by the supervising resident to assure accuracy

**Off Service Notes/Monthly Patient Handover**

At the end of every month, the intern is responsible for writing a detailed off-service note on all patients. If a patient has been admitted for more than 5 days, has been admitted to the ICU at any point during their stay, who has had any major procedure or complication a transitional discharge summary should be dictated. A transitional discharge summary is #64 on the dictation line

**Handover during monthly change over**

Residents are expected to give written and verbal handover to the on-coming resident when switching services (example- when changing from GI to Critical Care handover is expected).
**Incident/Occurrence Reporting**

Patient safety and quality improvement is of paramount importance in Internal Medicine. If there is a patient care situation that is a near miss, error, or system issue that negatively impacts patient care please submit a report to the Erlanger Incident/Occurrence Reporting system. Your attending may assist you in doing this and please always discuss these cases with your attending.

http://ehs-msasrl01/RMProWeb/riskweb3.DLL/FrmLogin

**Practice Data**

Erlanger supplies practice data monthly for the Inpatient medicine teams. This data will be shared at the resident business meetings and sometimes e-mailed. We are currently working on a Clinic scorecard for Individualized patient data.
Medical Record Completion Policy

Inpatient Rotations
1. All H&Ps need to be dictated the day of admission
2. Discharge Summaries should be dictated the same day and should not exceed 24 hours
3. Discharge summaries need to be completed on all patients admitted to the hospital, including those admitted for 23 hour observation
4. All records need to be signed in HPF in a timely manner
5. Any records exceeding 7 days are delinquent
6. Records exceeding 14 days will require action by the Department

Continuity Clinic
1. Notes in EMR should be completed prior to leaving clinic
2. EMR desktops need to be checked daily

Residents are encouraged to complete records on a daily basis to avoid ANY delinquent charts.

See Resident Handbook for H&P and DC summary templates

Discharge Summaries
All patients discharged to nursing homes or other medical facilities must have a completed discharge summary to accompany the patient. This summary can be dictated on a STAT basis for immediate transcription. If somehow the transcription has not come up prior to the time of patient transport, please instruct the nurse to send a photocopy of the handwritten discharge instructions and discharge medications, as well as your most recent progress note, to accompany your patient until the transcription is available. Advanced directives completed in the hospital MUST be attached to this summary.

All other discharge summaries (patients discharged to home) must be dictated within 24 hours of discharge, and preferably on the day of discharge. Be sure to “CC” the patient’s primary care provider, or the physician that the patient will be following up with, at the end of your dictation.

All patients require a discharge summary, including those admitted for 23 hour observation.
**Scholarly Activity Requirement**

Clinical research is a key mission of the Department of Internal Medicine. Faculty investigators at College of Medicine are known for results with high impact on improving health outcomes.

The UTC Internal Medicine Residency Program promotes and nurtures resident research and productivity to:

- Train the next generation of clinical investigators and physician-scientists
- Promote intellectual and academic curiosity
- Support academic subspecialty fellowship applications
- Lay the foundation for successful careers in academic medicine

All Internal Medicine residents are required to carry out scholarly activities and obtain at least 21 points during the 3-year residency program. There are diverse opportunities, including case reports, literature reviews, teaching conferences, quality improvement, and clinical research projects. Residents are strongly encouraged to directly become involved in clinical research, including patient-oriented research.

**Research Goals and Objectives**

The research component of resident training is aimed to establish competency in the design, conduct, interpretation, and presentation of research by encouraging the resident to complete at least one major project and to participate in additional projects, time permitting.

The expected benefit of secondary projects includes the opportunity to enlarge upon previous research and topics, the opportunity for co-resident mentorship, and opportunities for additional authorships.

The research experience is based on a mentorship model where the resident and faculty research mentor will collaborate to develop and execute a research project. Selection of clinical research projects follows a similar protocol; that is, the resident research interest should match with the appropriate faculty mentor.

**Research Studies**

Residents can choose one of the following study designs

*Prospective Clinical Studies:* Studies in which data is collected prospectively whether a clinical trial or a prospective observational study. As such studies take significant amount of time in data collection, residents are encouraged to identify research topic and faculty mentor very early, preferably within few months of starting residency.

*Retrospective Clinical Studies:* In these studies, data has already been collected, generally during clinical encounters. Depending on the study question, these studies can take a significant amount of time as often data needs to be pulled from medical records. Ideally, these studies should be started within the first year of residency. Residents are strongly encouraged to identify mentors
(seek help from PD or APD if you have difficulty in identifying mentors) during the first year of residency.

**Meta-analysis and Systematic Reviews:** These studies summarize results from published literature and build evidence-base that can be ultimately used for developing guidelines. Often, a team of two or more investigators is needed and literature review and analysis may take up to a year. Residents interested in working on a meta-analysis/systematic review should start working in it during the latter part of first year or early part of second year of residency.

**Secondary Data Analysis:** Residents who are comfortable with statistical analysis or who want to learn statistical analysis may want to analyze publicly available dataset for their question. Several datasets are available including NHANES, CHANES, and CMS datasets from Hospital Compare website. Residents should start their project during the latter part of first year or early part of the second year of residency.

**Scholarly Points for Research**
The process of developing, conducting, analyzing, and publishing a study is long and it is possible that a resident may not be able to complete all these steps in a timely fashion; for example, often acceptance at a peer-reviewed medical journal takes several months. While the ultimate goal of the research is to have it published, each stage of the process is given some points to have residents obtain credit towards their yearly scholarly goal.

**Justification for Scholarly Points**
The scholarly points are not a reflection of time devoted towards a project but a reflection of completion of certain stages in a research project and relative importance of those stages within a research project. The ultimate goal of a research project is publication in a peer-reviewed journal; without a publication, a research ‘never’ happened for the outside world. Hence, maximum points are given for manuscript publication. Preparation and acceptance of proposal by SRC highlights the fact that the study question and design is reasonable. Acceptance by IRB confirms that the patient safety and data confidentiality aspects of the study are adequate. The process of data collection and data summary exposes a resident to the nuances of in-the-field issues with data collection and subsequent analyses. Therefore, all these activities are given a total of 14 points to recognize the learning that a resident goes through. Below is the list of points for research activity.

**Scholarly Activity Requirement 2014-2015**

<table>
<thead>
<tr>
<th>Research Project</th>
<th>Up to a max of 35 points</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preparation and SRC acceptance of proposal</td>
<td>3 points</td>
</tr>
<tr>
<td>Acceptance of IRB</td>
<td>3 points</td>
</tr>
<tr>
<td>Data collection and data summary</td>
<td>3 points</td>
</tr>
<tr>
<td>Poster presentation of research</td>
<td>5 points</td>
</tr>
<tr>
<td><strong>Manuscript acceptance in PubMed listed journal</strong></td>
<td></td>
</tr>
<tr>
<td>First author</td>
<td>21 points</td>
</tr>
<tr>
<td>Second Author</td>
<td>15 points</td>
</tr>
<tr>
<td>Third Author</td>
<td>10 points</td>
</tr>
<tr>
<td>All Authors after Third Author</td>
<td>5 points</td>
</tr>
<tr>
<td><strong>Manuscript acceptance in non-PubMed listed journal</strong></td>
<td></td>
</tr>
<tr>
<td>First author</td>
<td>15 points</td>
</tr>
<tr>
<td>Second Author</td>
<td>10 points</td>
</tr>
</tbody>
</table>
All Authors after Second Author  5 points

**Other Scholarly Activity Points**

- Case Report published in a PubMed listed journal  10 points
- Quality Improvement Project published in a PubMed listed journal  10 points
- Case Report published in a non-PubMed journal  7 points
- Quality Improvement Project published in a non-PubMed listed journal  7 points
- Grand Rounds  7 points
  
  *Grand Rounds presentation should be mentored by a faculty*

- Workshop Presentation at regional/national meeting  7 points
  
  *Mentored by a faculty*

- Creation of Evidence Based Order set approved by hospital  6 points
- Case Report Poster presented at regional/national meetings  5 points
- Quality Improvement Poster presented at regional/national meetings  5 points
- TNACP Jeopardy (2 points for questions/ 1 point for running)  3 points
- Team Based Learning Modules  3 points
- Invited Lectures (ex. to RNs or community)  3 points
  
  *These lectures should be scheduled after identification and consultation with faculty mentor who will work with community/nursing to agree upon topics, guide the preparation of the presentation and then present at the presentation to provide written formal evaluation. Points are only for new lectures. If same lecture is repeated, only one point is given for each repetition. Points will only be granted after written evaluation from the faculty has been received.*

- Book Review Published in a peer-review journal  3 points
- Letter to the Editor  3 points
- Commentaries Published in a peer-review journal  3 points
- Medical Student Lectures (min 3/year-max 6/year)  3 pt/lecture
  
  (max 12 points during 3 years from student lectures)
  
  *These lectures should be mentored by a faculty who will identify topics, guide the preparation of the presentation and then be present at the presentation to provide written formal evaluation. Points are only for new lectures. If same lecture is repeated, only one point is given for each repetition. Points will only be granted after written evaluation from the faculty has been received.*
Conference

1. Please see monthly conference schedule for required conferences, which includes: morning reports, noon conference, journal club, M&M, grand rounds, and Health Care Principles in Practice
2. Please be respectful of the presenter and be on time
3. Residents are expected to attend all conferences when on rotations during the day in the hospital unless an unstable patient requires attention
4. Residents on night medicine, off-days, vacation, and off-site rotations are not expected to be present, but all others should be in attendance
5. Grand Rounds and Health Care Principles and Practice are recorded to permit residents to view at later times
6. Residents are responsible for the accuracy of sign-in sheets and for maintaining their monthly and cumulative conference attendance
7. Signing in for days not attended or for other residents is unethical and unprofessional.
8. See appendix for conference schedule
Moonlighting
1. PGY2/3 residents desiring to moonlight must notify and have written permission from the Program Director prior to moonlighting
2. The request should include the time, place, and hours of moonlighting, and should be submitted prior to the scheduled activity
3. All residents desiring to moonlight must obtain a Tennessee Medical license and malpractice insurance coverage for any professional work outside of residency activities. The Tennessee Claims Commission, which provides malpractice coverage for residents in their training activities, does not provide coverage for moonlighting activities.
4. Moonlighting schedules must be sent by e-mail to Ms. Deborah Fuller at the beginning of each month including dates, location, and duty hours.
5. **No moonlighting is allowed during Inpatient Medicine or Critical Care rotations**
6. **Moonlighting hours must be logged into New Innovations and total duty hours (residency shifts + moonlighting) may NOT exceed 80 hours per week.**
7. Moonlighting schedules should not interfere with your regular duties. Residents should not leave their rotation site before 5 PM or before their duties are completed in order to begin a moonlighting shift.
8. Failure to comply with the above or marginal-to-unsatisfactory evaluations will result in loss of moonlighting privileges.

http://utcomchatt.org/docs/Moonlighting_Policy.pdf

Pharmaceutical Company Sponsorship of Lunches/Dinners for Residents

*Pharmaceutical representatives are not allowed to participate in residency activities.*

The Department of Medicine strongly discourages resident attendance at pharmaceutical company sponsored dinners as studies have shown that physicians do not detect the inaccuracies in presentations. A substantial literature has developed illustrating that pharmaceutical presentations alter physician prescribing towards more expensive branded medications instead of generic products and national guidelines.

No announcements, promotions, or arrangements for industry sponsored activities can occur at resident conferences. The University of Tennessee College of Medicine Chattanooga policy concerning industry relationships is located in the Appendix of this document.

http://utcomchatt.org/docs/Physician_Industry_Guidance_Revision_5_19_08.pdf
Medical Student Responsibilities

M3 Medical Students:
1. M3s are supervised by the team intern
2. Students are to be assigned 1-2 new patients per call
3. Medical students should be carrying a minimum of two patients at all times up to a max of 5
4. They are to perform and write comprehensive H&Ps with a complete A&P for each problem.
5. M3s are expected to write daily progress notes and these must be co-signed by the intern/resident
6. They are expected to pre-round on their patients and present during work and attending rounds
7. Please review all physical examination findings with the students.
8. Review and practice oral presentations with the student their 1st few days prior to rounds
9. Please have the students write orders on their patients whenever possible and co-sign
10. Students should have at least 2 SOAP notes evaluated and corrected by the resident
11. During the course of the Clerkship, students are to be asked to present a 5-10 minute topic assigned by the resident reflecting a relevant clinical management issue which may come up on rounds. One to two presentations a week is the expectation. Students will give you a student presentation evaluation sheet which you must fill out and turn back to the student.
12. H&Ps must be completed within 24 hours and turned into the resident. The resident needs to review them as soon as possible (within 24 hours) and return them corrected to the medical student. The medical students will turn in their corrected H&Ps to the Clerkship Director.
13. Students may not dictate.
14. Feedback should be provided regularly (daily) and they are expected to complete mid-month evaluations from the attending and resident.
15. The Medicine shelf exam is taken the last Friday of the clerkship.
16. Students are expected to abide by the 80 work week.
17. Days off parallel those of your intern.
18. Days on call: students are excused at 8:00 PM.
19. If a concern arises regarding student performance or professionalism, this should be brought to the attention of the Clerkship Director immediately.

JUNIOR INTERNS (JI)
1. JI’s function as interns - directly under the supervision of the senior resident (not interns)
2. Orders should be written by the JI on all of his/her patients. These must be co-signed by the resident before the nursing staff can take them off. It is the JI’s responsibility to make sure that orders are not taken off until they are co-signed.
3. JI’s should admit 1-3 patients per call and should follow up to 5 patients at a time.
4. JI’s may not dictate
5. Duty hour rules apply
6. Feedback should be timely and include a written Mid-Month evaluation
7. Concerns about professionalism, performance, etc., should be brought to the attention of the attending and Clerkship Director as soon as possible
**Patient Assignments**

**Continuity Clinic**
During ambulatory assignments, patient visits for residents should average:
- **PGY 1:** 3 to 5
- **PGY 2:** 4 to 6
- **PGY 3:** 4 to 8

Each resident must have a total of 130 clinic sessions over the three years of training.

**Inpatient Medicine**
- A first year resident must not be responsible for more than five new patients per admitting day.
- A first year resident must not be assigned more than eight new patient admissions in a 48-hour period.
- A first year resident must not be responsible for the ongoing care of more than 10 patients during inpatient ward medicine as well as subspecialty rotations.
- When supervising more than one first-year resident, the second- or third-year resident must not be responsible for the ongoing care of more than 18 patients.
- The second- or third-year resident must not be responsible for admitting more than a total of 10 new patients per admitting day or more than 16 new patients in a 48 hour period, including the first-year resident’s patients being supervised.
- If the team has admitted the maximum allowable patients for their team (8 or 10 depending on whether single or dual intern team), the “on-call” team cannot admit additional patients.

**Consult Services**
The numbers of admissions are not specified and the supervising attending will monitor
**Autopsies**
Residents should attempt to obtain autopsies for all unexpected deaths and may attend autopsies performed on their patients. When requesting an autopsy, always discuss with an attending first and the procedure to request an autopsy can be assisted by A1 (administrator-on-call) Residents should be notified when the autopsy is to be performed. The final autopsy report is to be sent to the Department of Medicine for distribution to the residents caring for the patient. Also, the report can be accessed on the Erlanger Net Access report under the Pathology section.

**Team Deaths and Morbidity and Mortality Conference**
All team deaths must be recorded and reviewed with the team at the end of the rotation. At least one case will be fully discussed during M&M. Additionally, one health care matrix should be completed and discussed with the team and attending.
**Required Rotations and Electives**
A full Goals and Objectives can be found at: [www.utcomchatt.org/subpage.php?pageId=568](http://www.utcomchatt.org/subpage.php?pageId=568)

**Inpatient Medicine and Night Medicine**
6 months of Inpatient must be completed your intern year
A total of 12 months is required for graduation
Residents may not do back to back night medicine months
Residents may not be assigned more than 5 months of night medicine during residency training

**Critical Care**
Three months required during the 3 years of residency. A maximum of 6 months of Critical Care rotations can be scheduled.

**Emergency Medicine**
One month must be completed during training, usually intern year
The Emergency Medicine rotation consists of 18 twelve hour duty shifts scheduled by the ER teaching faculty. The 18 scheduled shifts will be a combination of the following: 7:00am-7:00pm, noon – midnight, and 7:00pm-7:00am. Duty shifts (including time spent in continuity clinic) must be separated by at least a 10-hour rest interval. Residents must follow all duty hour requirements including maximum 80 hours/week on average and one day off in seven on average. Send a copy of your ER work schedule to the Program Coordinator and UMA Clinic Nurse Manager. If your ER schedule somehow allows for you to be out of town during weekdays you must notify the Department of Medicine office of your plans in advance.

**Infectious Diseases**
A one month Infectious Diseases rotation is required.

**Hematology/Oncology**
A one month Hematology/Oncology rotation is required during the PG-2 or PG-3 year. Separate Hematology and Oncology rotations are available if desired.

**Geriatric**
A one-month Geriatric rotation is required during the PG-2 or PG-3 year for all Internal Medicine residents.

**Gastroenterology**
A one month rotation is required in the PG-2 or PG-3 year for all Internal Medicine residents.

**Endocrinology**
A 2-4 weeks Endocrinology rotation is required during the PG-2 or PG-3 year.

**Rheumatology**
A 2-4 week rotation is required in the PG-2 or PG-3 year.

**Psychiatry**
A 2-4 week Psychiatry rotation is required, usually during the PG-2 or PG-3 year.

**Neurology Rotation**
One month is required in PG-1, 2, or 3 year.

**Nephrology Rotation**
One month required in PG-1, 2, or 3 year.

**Cardiology Rotation**
One month required PG-1 year and 1 month is required as a PGY2 or 3.

**Ambulatory**

**Private Office**
1 month will be mandatory, stating with the class of 2017

**Available Electives:**
Allergy
Dermatology
Surgical Critical Care
Research
Radiology
Interventional Radiology
Pathology
Sports Medicine

**Away Rotations**
There is limited availability of away rotations (external to the UT College of Medicine Chattanooga and Erlanger). Away rotations will only be approved for rotation/educational opportunities that are not available at Erlanger and are not available for any first year resident. Away rotations must be discussed with the program director at least 6 months prior to a desired away rotation. Once approved by the Department, away rotations must also be approved by the Associate Dean/DIO, the Dean, and the Erlanger President before arrangements can be finalized with the external institution.
Procedures

The American Board of Internal Medicine requires knowledge competence in the following procedures. The ability to competently perform those identified by asterisks is also required:

1. Abdominal paracentesis
2. Advanced cardiac life support (ACLS) *
3. Arterial line placement
4. Arthrocentesis
5. Central venous line placement
6. Drawing venous and arterial blood *
7. Incision and drainage of an abscess
8. Lumbar puncture
9. Nasogastric intubation
10. Pap smear and endocervical culture *
11. Placing a peripheral venous line *
12. Pulmonary artery catheter placement
13. Thoracentesis

Knowledge competence includes knowing and understanding the following for each procedure: Indications, contraindications, recognition and management of complications, pain management, sterile technique, specimen handling, interpretation of results, requirements of and knowledge to obtain informed consent.

See spreadsheet in appendix for required departmental procedures

If a resident desires to obtain performance competence in any of the procedures not required, he/she should notify the Program Director so that appropriate learning sessions can be arranged.

Before residents can supervise or teach any procedures, required or optional, to other residents or interns, the supervising resident must have completed a sufficient number to be deemed competent to perform the procedure independently. All Internal Medicine residents will be given log books in which they should document procedures which they perform. Each page has a carbon copy which should be submitted on a periodic basis (monthly is suggested) to Ms. Deborah Fuller or Karen Sutberry in the Department of Medicine. The original log book should be kept by the resident for his/her personal records.

We would encourage residents to continue logging procedures even after the minimum numbers of procedures is met for graduation as this is useful for post-residency credentialing and hospital privileges.
Disagreements between Residents and Interns
Any disagreement (personal or professional) between residents or ancillary staff should be resolved in a diplomatic and professional manner. Please do not voice your disagreements loudly in the presence of patients, patient families, or at nursing stations. If the disagreement cannot be resolved between individuals, it should be brought to the attention of the attending. If it cannot be resolved at this level, the Program Director should be notified.

Education for Life
A principal objective of the Internal Medicine Residency Program is to foster life-long habits of critical thinking and continuing education. The program requires that a written Educational Plan for a Life in Medicine be presented to the Program Director prior to the PGY3 exit interview. Such a plan should consider (but not be limited to) the following:

1. Keeping up with the medical literature
2. Employing the literature in patient care
3. The role of continuing medical education meetings
4. The role of specialty society meetings
5. Self-learning
6. Audiovisual material
7. Computerized material
8. Preparing for recertification exams

Resident Selection
All applications for the residency program are given deliberate consideration. All applicants should have passed Part I and II of the USMLE on their first attempt. The ERAS system should be used for PGY-1 applications. Excellence in communication, teamwork, and interpersonal relationships are required. The Department of Medicine follows University of Tennessee policies concerning international medical graduate applicants. Preference will be given to residents who have successfully passed the Clinical Skills exam.
Program Evaluation Committee (PEC)

The PEC is responsible for the planning, developing, implementing, and evaluating educational activities of the program. They should review and make recommendations for revision of competency-based curriculum goals and objectives.

The PEC should address areas of non-compliance with ACGME standards and review the program annually using evaluations of faculty, residents, and others.

The program, through the PEC, must document formal, systematic evaluation of the curriculum at least annually, and is responsible for rendering a written, annual program evaluation.

Members include the program director, associate program director, program coordinator, core clinical faculty and representatives from each PGY class. Resident representatives will be appointed by the program director and the PGY1 representative will be appointed after at least 3 months into academic year.

If you have any suggestions for program improvement you are welcome to bring these issues up at the resident business meeting or contact your resident representative to address at the PEC meeting.

2015-2016 Resident Representatives
PGY3- Drs. Claydon, Shehata, Turner
PGY2- Dr. Hyde
PGY1- TBD

The program must monitor and track each of the following areas:

I- Resident performance
   a. Including outcome assessment of the educational effectiveness of inpatient and ambulatory teaching (i.e., In-Training Exam results)

II- Faculty development

III- Graduate performance
   a. At least 80% of those completing their training in the program for the most recently defined three-year period must have taken the certifying examination
   b. A program’s graduates must achieve a pass rate on the certifying examination of the ABIM of at least 80% for first-time takers of the examination in the most recently defined three-year period

IV- Program Quality
   a. Residents and faculty must have the opportunity to evaluate the program confidentially and in writing at least annually
   b. The program must use the results of residents’ and faculty members’ assessments of the program together with other program evaluation results to improve the program

V- Monitor progress on the previous year’s action plan
   a. The ability to retain qualified residents by graduating at least 80% of its entering categorical residents averaged over the most recent three-year period
VI- The PEC must prepare a written plan of action to document initiatives to improve performance in one or more of the areas listed in section, as well as delineate how they will be measured and monitored.

VII- The action plan should be reviewed and approved by the teaching faculty and documented in meeting minutes

   a. The department should share appropriate inpatient and outpatient faculty performance data with the program director.
   b. The program must organize representative program personnel, at a minimum to include the program director, representative faculty, and one resident, to review program goals and objectives, and the effectiveness with which they are achieved.

**Program Evaluation**

Each resident is also required to confidentially complete an overall program evaluation annually. One evaluation will be submitted by the GME office and one is submitted by the ACGME. An aggregated summary of these evaluations (without individual identifiers) is provided to the Program Director and is reviewed with residents and faculty at the annually.
## Resident Spread Sheet

### Appendix A

<table>
<thead>
<tr>
<th>Resident Name</th>
<th>Score</th>
<th>Req for</th>
<th>Req to perform</th>
<th>Pt Care</th>
<th>Eval</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Graduation</td>
<td>Independently</td>
<td>Year</td>
<td>Rotation</td>
</tr>
<tr>
<td>USMLE 1</td>
<td>ACLS**</td>
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<tr>
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<td></td>
<td>Femoral</td>
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<td></td>
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<td>Arterial stick</td>
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### Percentile

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<td>ITE PGY2</td>
<td>Thoracentesis</td>
<td>3</td>
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<td>ITE PGY2</td>
<td>Arthrocentesis/Joint injection</td>
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<td>5</td>
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<tr>
<td>Puncture biopsy</td>
<td>3</td>
<td>5</td>
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<tr>
<td>Lumbar puncture</td>
<td>3</td>
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<tr>
<td>Mini CEX</td>
<td>Paracentesis</td>
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<tr>
<td>PGY1 0 of 4</td>
<td>Peripheral venous IV</td>
<td>3</td>
<td>3</td>
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<tr>
<td>PGY2 0 of 2</td>
<td>I&amp;D abscess</td>
<td>0</td>
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<tr>
<td>PGY3 0 of 2</td>
<td>Arterial line</td>
<td>0</td>
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<td>NGT placement</td>
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</tbody>
</table>

**Clinic Sessions**: *Must have completed 1 ACLS eval and signed off on 1 central line site to promote to PGY2.

0 of 130 Date: 2 2

<table>
<thead>
<tr>
<th>Conference Attendance</th>
<th>HPP Attendance</th>
<th>ABIM Rules</th>
<th>Hopkins Modules</th>
<th>Handover Eval</th>
<th>Lifelong Learning Plan</th>
<th>Directed Reading</th>
<th>Scholarly Activity</th>
<th>Peer Eval Review</th>
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<td>36 months of training</td>
<td>24 Direct pt responsibility</td>
<td>Up to 3 non-IM electives</td>
<td>3 months Critical Care</td>
<td>ACLS certification</td>
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### Total

21 required

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**GME Policy #240: Lab Coats and Dress Code Policy**
Lab Coats and Dress Code

The UT College of Medicine Chattanooga (UTCOMC) has established a dress code policy for residents and medical students that basically outlines appearance as "neat, clean, and professional." Men should wear business-type slacks with shirt and tie. Women should wear business type dress or suit, or slacks/skirt with neat blouse or top. Conservative dress shoes with socks or hose must be worn. Clean, conservative tennis or running shoes are permitted due to long work and call hours. Residents must wear the photo ID badges issued from Erlanger Human Resources (HR), or an official UT ID, denoting them as a Resident or Fellow in a specific residency or fellowship program. UTCOMC has agreed to comply with the Erlanger Professional Dress Code Policy.

Residents must wear UT-issued white lab coats. These have the UT logo monogrammed and denote the individual's name. Each coat also indicates that the individual is a UT Resident or UT Fellow in a specific department or program. Residents and Fellows must also wear their Erlanger Photo ID badges with the personalized lab coats. Lab coats will be distributed to new residents at New Resident and Fellow Orientation. Replacement coats for returning residents (with the UT logo and monogrammed name) will be distributed by the end of summer via the departments.

Blue scrub suits are to be worn only in restricted areas of the hospital (ICU, Labor and Delivery, operating rooms, etc.) and are not to be worn outside these areas. Violations of this policy can lead to infection control problems as well as depleting the hospital's supplies of scrub suits for the operating rooms and ICU areas. Erlanger's dress code policy does not allow any employee to leave the hospital in scrub suits. Scrubs are distributed via ScrubX machines in several locations within the hospital. Photo ID badges issued from Erlanger HR have a unique embedded bar code that interfaces with the ScrubX machines. Residents/Fellows are allocated a specific number of scrubs available at one time depending upon their specialties. Soiled scrubs must be returned to the ScrubX machines before clean one can be issued.

Medical students follow the same dress code as do residents with a small difference -- they wear the short, white lab jackets. UT medical students are required to have the UT Medical Student patch denoting their status as well as continuing to wear the Erlanger Photo ID badge which further indicates their student status.

Both residents and medical students are responsible for laundering their own coats and jackets. Erlanger does not provide laundry service.

Reviewed and Approved by the GMEC 11/22/2013.

Patient Privacy Policy
# INTERNAL MEDICINE RESIDENT CONFERENCE SCHEDULE 2015-2016

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<tr>
<th>Monday</th>
<th>Tuesday</th>
<th>Wednesday</th>
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<tr>
<td>8:00 Case Discussion (pre-call team)</td>
<td>8:00 Radiology Conf</td>
<td>8:00 Subspecialty Case</td>
<td>8:00 Grand Rounds/Chief</td>
<td>8:00 Night Float Case Discussion</td>
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<tr>
<td>No Noon Conference</td>
<td>12:30 Hem/Onc</td>
<td>12:30 ID (even months)</td>
<td>12:30 Clinical Reasoning EKG school (pending EM)</td>
<td>12:30 Business Mtg (in WW7) PGY 3s (July, Oct, Jan, April) PGY 2s (Aug, Nov, Feb, May) PGY 1s (Sept, Dec, March, June)</td>
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<td>GI (odd months)</td>
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<tr>
<td>8:00 Case Discussion (pre-call team)</td>
<td>8:00 M&amp;M/Quality Case (pre-call team)</td>
<td>8:00 Subspecialty Case</td>
<td>8:00 Grand Rounds/Chief</td>
<td>8:00 Night Float Case Discussion</td>
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<tr>
<td>No Noon Conference</td>
<td>12:00 GME/HPP (Probasco)</td>
<td>12:30 Cardiology</td>
<td>12:30 Nephrology</td>
<td>12:30 Board Review/ Jeopardy</td>
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<td>8:00 Case Discussion (pre-call team)</td>
<td>8:00 Radiology Conf</td>
<td>8:00 Subspecialty Case</td>
<td>8:00 Grand Rounds/Chief</td>
<td>8:00 Night Float Case Discussion</td>
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<tr>
<td>No Noon Conference</td>
<td>12:30 Rheumatology</td>
<td>12:30 Crit Care (odd m) Mega Codes (Aug, Dec, April) CPC (Oct, Feb, June)</td>
<td>12:30 Palliative Care (even) Ambulatory (July, Sept, Nov) Endo (Jan, March, May)</td>
<td>12:30 Journal Club</td>
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<tr>
<td>8:00 Case Discussion (pre-call team)</td>
<td>8:00 M&amp;M/Quality Case (pre-call team)</td>
<td>8:00 Subspecialty Case</td>
<td>8:00 Grand Rounds/Chief</td>
<td>8:00 Pharmacy</td>
</tr>
<tr>
<td>No Noon Conference</td>
<td>12:30 Beyond Clinical (Mindfulness / Wellness/ Professionalism/ Business)</td>
<td>12:30 Pulmonology</td>
<td>12:30 Neurology</td>
<td>12:30 Hospitalist Series (Get with the Guidelines, Perioperative Mgt, Wilderness Med, Women’s Health, Other)</td>
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<tr>
<td>5th Monday</td>
<td>5th Tuesday</td>
<td>5th Wednesday</td>
<td>5th Thursday (March)</td>
<td>* July focus on Emergencies **No Conf last week Dec, 1st week Jan ***June focus on Board Review ****June last week, Intern Orientation</td>
</tr>
<tr>
<td>8:00 Case Discussion (pre-call team)</td>
<td>8:00 M&amp;M/Quality Case (pre-call team)</td>
<td>8:00 Subspecialty Case</td>
<td>8:00 Grand Rounds/Chief</td>
<td>8:00 Pharmacy</td>
</tr>
<tr>
<td>No Noon Conference</td>
<td>12:30 Psychiatry (Sept, March)</td>
<td>12:30 OB/GYN (July, Sept, March, June)</td>
<td>12:30 Organ Donation (March)</td>
<td>12:30 Hospitalist Series (Get with the Guidelines, Perioperative Mgt, Wilderness Med, Women’s Health, Other)</td>
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GME Policy #630: Reappointment, Promotion, and Non-Reappointment

REAPPOINTMENT, PROMOTION, AND NON-REAPPOINTMENT

Appointments to each residency or fellowship program are made on an annual basis with the expectation of continuation within the one-year appointment and of reappointment yearly throughout the duration of the residency or fellowship period.

Re-appointment and promotion to the subsequent year of training require satisfactory and cumulative evaluations by faculty that document satisfactory progress in scholarship and professional growth. Individual programs must establish criteria for promotion and completion of the program that include fulfilling overall program requirements, rotation requirements, appropriate skills and responsibilities as outlined in the Initial Resident Agreement of Appointment. Meeting these requirements includes demonstrated proficiency in:

1. Satisfactory progress in assessment from faculty, colleagues, and the program’s Clinical Competency Committee regarding the ACGME specialty milestones and general competency domains appropriate for the level of training –
   a. Patient Care
   b. Medical Knowledge
   c. Practice-Based Learning and Improvement
   d. Interpersonal and Communication Skills
   e. Professionalism
   f. Systems-Based Practice
2. Incremental increase in clinical competence including performing applicable procedures;
3. Appropriate increase in fund of knowledge; ability to teach others;
4. Clinical judgment;
5. Necessary technical skills;
6. Humanistic skills; communication with others;
7. Attendance, punctuality, availability and enthusiasm;
8. Adherence to institutional standards of conduct, rules and regulations, including program standards and hospital and clinic rules with respect to infection control policies, scheduling, charting, record-keeping, and delegations to medical staff;
9. Adherence to rules and regulations in effect at each health care entity to which assigned;
10. Other - e.g., satisfactory scores on examinations if designated for that purpose by specialty, scholarly activity, including participation in patient safety, quality improvement, and research participation, etc. Note: In-training examination scores cannot be the sole factor in a decision not to reappoint a Resident/Fellow.

USMLE Step 3 Requirement
The UT College of Medicine Chattanooga acknowledges that Residents/Fellows who complete GME training at this institution should be able to become licensed as a result of their training. The UTCOMC encourages each program to accept candidates who have passed both the United States Medical Licensing Examination (USMLE) Steps 1 and 2 [or Parts 1 and 2 of the Comprehensive Osteopathic Medical Licensing Examinations (COMLEX) for osteopathic candidates at the discretion of the individual departments]. Similarly, Fellows offered appointments must provide proof to the Program Director that they have already passed USMLE Step 3 (or COMLEX Part 3 if accepted by the Department).

All Residents are required to pass USMLE Step 3 (or COMLEX Part 3 if acceptable to the Department) before they can advance to the PGY-3 level of training and to eventually receive a certificate of completion of residency training. All Residents who are appointed for a July – June
academic year must register early enough during the second year of training in order to provide proof of passing the exam by June 30. Recommended deadline to register in order to meet this requirement is February 28. Failure to provide proof by the end of the academic year could result in non-reappointment to the program. In that case, the Resident will be terminated from the program. The only exception would be if the Residents has taken the exam and is awaiting results on June 30. At the discretion of the Program Director, the Resident may continue training but will not be promoted until proof is received. It is the responsibility of the Resident to provide the necessary proof to the Program Director and Director of Graduate Medical Education. Any examination fees would be the responsibility of the Resident. At the discretion of the Chair and/or Program Director, professional development funds may be used to reimburse initial registration fees (up to the maximum available funds) paid during the PGY-2 level of training at the Chattanooga Campus.

**Promotion**
Residents/Fellows judged by a program to have completed satisfactorily requirements for a specific level of training will be promoted to the next higher level of responsibility unless the Resident/Fellow is specifically appointed to a training track of limited duration and not designed to achieve full certification (e.g., a one-year preliminary position such as Preliminary Surgery). No Resident/Fellow may remain at the same level of training for more than 24 months, exclusive of leave. A Resident/Fellow whose performance is judged to be satisfactory will advance until the completion of training, having met all program requirements.

**Non-Reappointment**
Residents/Fellows not demonstrating satisfactory performance and progress in accordance with the aforementioned items, as well as specific program requirements, may face non-reappointment to the program. In these situations, a Resident/Fellow must be given written notice of the intent not to reappoint or promote. Every effort must be made to give a Resident/Fellow at least four months notice of the intent not to reappoint, or the possibility of non-reappointment based on remediation, prior to the end of the appointment period. If the primary reason for non-promotion or non-reappointment occurs within the last four months of the level of training, or if remediation has not been completed and the decision is still uncertain, the program must give as much written notice as circumstances reasonably allow.

*Reviewed and Approved by the GMEC, 5/20/2014.*
GME Policy #700: Disciplinary and Adverse Actions, including Dismissal

DISCIPLINARY AND ADVERSE ACTIONS, INCLUDING DISMISSAL

Disciplinary actions are typically utilized for serious acts requiring immediate action. These actions include suspension, probation (including remediation), and dismissal. The residency program, the University of Tennessee College of Medicine Chattanooga (UTCOMC), 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.

Adverse actions may result when continued remediation actions have been unsuccessful. These actions may include probation, denial of Certificate of Completion, or non-renewal of agreement and will become a permanent part of the resident training record. All significant adverse actions are subject to the University of Tennessee Graduate Medical Education Academic Appeal Process.

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 UTCOMC 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. All suspensions must be reported to the DIO.

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. Additional action may include, but is not limited to counseling, fitness for duty evaluation, referral to the Aid for Impaired Residents Program, probation, drug testing, non-reappointment to the program, or dismissal. Suspension may be with or without pay at the discretion of institutional officials. At the discretion of the Program Director, suspension may include loss of up to one week of the three total weeks leave provided to all Residents and Fellows or may include unpaid leave days as determined appropriate by the Program Director.

Performance Difficulties, 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. A Resident or Fellow will receive a Performance Deficiency and Remediation (PDR) regarding performance difficulties, whether or not it is called remediation or probation. However, a Resident/Fellow may be placed on probation at any time consistent with individual program policies.

Probation is typically the last opportunity to correct deficiencies and 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. Also,
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 a 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.

**Non-Reappointment**
A decision of intent not to reappoint a Resident/Fellow to the program should be communicated to the resident in writing by the program as soon as possible but hopefully no less than four months prior to the end of the academic year. If the primary reason for non-reappointment occurs during the last four months of the academic year, the program will provide the Resident/Fellow with as much written notice as circumstances reasonably permit. A copy of the notification, signed by the Program Director and the Resident/Fellow, must be sent to the DIO.

**Denial of Certificate of Completion**
A Resident/Fellow 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. Each residency program is responsible for establishing specific written criteria for denial of certificate of completion. Residents/Fellows denied a certificate of completion must be notified in writing of unsatisfactory performance by the Program Director at least four (4) months prior to scheduled completion of program. In most situations, the Resident/Fellow should be notified of this pending action as soon as possible. A copy of notification, signed by the Program Director and Resident/Fellow, must be sent to the DIO. In certain situations, a Resident/Fellow denied a certificate of completion may be offered the option of repeating the final academic year or period but only at the discretion of the Program Director and DIO and given available funding.

**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. Residents/Fellows who are dismissed from the program are not eligible for a certificate of completion.

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)
GME POLICY # 715
PERFORMANCE DEFICIENCY AND REMEDIATION (PDR)

Resident/Fellow:                          Date:

This is to officially inform you of placement on Performance Deficiency and Remediation. Based upon information provided by members of the faculty, your performance in the following competencies has been identified as unsatisfactory.

☐ PATIENT CARE
Residents/Fellows 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/Fellows 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 based on 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

☐ MEDICAL KNOWLEDGE
Residents/Fellows must demonstrate knowledge about established and evolving biomedical, clinical, and cognate (e.g. epidemiological and social-behavioral) sciences and the application of this knowledge to patient care. Residents/Fellows are expected to:

- demonstrate an investigatory and analytic thinking approach to clinical situations
- know and apply the basic and clinically supportive sciences which are appropriate to their discipline

☐ PRACTICE-BASED LEARNING AND IMPROVEMENT
Residents/Fellows must be able to investigate and evaluate their patient care practices, appraise and assimilate scientific evidence, and improve their patient care practices. Residents/Fellows 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 on-line medical information; and support their own education
- facilitate the learning of students and other health care professionals

**INTERPERSONAL AND COMMUNICATION SKILLS**
Residents/Fellows 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/Fellows 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

**PROFESSIONALISM**
Residents/Fellows must demonstrate a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population. Residents/Fellows are expected to:

- demonstrate respect, compassion, and integrity; a responsiveness to the needs of patients and society that supercedes self-interest; accountability to patients, society, and the profession; and a commitment to excellence and on-going professional development
- demonstrate a commitment to ethical principles pertaining to provision or withholding of clinical care, confidentiality of patient information, informed consent, and business practices
- demonstrate sensitivity and responsiveness to patients’ culture, age, gender, and disabilities

**SYSTEMS-BASED PRACTICE**
Residents/Fellows 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/Fellows 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
Deficiencies and Remediation Plan:

<table>
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<tr>
<th>Competency &amp; Deficiencies</th>
<th>Remediation Plan</th>
<th>Outcome Measures</th>
<th>Completion Date</th>
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Additional Program Director Comments & Recommendations

Resident/Fellow & Program Director Acknowledgement:

On this date, I have met with the Program Director regarding my performance in the residency or fellowship training program. I have read this Performance Deficiency and Remediation notification and the above recommendations by the Program Director. I understand that failure to correct these areas of marginal/unsatisfactory performance could result in any or all of the following: probation, dismissal, or non-renewal of appointment.

Resident/Fellow Signature ________________________________ Date __________

Program Director Signature ________________________________ Date __________

Associate Dean and DIO ________________________________ Date __________
ACADEMIC APPEALS AND DUE PROCESS

Review Process for Disciplinary or Adverse Academic Actions
The University of Tennessee College of Medicine Chattanooga (UTCOMC) assures the Resident/Fellow the right to appeal any disciplinary or adverse academic action taken by the residency program or institution that results in dismissal, non-reappointment, non-promotion to the next level of training, refusal to recommend a Resident to sit for boards, or other actions that could significantly threaten a resident’s intended career development. Disciplinary actions are typically utilized for serious acts requiring immediate actions. These actions include suspension, remediation, probation, and dismissal. The residency program, the UTCOMC, the Statewide University of Tennessee Graduate Medical Education (GME) 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 GME Academic Appeal process. All disciplinary actions will become a permanent part of the Resident/Fellow training record.

The Academic Appeal Process is intended to provide a formal, structured review to determine if policies and procedures leading up to the disciplinary or adverse academic action were followed in a fair and reasonable manner. Remediation actions initiated by Performance Alert Reviews (PARs) are not appealable unless the action results in non-promotion. All appeals must be processed according to the following policies and procedures.

The Resident/Fellow has the right to obtain legal counsel at any level of the Academic Appeal process, but attorneys are not allowed at academic grievance hearings or at reviews. The UTCOMC cannot compel participation in the Academic Appeal process by peers, medical staff, patients, or other witnesses, even if such is requested by the Resident/Fellow seeking review. Resident/Fellows who have been dismissed will receive no remuneration during the review.

Departmental Review
Resident/Fellows may initiate review of a disciplinary or adverse academic action(s) by submitting a written request for review to the Department Chair within (10) ten-business days. The following Academic Appeal Procedures shall apply:

1. A written request for review must be submitted to the Department Chair within ten (10) business days.

   Or the Resident/Fellow may waive this departmental-level review and begin the review process at the Associate Dean/DIO level (See Waiver of Departmental Review at the end of this policy). The signed Waiver of Departmental Review and a written request for review must be submitted to the Associate Dean/DIO within ten (10) business days of notice of dismissal or adverse academic action.

2. The initial review request must include: (a) all information, documents and materials the Resident/Fellow wants considered, and (b) the reason the Resident/Fellow believes dismissal is not warranted. The Resident/Fellow may submit names of fact witnesses whom the Chair has
discretion to interview as a part of the review process.

3. The Chair may appoint a designee or designate an advisory committee to review the decision. The committee’s recommendation to the Chair shall be non-binding.

4. On reaching a decision, the Chair will notify the Resident/Fellow in writing. If the decision is adverse to the Resident/Fellow, the notice shall advise the Resident/Fellow of the right to request a review on the record at the GME Review Level.

**GME Review**

5. If the Resident/Fellow desires further review, a written request must be submitted to the UTCOMC Associate Dean/DIO within ten (10) business days of notice of the departmental decision. The written request for review must be sent to the Associate Dean/DIO, 960 East Third Street, Suite 104, Chattanooga, TN 37403. The request must include:
   a. any information the Resident/Fellow wants considered, and
   b. any reason the Resident/Fellow feels dismissal is not warranted.

The Resident/Fellow may submit names of fact witnesses whom the Associate Dean/DIO has discretion to interview as a part of the review process.

6. At the discretion of the Associate Dean/DIO, a hearing may be permitted if requested by the Resident/Fellow. The Associate Dean/DIO shall determine whether a hearing or review on the record is appropriate. Review on the record may include a face-to-face meeting with the Resident/Fellow and interviews with witnesses by the Associate Dean/DIO.

7. Upon reaching a decision, the Associate Dean/DIO will notify the Resident in writing and advise the Resident/Fellow of the right to further review at the next level of institutional review.

**Institutional Review**

8. If the Resident/Fellow desires additional review by the Executive Dean of the College of Medicine (Memphis), a written request must be submitted with ten (10) business days after being advised of the outcome of the GME level of review. The request should be sent the Executive Dean, College of Medicine Memphis, 910 Madison Avenue, 0th Floor, Memphis, TN 38163. The request must include:
   a. any information the Resident/Fellow wants considered, and
   b. any reason the Resident/Fellow feels dismissal is not warranted.

The Resident/Fellow may submit names of fact witnesses whom Executive Dean has discretion to interview as a part of the review process.

9. The Resident/Fellow and Associate Dean/DIO will receive written notification of the final review decision.

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

*Revised 6/28/2014 and approved by the GMEC 7/15/2014.*
SAMPLE
Waiver of Departmental Review Statement

I, _______________________________________________________, MD (or DO), hereby waive the first level of review (Department-level) of the disciplinary or adverse academic action(s) taken by my residency (or fellowship) program or other University of Tennessee Health Science Center officials.

I elect to waive departmental-level academic review and commence the process with review at the GME level by the Associate Dean/DIO of the UT College of Medicine Chattanooga.

Resident/Fellow Signature ________________________________________________________________

Date Signed and Submitted: ____________________________

Resident’s/Fellow’s Name: ________________________________

Residency Program: ____________________________________________

Level in the Program: ________________________________
GME Policy #250: GME Leave Policy

GME LEAVE POLICIES

All programs are required to use New Innovations to track the use of all leave time taken by Residents and Fellows. Based upon specialty board requirements, individual program leave policies may be more restrictive than the following GME policies.

Annual Leave (Vacation)

Paid annual leave (vacation) is given during each 12 month period of training: three (3) weeks, which are comprised of 15 work days (Monday through Friday). Most programs also try to give at least the weekend before or after vacation time, and some programs may be able to give both weekends (at least six (6) weekend days). These decisions are at the discretion of the Program Director. Vacation may also include any time off given by the program during the Christmas – New Year’s holiday period. Not every program grants additional time off during this period – it is dependent upon clinic and patient care schedules and must be determined by individual Program Directors. Annual leave/vacation must be approved in writing and in advance by the Program Director. Annual leave/vacation must be used for any time away from the program not specifically covered by other leave benefits below. Annual leave does not carry over from year to year, and Residents and Fellows may not be paid for unused leave at the end of the academic year. Residents and Fellows terminating before the end of their training year will be paid only through their final active working day and will not be paid for unused annual leave. GME disciplinary policy permits the Program Director to take up to one week of vacation as a disciplinary measure (i.e., up to one week of vacation may be at risk for disciplinary action as well as additional leave without pay). Note: Interview days are considered Annual Leave unless taken during regularly scheduled days off.

Sick Leave

Residents and Fellows are allotted three (3) weeks of paid sick leave per twelve (12) month period for absences due to personal or family (spouse, child, or parent) illness or injury. In the UT GME System, annual paid sick leave consists of a total of twenty-one (21) days, including a maximum of fifteen (15) regular “working days” (Monday through Friday), plus up to six (6) “weekend days” (Saturday and Sunday). A physician’s statement regarding illness or injury and “fitness for duty” may be required for absences of more than three consecutive days or an excessive number of days throughout the year. Sick leave is non-cumulative from year to year. Residents and Fellows are not paid for unused sick leave. Under certain circumstances, additional sick leave without pay may be granted with the written approval of the Program Directors, who will send a copy of this approval to the Graduate Medical Education (GME) Office. The Resident or Fellow may be required to make up any time missed (paid or unpaid) in accordance with Residency or Fellowship Program and board eligibility requirements.

Family and Medical Leave (FML)

Residents and Fellows who have been employed for at least twelve (12) months and have worked at least 1,250 hours during the previous twelve (12) month period are eligible for qualified family and medical leave under provisions of the federal Family Medical Leave Act (FMLA). FMLA provides eligible employees up to twelve (12) weeks of protected unpaid leave for the birth or adoption of a child or a serious health condition affecting the employee or his or her spouse, child or parent. Residents are required to use all available sick and annual leave days to be paid during FML. (See UT Personnel Policy #HR0338 for details.)
The UT College of Medicine Chattanooga Graduate Medical Education Office recognizes the importance of the early development of a relationship between parent and child and supports the use of time off for resident leave related to the recent birth or adoption of a child. Under Tennessee law, a regular full-time employee who has been employed by the university for at least twelve (12) consecutive months is eligible for up to a maximum of four (4) months leave (paid or unpaid) for pregnancy and adoption. After all available paid sick and annual leave has been taken, unpaid leave may be approved under FML and Tennessee law provisions. The state benefit and FML benefit run concurrently with paid leave or any leave without pay.

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, parental, or adoptive leave will be granted in conjunction with Family Medical Leave and Tennessee law. Except in case of emergency, all maternity, parental, or adoptive leave should be requested at least three (3) months in advance of all expected date of birth or adoption in order to ensure adequate coverage in the program. Extended leave may result in the need for extended training time in order to meet program and/or board eligibility requirements. It is the responsibility of both the Program Director and resident or fellow to verify the amount of additional training required and specific end dates of training.

The UTHSC Human Resources office has administrative oversight for the FML program. The Program Coordinator or Program Director should contact the UTCOM Chattanooga GME Office when it appears a resident may qualify for FML. The GME Office will coordinate with UTHSC HR and the Program Director to approve or disapprove a resident’s request for FML leave. Resident rights and responsibilities under FMLA can be found on the UTHSC GME website: http://uthsc.edu/GME/pdf/fmlarights.pdf.

Educational Leave
Educational leave is granted at the discretion of the Program Directors, but may not exceed ten (10) days per twelve month period. Residents and Fellows should be advised that some Medical Boards count educational leave as time away from training and may require an extension of their training dates.

Bereavement Leave
Residents and Fellows may take up to three (3) days of paid leave for the death of an immediate family member. Immediate family shall include spouse, child, parent, grandparent, grandchild, brother, or sister of the trainee. With approval of the Program Directors, additional time may be taken using annual leave or leave without pay.

Military Leave
Military leaves of absence will be administered in accordance with the provisions of University Personnel Policy #370: http://uthsc.edu/policies/w932_document_show.php?p=364. Residents and Fellows must notify their Program Director when military leave will be required and must provide their Program Director with appropriate documentation of their military service. Depending on the length of leave and specialty board requirements, training time may be extended.

Jury Duty
Residents and Fellows may turn in their compensation for jury duty and be paid or may keep the compensation and take annual leave or leave without pay.

**Holidays**
Due to the twenty-four (24) hour nature of patient care, residents are not entitled to holiday leave unless the hospital or program service/clinic closes for that holiday. Time off for a holiday is based on a Resident’s or Fellow’s rotation assignment. A Program Director may approve time off on a holiday for a resident who is rotating on a clinic or service that closes due to the holiday.

**Extended Absence from Training or End of Leave**
An extended absence, for any reason, may prevent a resident/fellow from fulfilling the requirements for participating in educational and scholarly activities and achieving the residency/fellowship responsibilities (See GME Resident/Fellow Agreement of Appointment). Generally, leaves of absence may be granted for a maximum of six months. Residents and Fellows are subject to termination upon: a) exhausting all available annual leave, sick leave, and other approved or statutory leave, or b) failing to return to work as scheduled at the end of any authorized or statutory leave.

An absence will be charged against any accrued annual, sick, or other available approved unpaid leave. If all such paid and unpaid leaves have been exhausted, the absence will be unexcused and the resident/fellow subject to dismissal for job abandonment.

The Associate Dean/DIO or Director of GME, in his or her discretion, may authorize additional leave but only in extraordinary circumstances. A resident who fails to return as scheduled from an approved leave may be terminated due to job abandonment (see GME Policy on Disciplinary and Adverse Actions).

Notes:
- Residency positions will be protected for individuals on approved Family Medical Leave or as required by law.
- Residency positions for individuals in a prescribed AIRS program may be protected as described in GME AIRS Policy.
- An unpaid leave of absence may affect a resident’s visa status.
- A leave of absence may require extending training in order to complete program or meet board certification eligibility requirements.

**Compliance with Board Requirements for Absence from Training**
It is the responsibility of each Program Director to verify the effect of absence from training for any reason on the individual’s educational program and if necessary to establish make-up requirements that meet RRC or board requirements of the specialty. All training extensions necessary to meet board eligibility are paid with full benefits. Board certification eligibility information is provided to Residents and Fellows by each program and can also be accessed through the American Board of Medical Specialties: [http://www.abms.org](http://www.abms.org).

Failure to comply with leave policies, including obtaining written prior approval, may result in leave without pay. Programs may have additional leave restrictions based upon individual specialty board requirements and will distribute their program policies and procedures to Residents and Fellows and Faculty. As stated earlier in this policy, up to one (1) week of annual leave/vacation may be at risk for disciplinary actions at the discretion of each Program Director.
Reporting Time Off
UT requires that all employees report time off, whether paid or unpaid, including GME Residents and Fellows. Effective July 1, 2015, residents and fellows must report time off each month via the UT Resident/Fellow Timesheet, sign, and submit to the program director for approval. Copies will be uploaded in the New Innovations Personnel Data files each month and maintained by the program and the GME Office.

Revised and approved by the GMEC 4/21/2015
GME Policy #255: UT Resident Time Off Form

UT RESIDENT TIME OFF FORM

In order to be in compliance with the UT Health Science Center and its Graduate Medical Education Policies, the UT College of Medicine Chattanooga will begin using a monthly UT Resident Time Off Form as of July 1, 2015. This action was approved by our Graduate Medical Education Committee at its April 2015 meeting. Maintaining these forms should assist residents, fellows and Residency Program Coordinators in tracking all time off taken by residents and fellows each year.

Procedure –

- All residents and fellows will be required to complete the Resident Time Off Form each month throughout training – even if no time off is taken during a given month.

- If no days off are taken, the resident will complete the top portion of the form with Name, Month Year, and Program, and sign the form at the bottom.

- Coordinators will enter the individual UT Personnel # on each form for residents.

- Residents should sign each form.

- Residents should only report time off – not time worked – on this form.

- Residents should not list the “one day off in seven” or your weekends that are regularly scheduled time off on this form.

- This form is to report and document annual leave (vacation), sick leave, conference leave, and any other time off each month.

- Residents will enter a “1” for each day they are reporting off – this reflects a number of days and not hours since hours can vary tremendously between departments and rotations.

- UT policy officially states that interview days should be taken from annual leave; however, the DIO has agreed to leave that to each department’s discretion.

- If your department permits residents to take off personal days, or interview days outside regular vacation, that would be reported as “Other Leave.”

- Any sick leave or Family Medical Leave beyond paid vacation and paid sick leave should be listed as “Other Leave.”

- Days during the Christmas and New Year’s Holidays should be listed under Annual Leave since this is part of the three weeks vacation provided each resident.

- Residents permitted to be off for any other holidays that their departments and clinics are closed should list those days under “Other Leave.”
Residents will continue to log duty hours and vacation via the Duty Hours portion of the New Innovations System.

Every resident/fellow must complete this form at the end of each month, print, sign, and give to the Coordinator by the 15th of the following month.

In June each year, each resident who is leaving must submit to the Coordinator by the last working day when they exit with the department.

Once a resident has submitted the form to the Coordinator, the Coordinator should scan as a pdf file, save as RTO-name-mo-yr.pdf and upload into the Resident Time Off Reports folder in the Attached Files portion of each resident’s Personnel Data file in New Innovations.

Approved 6/17/2015
RESIDENT TRAVEL, PROFESSIONAL DEVELOPMENT EXPENSES, AND REIMBURSEMENT (2015-2016)

The UT College of Medicine Chattanooga provides each department with professional development funds to support resident and fellow education during training in our Graduate Medical Education Programs. These funds are intended to educationally benefit residents and fellows during our GME Programs and not something to be purchased in the final months of training for use at another institution or in your next practice.

The UT College of Medicine Chattanooga encourages residents to attend national or regional educational conferences (including board reviews) each year. Given available funding, each department is provided funds to be used to support resident professional development; however, the amount available for each resident is left to the discretion of each Department Chair and Program Director. **It is the responsibility of each Department to communicate amounts available to each trainee and monitor that department totals are not exceeded.** Reimbursement must be within the University fiscal policies, including Travel Policy and Guidelines. Departments should provide a list of amounts allocated to each resident for the Business Office by July 1 each year.

In order to be reimbursed for any professional development expenses approved by the department, it is the resident’s ultimate responsibility to adhere to the University fiscal policies. Residents must submit original receipts to the Residency Coordinator for processing. It is the responsibility of each Residency Coordinator to assist residents in securing pre-approval for educational travel and for preparing travel expense reports and with receipts to the UT College of Medicine Chattanooga Business Office for reimbursement.

**Depending upon each program’s guidelines and decision about the amount of funds available for residents and which PGY levels may receive reimbursement, listed below are educational items and expenses considered appropriate professional development expenses:**

Approved reimbursable expenses if funds are available:

1) Travel expenses to approved CME conferences **planned by ACCME accredited providers.** Conferences should be in a specialty related to the resident’s training and career plans and must be in the continental US or the national meeting of a specialty society or organization. Prior travel authorization and review of the conference brochure or website details must be documented by the department. **It is recommended that travel be arranged through the University of Tennessee recognized travel agency, World Travel, to ensure that all University policies are followed.**

2) Electronic educational materials
3) Video course registration
4) Hard copy medical-related books
5) Board Reviews (hard copy, CD-ROM, online, etc.)
6) USMLE Step 3 Prep Course or materials
7) Membership fee for specialty organizations
8) USMLE Step 3 registration fee*
9) Smart phone up to $250 maximum
10) iPad or similar tablet up to $250 maximum
11) Laptop computer
12) Small medical equipment such as a stethoscope, surgical loupes, or neural reflex hammer

* Transitional Year Residents may be reimbursed the full cost of USMLE Step 3 Registration since they do not have an in-training examination.

Non-approved expenses (may include but are not limited to the following):

1) Certification board exam fees
2) Medical license fees
3) Printers, including palmtops
4) Digital cameras

Purchase and reimbursement for these educational and professional development expenses must be approved by the Chair and/or Program Director, accompanied by original receipts, and an appropriate expense form must be provided by the resident and Residency Program Coordinator. Once receipts and expenses have been approved and submitted within the University financial system (IRIS), reimbursement will be processed and payment will be issued via direct deposit into your primary bank account on file.

Receipts and expenses should be submitted within 30 days of purchase of items or travel during the year.

The deadline for submitting all resident reimbursement receipts, explanations, and travel expense reports to the Business Office each academic year is April 1, with the exception of travel that has been pre-approved but has not yet occurred by April 1.

Books and Other Educational Materials Reimbursement
For books or other items purchased, receipts must indicate that the order is complete and that payment has been made – not just that the item has been ordered. A copy of a bank statement is not proof of a book purchase or travel expense and is not acceptable by the University as an original receipt.

It is the responsibility of the traveler to review and follow all UT travel policies before making arrangements and traveling.

UT Travel and Reimbursement Guidelines – Click on the link to view the University of Tennessee Travel Policies and Guidelines: http://policy.tennessee.edu/fiscal_policy/fi0705/

Interactive forms that must be completed online at the above policy link are:
- Travel Authorization Form (T-18)
- Travel Expense Worksheet (T3)

Again, it is advisable that travel arrangements be made through World Travel, out of Knoxville, since it is recognized by the University and helps ensure adherence to the University of Tennessee Travel Policies.

To access World Travel information:
- Use the following information to log in –
University of Tennessee travel and reimbursement guidelines must be followed. **A foundation will not be reimbursed for payment made on behalf of the resident. Receipts must be in the resident’s.**

**Conference and Travel Approval**
Prior to attending a conference or traveling on behalf of the University, the resident must have the conference and travel pre-approved by the Department Chair or Program Director, and the Associate Dean/DIO for the UT College of Medicine Chattanooga. A copy of the conference brochure must be submitted with the **UT Travel Authorization Form (T-18)**. Travel should be approved at least one month prior to traveling so the resident may obtain the best airfare or hotel rates. The form will be returned to the Residency Program Coordinator after the DIO signs it. Once the resident has returned from the conference, he/she must submit **original receipts** to the Residency Program Coordinator as soon as possible but no later than 2 weeks from his/her return. The Coordinator will prepare a **UT Travel Expense Report (T-3)**, signed by the resident and the Program Director or Chair to the Business Office of the UT College of Medicine Chattanooga. All documentation should be submitted within 30 days of the ending date of the conference or the resident and the Coordinator will be required to submit a written explanation as to why this requirement was not followed.

**The University of Tennessee System Accounting Office, not the GME or local Business Office, makes the final determination as to interpretation of the UT Travel Policy and what is acceptable.**

**Travel Package Deals (such as Expedia, Hotwire, etc.)**
The UT College of Medicine Chattanooga has determined that residents may not use a travel package deal for travel arrangements (airfare, lodging, etc.). Examples include bundled airfare, lodging, and rental car.

**Hotel Reimbursement**
A hotel receipt when a resident has attended a conference must show a $zero balance. If you stay at the Conference Hotel, you may be reimbursed up to the conference rate plus taxes, given you have available funds, but you must include the brochure or web page that details the conference hotel rate. If the room block at the conference rate is full or if you waited until after the deadline to reserve your room, you will not be reimbursed more than the conference rate to stay at an alternative location. The hotel receipt must be in your name. If you split the charges with another resident, you must get the hotel to give each of you a receipt in our own name to be reimbursed. If you do not stay at the conference hotel, you will be reimbursed for up to the federal per diem plus taxes for that city and state (US GSA Federal Conus Rates at [www.gsa.gov/perdiem](http://www.gsa.gov/perdiem)). The UT Travel agency, World Travel, can assist you with finding alternative hotels.

**Airfare**
You must attach a copy of your receipt that includes your itinerary, the cost of the ticket with a $zero balance, and the designation or code for coach fare. An original receipt is required for baggage fee reimbursement.
Rental Car  
Residents will not be reimbursed for car rental unless they receive prior approval from the UT College of Medicine Chattanooga Business Manager and can document that the cost of taxis or airport shuttle would exceed car rental during the conference. If the Business Manager does approve a rental car, you must attach a paid rental car receipt with the travel expense form. The University will not reimburse for insurance or other extra charges such as GPS. You must also attach original gas receipts for reimbursement if claiming that expense. Going through World Travel will ensure that you get the lowest rates possible, but should only be arranged if the Business Manager has given her approval.

Mileage  
If you drive your personal car to a conference, you may be reimbursed the current mileage rate (currently $.47 per mile). You must attach a Good Maps or comparable document to show mileage from your home address to the hotel.

Taxis or Toll  
Taxis or tolls that are under $50 do not require a receipt. Any amount $50 or more must have an original receipt attached. You must state where you went; e.g., airport to hotel or conference center.

Food  
You do not need to attach receipts for food. The University reimburses a per diem amount based on the city and state to which you traveled for the conference (www.gsa.gov/perdiem).

Other  
You must attach original receipts and an explanation for any other individual expenses related to the travel that you feel should be reimbursed.

*Originally Reviewed and Approved by the GMEC 2/22/2011.*

*Revised 6/17/2015.*
GME Policy #800: Vendor and Industry Guidelines

VENDOR REPRESENTATIVES, INDUSTRY, AND PROMOTIONAL ACTIVITIES
GUIDELINES FOR RESIDENTS AND FACULTY

Definition of terms

Commercial interest: Shall include pharmaceutical, biomedical devices, equipment, and other health-related entities

Continuing Medical Education (CME): A conference or meeting held at an appropriate location, where the gathering is primarily dedicated, in both time and effort, to promoting objective scientific and educational activities and discourse and the main incentive for bringing attendees together is to further their knowledge on the topic(s) being presented. An appropriate disclosure of financial support and resolution of conflicts of interest should be made.

Detailing: Marketing that involves individual pharmaceutical or device sales representatives (detailers) meeting with doctors to promote specific medications or products

Faculty: All physicians and others with academic appointments, whether voluntary or salaried, engaged in teaching physicians in training

In-service education program: Informational presentation or discussion by industry representatives and others speaking on behalf of a company to provide scientific and educational information

Meals: Occasional meals (but no entertainment/recreational events) offered in a venue and manner conducive to informational communication providing scientific or educational value

Representatives (i.e., “commercial interest representative”): Industry officials, vendors, sales, and marketing professionals

Principles

The primary mission of the University of Tennessee College of Medicine Chattanooga clinical training programs is to prepare trainees to render patient-focused, competent, evidence-based, and responsible clinical care. One component of this training is the acquisition of basic and advanced knowledge of commercial products. A second component is to critically evaluate sources of medical information from both academic and commercial sources, and to determine their relative worth, recognizing that academic sources should be emphasized.

Physician conflicts of interest generated by commercial interest marketing activities should be resolved consistent with obligations to patient care and medical education.

Attending faculty and house staff are committed to intellectual rigor, objectivity and the practice of evidence-based medicine in the transmission of medical information.

Detailing should not inappropriately bias physician practice.
Guidelines

Faculty
1. Faculty should model behavior consistent with ethical guidelines developed by responsible professional organizations (American Medical Association, Accreditation Council for Continuing Medical Education) regarding relationships between physicians and commercial entities.

2. Regardless of venue or sponsorship, faculty must present only objective, balanced materials consistent with established norms of the ACCME and AMA.

3. Faculty may not receive honoraria for activities involving medical education of trainees and house staff given on campus or at UT College of Medicine Chattanooga-affiliated ambulatory sites during usual working hours or in the course of usual working responsibilities.

4. Faculty may serve as consultants to commercial entities for clearly defined professional services.

5. Faculty are required to disclose significant financial interests, including but not limited to:
   a. Salary for services from a single source when aggregated over 12 months expected to exceed $5,000.
   b. Equity interests including gifted stock in faculty/staff/student owned companies or a company proposing to sponsor research at UTHSC.
   c. Intellectual property rights (patents, copyrights, and royalties).

Physicians in Training (Trainees)
1. Trainees may not organize or promote, either on campus or off campus, non-CME approved, commercially-driven educational activities without Program Director/Chair approval.

2. Trainees may not attend detailing meals off campus or at ambulatory sites during work hours unless a faculty physician is present during the program.

3. Trainees may not engage in any detailing activities (including computer-based detailing), either on campus or off campus, for which they receive gifts or payments.

4. Trainees may not receive honoraria for participation in lectures or detailing programs including those described as peer groups, advisory boards, dinner lectures, etc.

5. Trainees may attend social events associated with educational activities only if:
   a. The dollar amount spent on the attendee is modest.
   b. The educational portion of the conference accounts for a substantial majority of the total time accounted for by the educational activities and social events together.
   c. A faculty member is present.

Commercial Interest Representatives in the Hospital Setting
1. Commercial interest representatives are not permitted access to faculty in any patient care areas except to provide in-service training and then only by appointment. (Erlanger Policy requires each
representative to register with the appropriate hospital department and to obtain a visitor badge each
time he/she visits or checks in with the Surgical Resource Coordinator prior to entering a surgical area).

2. Commercial interest representatives are permitted to speak with trainees only between 8:00 am and 4:00 pm by making appointments with a Chief Resident, Program Director, or Department Chair.

3. Commercial interest representatives are permitted in non-patient care areas by appointment only. Appointments will normally be made for such purposes as: 1) in-service training for research, clinical equipment, or devices already purchased, or 2) evaluation of new purchases of equipment, devices, or related items.

4. Appointments to obtain information about new drugs in the formulary will normally be issued by the hospital pharmacy.

5. Appointments may be made on a per visit basis or as a standing appointment for a specified period of time at the discretion of the faculty member, his or her department or program, or designated hospital personnel issuing the invitation and with the approval of appropriate hospital management.

Commercial Support of CME Approved Educational Activities
All educational activities approved for AMA Category 1 credit shall adhere to Accreditation Council for Continuing Medical Education (ACCME) Standards for Commercial Support. Such standards ensure independence; resolution of personal conflicts of interest; appropriate use of commercial support; appropriate management of associated commercial promotion, content and format without commercial bias; and disclosures relevant to potential commercial bias.

Presentations by Commercial Interest Representatives in Outpatient Settings
Presentations by commercial interest representatives may have specific value in terms of assisting faculty in educating trainees in analysis of promotional material and in recognizing marketing techniques. Presentations by representatives and attended by trainees in outpatient settings must conform to the following:

1. All on-campus presentations by commercial interest representatives must be organized and directed by the Department Chair or designee.

2. Attendees must include at least one faculty physician.

3. Representatives must make promotional materials to be used during a meeting available to the faculty preceptor prior to the meeting in a time frame acceptable to the preceptor.

4. A faculty member should be prepared to discuss the promoted material in an objective and evidence-based fashion or assign this responsibility to a trainee. This preparation may include critical review of the promotional material and presentation of additional or refuting studies referencing the promoted information with consensus panel statements, position papers, etc. (See attached guidelines.)

5. The representative may remain for the discussion portion of the meeting at the discretion of the faculty physician in attendance.

Educational Programs on Marketing and Promotion
The Healthcare Principles in Practice series presented by the Dean’s Office of the UT College of Medicine Chattanooga will include education about commercial industry sales and promotion. Content may address:

1. An overview of the commercial interest industry: financials, participation in research and CME, lobbying size compared with other industries, marketing techniques and evaluation of promotional literature

2. Techniques utilized to influence physician prescribing: review of research studies analyzing the results of vendor/sales/MD interactions

3. Recognition of clinically relevant and irrelevant drug information, value of commercial industry presentations compared with other sources of information, and identification of omitted information

4. Ethical issues/conflicts of interest raised by interactions with industry

**Gifts and Compensation**

1. Soliciting or accepting personal gifts or the use of gifts, gratuities, and favors from industry representatives is not allowed, as it creates the possibility of (or appearance of) favored treatment or an unfair influence for the outside entity.

2. UTHSC personnel may not accept gifts or compensation for listening to sales talks by industry representatives or prescribing medications.

3. UTHSC personnel may not accept meals or other gratuities supplied directly by industry.

4. Grants and gifts provided to the University to support education and development activities are permissible. However, industry officials cannot exhibit industry products, service, devices, or promotional materials directly within the education or development activity site. Such displays are permitted, however, at general vendor designated areas.

5. Consulting agreements which provide remuneration without associated duties are prohibited.

6. A faculty member/staff/student may not participate in a sponsored program if he, she, or a family member has a significant interest in the sponsoring organization. Note: This prohibition applies to any family member (not just spouse, dependent children, parents, and non-dependent children).

7. UTHSC may not participate in a sponsored program if the Dean, Department Chair, or other supervisor has a significant financial interest in the sponsoring organization.

**Product Samples**

Acceptance of sample medications and other products is an example of a promotional activity and therefore should be limited among the hospital’s clinical departments and faculty practices. Sample products may be helpful to patients who have financial difficulty in obtaining needed medications. However, prescribing and distributing branded medications solely because of gratis availability is inappropriate.

1. It may be acceptable to distribute a specific branded medication sample to treat a condition provided 1) the quality of care to the patient is no way compromised by selection of medication (e.g., efficacy, risk profile, compliance, or cost) and 2) no acceptable generic alternatives exist.
2. Physicians should not accept from pharmaceutical detailers conditions of face-to-face interaction in order to procure product samples.

3. The physician (or designee) responsible for a clinical department or faculty practice determines the specific medication or product samples to be accepted for distribution.

Reviewed by the GMEC, 1/25/2010. Approved by the GMEC, 2/22/2011.
GUIDELINES FOR EVALUATING PHARMACEUTICAL SALES AND PROMOTIONAL ACTIVITIES WITH HOUSE STAFF:
AN OUTLINE FOR FACULTY PRECEPTORS

1. Promotional material must be provided well in advance of the meeting with the pharmaceutical representative to ensure an informed and critical review:
   a. Assign house staff to perform a literature search for additional studies related to the claims made in the promotional materials.
   b. For studies provided by pharmaceutical representatives, note the peer review standard/repute of the journal in which the students are published.
   c. Note the source of funding of the study.
   d. Note whether results include intermediate outcomes and whether graphs contain “numeric distortion.”
   e. Also note any extemporaneous claims made by the representatives during his/her presentation regarding absolute and relative efficacy, safety, tolerability, and ask for data to support these claims.

2. During and after the presentation, identify commonly used sales techniques:
   a. **Attention:** Get the attention of the prospect (physician) through some advertising or prospecting method (LUNCH, pens, etc.).
   b. **Interest:** Build the prospect’s interest by using various appeals and arguments.
      - APPEAL TO POPULARITY—both personal popularity or “friendship,” and external popularity—“all the GI docs at St. Elsewhere use it.”
      - APPEAL TO AUTHORITY—“The Chief of Cardiology at St. Elsewhere has had great success with this drug.”
      - APPEAL TO EMOTION—Gratitude, obligation, friendship, etc.
      - THE NON SEQUITUR—fallacy of irrelevant conclusions, or fallacy of ignoring the issue—“ACE inhibitors improve survival in CHF … our ACE inhibitor [not FDA approved for CHF] is more effective in controlling blood pressure than X’s drug.”
   c. **Desire:** Build the prospect’s desire for the product by describing its features and letting them sample it (free samples).
   d. **Conviction:** Increase the prospect’s desire for the product by statistically proving the worth of the product. (See comments above regarding literature/studies.) Use testimonials from
happy customers.

e. **Action:** Encourage the prospect to act. This is the *closing*—asking for the prospect’s commitment to try or prescribe it.

*Reviewed and Approved by the GMEC, 2/22/2011.*
Professionalism Policy

It is the policy of the University of Tennessee College of Medicine Chattanooga (UTCOMC) to treat all individuals within the Erlanger Health System or any other facility in which patient care and/or training is being conducted, with courtesy, respect, and dignity. To that end, the UTCOMC requires that all individuals (faculty, residents, fellows, medical students and staff) conduct themselves in a professional and cooperative manner. It is also the policy of UTCOMC to be sensitive to a practitioner’s health or condition that may adversely affect that individual’s ability to provide safe, competent care to his/her patients. The concern is for high-quality patient care always, but it is accompanied by compassion for the practitioner whose abilities may be diminished in some way due to age, medical illness, substance abuse, impairment, or disruptive behavior. It is the responsibility of the UTCOMC to investigate and respond to unprofessional, impaired or disruptive behaviors.

Definitions:

Impairment – A change in the health status of an individual that jeopardizes the practitioner’s ability to carry out his/her delineated privileges with good quality. Examples may include but not be limited to:

- Stress
- Burnout
- Deterioration through the aging process
- Loss of motor skills

Acute Impairment – May be derived from substance abuse/dependence, physiological, emotional, or psychological difficulty and may be evidenced by a variety of behaviors or other observations not limited to a single event or episode.

Disruptive Behavior – Exhibitions of a pattern of behavior characterized by one or more of the following actions:

- Use of threatening or abusive language directed at nurses, hospital personnel or other physicians.
- Use of degrading or demeaning comments regarding patients, families, nurses, physicians, hospital Personnel, or the hospital
- Use of profanity or other grossly offensive language while in a professional setting
- Use of threatening or intimidating physical contact
- Making public derogatory comments about the quality of care being provided by other physicians, nursing personnel, or the hospital, rather than working through the peer review process or other avenues to address these issues
- Writing inappropriate medical records entries concerning the quality of care provided by the hospital or any individual
- Imposing personal requirements on ancillary staff which have nothing to do with better patient care and serve only to burden staff with “special” techniques and procedures
- Creating a hostile environment, which can increase risk management problems and decrease morale
Procedure:

Impairment/Illness/Treatment

If an individual has a reasonable suspicion that a faculty member, resident, or fellow (hereafter referred to as “physician”) is impaired or his/her health is such that his/her patient care activities could be compromised, the following steps should be taken:

1. The individual who suspects the physician of being ill or impaired must contact the Dean of the UTCOMC, or his designee, and give an oral report. A written report must follow as soon as possible, preferably within 24 hours. The report must be factual and shall include a description of the incident(s) that led to the belief that the physician might be ill/impaired. The individual making the report does not need to have proof of the illness/impairment, but must state the facts that led to the suspicions.

2. The report will be promptly reviewed by the Dean who shall determine if there is sufficient information to warrant further investigation.

3. If the subsequent investigation produces sufficient evidence that the physician is ill/impaired, the Dean shall meet with the physician or designate another appropriate individual to do so. The physician shall be told of the results of an investigation or the self-reported change in health status indicating that he/she suffers from an illness/impairment that affects his/her practice. The physician will not be told who filed the report, and may not be told the specific incident(s) contained in the report.

4. Depending on the severity of the problem and the nature of the illness/impairment, the Dean may exercise any of the following:
   a. Allow physician to voluntarily take a leave of absence to seek treatment/rehabilitation.
   b. Impose appropriate restrictions on the physician’s privileges and sign an agreement to abide by these expectations. Breech of this agreement becomes grounds for suspension or termination. Failure to sign an agreement will result in an automatic suspension or termination.
   c. Immediately suspend privileges and require the physician to undertake a rehabilitation program (including but not limited to a referral to the TMF or AIRS) as a condition of continued employment/training. If the physician agrees to undertake a rehabilitation program, he/she will be placed on a leave of absence and the University of Tennessee College of Medicine guidelines for a leave of absence will be followed.

5. If the investigation reveals that there may be some merit to the report, but not enough to warrant immediate action, the Dean will monitor the physician’s activities until he/she can establish whether there is an illness/impairment problem. All documentation of this investigation and ongoing monitoring will be secured in the Office of the Dean.

6. The Dean shall inform the individual who filed the report that follow-up action has been taken, but shall not disclose details of the investigation or the action, if any, taken.

Disruptive Behavior

The discovery process for disruptive behavior will be the same procedure as described in numbers 1 and 2 above for the impaired or ill physician.

1. For rare, isolated or minor events a collegial counseling session will be undertaken to inform the disruptive physician of the unacceptable behavior and the need to refrain from such behavior in
the future. The Dean may do the initial evaluation and counseling or designate another appropriate individual to do so.

2. For repeated or moderately egregious disruptions the Dean and a panel consisting of whomever else the Dean feels is appropriate will meet formally with the disruptive physician. A written and specific agreement should be signed outlining continued expectations and monitoring of behavior and consequences if agreement is breached.

3. For severe infractions, especially when the safety of others is jeopardized, the physician may be summarily suspended pending a thorough investigation.

4. Depending on the severity of the behavior under investigation and the physician’s response to initial counseling, behavior modification evaluation and treatment may or may not be recommended or required by the Dean.

5. If it is unclear whether the conduct was actually disruptive, the Dean may seek the expert opinion of an impartial individual experienced in such matters.
I have received and read the Policies and Procedures and Graduation Requirements of the Department of Medicine. I understand the policy for advancement and graduation from the Residency Program.

___________________________________________
Signature

___________________________________________
Print Name

___________________________________________
Date