

PROGRAM MANUAL

For

Residents in the Department of Medicine University of Kansas School of Medicine Kansas City, Kansas

This Manual compliments the House Staff Policy and Procedure Manual of the University of Kansas School of Medicine, Office of Graduate Medical Education (<http://www.kumc.edu/som/gme>). Residents should also refer to the divisional curricula of the Department of Medicine which may be found at http://www2.kumc.edu/internalmedicine/schedule-current_files/IMHousestaffManual.pdf.

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I. Introduction

Welcome to the Department of Medicine at the University of Kansas Medical Center. As a member of the training program here, you are joining a rich tradition dating back nearly 100 years. The University of Kansas Medical School was founded on this site in 1906. From the beginning, the Department of Medicine has been at the forefront of education, research, and training for the Medical School and the location of many visible and prestigious accomplishments in the Midwest. Faculty in this Department are, or have been, active in leadership of specialty societies in virtually all areas of Internal Medicine.

Despite these achievements, the accomplishment for which the Department is most proud is the character and quality of its graduates. Over 60% of the doctors in the Greater Kansas City area receive some or all of their training from the Medical School, with a large proportion matriculating through the Department of Medicine. Graduates of our training program constitute the largest group of internists in Kansas. Throughout the Midwest, the quality of our training program is recognized by hospitals and medical groups, making our graduates greatly sought after for various clinical positions. Our Department takes great pride in training highly skilled internists.

The training program utilizes three training sites: The University of Kansas Hospital is the principal training site, and additional rotations occur at the Kansas City VA Hospital and the Leavenworth VA Hospital. The educational rationale for presence at each training site is carefully considered. Clinical experience at the **University of Kansas Hospital** is the cornerstone of our residency training program because of its opportunities for residents to learn under the mentorship of both clinical investigators and medical educators, while caring for a patient population which includes tertiary care referrals from physicians throughout the region, as well as the local, culturally diverse primary care population. Our educational affiliation with the **Kansas City VA Hospital** is designed specifically to expose residents to a practice setting with increased autonomy, yet adequate faculty supervision, and a patient population with a different spectrum of disease than our university hospital. Residents also spend 2-3 months in their three years of training at the **Leavenworth VA Hospital** training site, designed to expose them to a rural, generalist-dominant setting which is representative of health care provision in many parts of our state.

II. Academic

As a physician in a residency program, you will receive post-doctoral training focused on the development of professional skills, clinical competencies as well as the acquisition of a strong foundation of knowledge in Internal Medicine. Our goal is to prepare you for the independent practice of Internal Medicine with an emphasis on professionalism and an appreciation for the lifelong learning process that is critical for maintaining professional growth and competency.

A. Mission

The KU Department of Internal Medicine strives to achieve excellence in its three-fold mission of patient care, teaching, and research. Our Department is committed to providing outstanding clinical service to its patients and the community, exceptional medical education for medical students, residents, and other health professionals, and innovative research to expand the frontiers of biomedical knowledge and clinical practice.

The Department of Medicine's Residency Program seeks to educate residents to be outstanding practitioners, lifelong learners, critical thinkers, and patient advocates. The Program seeks to provide an educational environment conducive to a lifetime of study, problem solving, and excellent clinical judgment in the practice of internal medicine. To this aim the Program seeks to: 1) Promote maximum achievement in each resident by identifying their individual strengths and weaknesses in the core competencies of internal medicine; 2) Develop measures designed to improve deficiencies, and assess progression toward mastery in each of the six defined core competencies which include: **Patient Care, Medical Knowledge, Practice-Based Learning and Improvement, Interpersonal Skills and Communication, Professionalism, and Systems-Based Practice**; 3) Foster a commitment to academic achievement by emphasizing the importance

of research and investigation both as a career choice and as a means of incorporating principals of critical thinking into each resident's clinical practice, continuing education, and professional development; 4) Work with each resident to formulate long-term career goals in the disciplines of internal medicine including primary care, hospital based practice, subspecialty medicine, academic/research or practice-based medicine; 5) Ensure that each resident is successful in becoming a board eligible and board certified physician in internal medicine.

B. Performance Expectations

The Department of Internal Medicine has criteria for the advancement/promotion of its residents. The final decision of whether to promote or graduate a resident is determined by the Residency Program Director, taking into consideration input received from the Department's Medical Education Committee as well as the faculty of the Department. Utilizing an electronic evaluation format, each resident is evaluated monthly in the six aforementioned competencies by his/her attending physician. Additionally, the House Staff officer is required to evaluate his/her attending, him/herself, and receives an evaluation from junior residents, medical students, clinic preceptors, and the nursing staff. The goal is to achieve a 360 degree evaluation of the resident's work and communication skills. All of the evaluations are reviewed by the Program Director and Associate Program Directors after which they are placed in the resident's file, which is available to the resident for review at any time. It is encouraged that the attending and resident speak directly about his/her evaluation at the completion of each rotation. Evaluations play a key role in deciding whether or not to advance a resident to the next level of training.

The criteria for advancement and final matriculation from the residency program are based upon the satisfactory achievement of the following core competencies as outlined by the American College of Graduate Medical Education (ACGME). The competencies, as well as the evaluation tools used to measure a resident's progress in each area, are listed below:

1. Patient Care

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

- a. Gather accurate, essential information from all sources, including medical interviews, physical examinations, medical records, and diagnostic/therapeutic procedures
- b. Make informed recommendations about preventive, diagnostic, and therapeutic options and interventions that are based on clinical judgment, scientific evidence, and patient preference
- c. Develop, negotiate, and implement effective patient management plans and integration of patient care
- d. Perform competently the diagnostic and therapeutic procedures considered essential to the practice of internal medicine

Evaluation tools: Chart-stimulated recall during night float conferences, mini-CEX (mini-clinical evaluation exercise), procedure log review during semiannual review

2. Medical Knowledge

Residents are expected to demonstrate knowledge of established and evolving biomedical, clinical, and social sciences, and the application of their knowledge to patient care and the education of others. This includes the ability to:

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

Evaluation tools: In-service Training examination

3. Practice-Based Learning and Improvement

Residents are expected to be able to use scientific evidence and methods to investigate, evaluate, and improve patient care practices. This includes the ability to:

- a. Identify areas for improvement and implement strategies to enhance knowledge, skills, attitudes, and processes of care
 - b. Analyze and evaluate practice experiences and implement strategies to continually improve the quality of patient practice
 - c. Develop and maintain a willingness to learn from errors and use errors to improve the system or processes of care
 - d. Use information technology or other available methodologies to access and manage information, support patient care decisions, and enhance both patient and physician education
- Evaluation Tools: 360 degree evaluations, continuity clinic QI projects

4. **Interpersonal and Communication Skills**

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

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

Evaluation Tools: 360 degree evaluations, standardized patient lab experience, mini-CEX

5. **Professionalism**

Residents are expected to demonstrate behaviors that reflect a commitment to continuous professional development, ethical practice, an understanding and sensitivity to diversity and a responsible attitude toward their patients, their profession, and society. This includes the ability to:

- a. Demonstrate respect, compassion, integrity, and altruism in relationships with patients, families, and colleagues
- b. Demonstrate sensitivity and responsiveness to the gender, age, culture, religion, sexual preference, socioeconomic status, beliefs, behaviors, and disabilities of patients and professional colleagues
- c. Adhere to principles of confidentiality, scientific/academic integrity, and informed consent
- d. Recognize and identify deficiencies in peer performance

Evaluation Tools: 360 degree evaluations, standardized patient lab experience, conference attendance tracking

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

- a. Understand, access, and utilize the resources, providers, and systems necessary to provide optimal care
- b. Understand the limitations and opportunities inherent in various practice types and delivery systems, and develop strategies to optimize care for the individual patient
- c. Apply evidence-based, cost-conscious strategies to prevention, diagnosis, and disease management
- d. Collaborate with other members of the health care team to assist patients in dealing effectively with complex systems and to improve systematic processes of care

Evaluation Tools: 360 degree evaluations, QI projects, and participation in Patient Safety Conference

In addition to all of these parameters, Internal Medicine residents are judged by whether they are competent to supervise others, to act with limited independence, and to be expected to pass the Internal Medicine Board examinations. A yearly in-service examination is given to all categorical residents to assess the continued growth of their knowledge base. The Program utilizes the examination to both simulate the ABIM exam and to help the residents identify specific areas needing more attention. Residents are strongly encouraged to prepare for this examination and to give it their best effort, to take advantage of it as a learning

tool. Before graduation a resident must have achieved all of these competencies, be deemed competent to act independently as a professional internist, and function well interdependently with all of the other members who comprise the health care team. He/she should exhibit leadership, refined management skills, cooperation with professionals, and an appreciation for the community in which he/she practices medicine.

Utilizing the “**RIME**” method of performance evaluation (**R**eporter, **I**nterpreter, **M**anager, and **E**ducator/**E**xpert) the Program must approve the resident for continuation to the next level of his/her training. The framework emphasizes a developmental approach, and it distinguishes between basic and advanced levels of performance for both ward and clinic rotations.

Specifically, for a **PGY-1** resident to be advanced to a second year resident, he/she must: 1) Master the skill of obtaining an accurate and thorough history and physical examination and demonstrate development in the area of physician-patient relationships, 2) Be able to communicate or report this information accurately and succinctly to others, 3) Exhibit the ability to construct a differential diagnosis based on the interpretation of history and physical examination findings as well as laboratory and/or radiological data, 4) Show acceptable development in the management of common internal medicine diseases and 5) Be able to educate medical students and demonstrate the responsibility and maturity necessary to become a team leader.

For a **PGY-2** to be advanced to the third year, he/she must: 1) Have fulfilled all the preceding requirements for advancement to the R2 year 2) Be able to demonstrate increasing skill in narrowing a differential diagnosis and be able to prioritize accordingly to arrive at a presumptive diagnosis independently, 3) Demonstrate an evidence-based therapeutic method of practice, 4) Demonstrate an ongoing growth and skill in interpretation and diagnosis including the ability to manage “new” clinical entities and educate on common clinical disease states.

For a **PGY-3** to be graduated from the program he/she must: 1) Be able to fulfill the previous outlined requirements for advancement, 2) Demonstrate competence in all areas of Internal Medicine, as defined by the 6 core competencies 3) Be able to act independently and responsibly as an internist, 4) Be able to act interdependently as a professional, 5) Be able to function independently as an educator/expert as exemplified by his/her ability to gather data, interpret it, construct a narrowed differential and institute an evidence-based treatment plan, 6) Be able to educate both patients and junior learners on the disease entity.

C. Educational Plan

The Department has established a written curriculum for all aspects of its residency education and training which is available to the residents and faculty for review on our website. In addition to the mission and performance expectations noted above, the curriculum contains teaching methodology, educational materials unique to particular subspecialty divisions, types of clinical encounters, patient population and sites of training, diagnostic and therapeutic procedures specific to or generally employed by a particular division, and a listing of the scheduled divisional conferences that a resident should avail themselves to while on that particular service. Most importantly, the curriculum contains a list of objectives for each level of training. These learning objectives are meant to be the minimum achieved while on each service.

As noted, all residents are expected to become familiar with the American Board of Internal Medicine (ABIM) requirements for the various subspecialties in Internal Medicine, as well as those areas required by the Residency Review Committee (RRC). Nonetheless, the curriculum in Internal Medicine is not intended to be identical for every House Staff. Individual residents will be given every opportunity to choose electives and opportunities to become proficient in procedures and skills that may be important or required for their particular career pathway.

The curriculum is balanced between inpatient and outpatient requirements, acute and chronic care, problems of the young (adolescents), middle-age, and elderly (geriatrics). The percentage or emphasis is largely determined by ABIM and RRC requirements and recommendations. For a categorical medicine resident, one-third of their time is spent on ambulatory medicine, made up of 130 clinic sessions in conjunction

with general and specialty medicine inpatient and outpatient rotations, and the required geriatrics, neurology, and ER rotations. All services have a required academic or teaching rounds component in addition to patient service rounds.

The Department has three to four weekly one hour Core Conferences which all residents must attend. These are broadcast to the Veterans hospitals in Kansas City and Leavenworth. Internal Medicine faculty and faculty from other medical school departments deliver these presentations, which are recorded and available for residents to review on the internal medicine residency website. The core conference series is designed to prepare residents for their certification examinations, and to meet the Residency Review Committee in Internal Medicine's requirements for education in both Internal Medicine and non-Internal Medicine specialties.

In addition to the core conferences, there is a daily Morning Report (MR), Pre-clinic Conference, and Grand Rounds once a week. In addition, the Clinical Pathology Conference, Patient Safety Conference, Ethics Conference, and Journal Club are held monthly. There is also a board review series designed for graduating residents which takes place near the end of the third year. In order to get feedback from the residents, a monthly House Staff meeting is conducted by the Chief Residents and the Program Directors.

Residents must have an attendance above the specified percentage for conferences as follows: inpatient medicine (including subspecialty inpatient services) as well as primarily inpatient consult services/electives 80%, CCU/geriatrics 40%, MICU, ambulatory/night float months, primarily outpatient consult months 20%. Off-site electives/ER have no required percentage but attendance is encouraged as the resident is able. (Please refer to ensuing section entitled "Attendance Policy") Each division also has their own regularly scheduled set of conferences, which are to be attended by the resident(s) rotating on that service. These conferences generally cover the areas of Basic Science, Clinical Discussion, Journal Club, and Research Update. Priority is given to the regularly scheduled set of conferences for all House Staff. (See Conferences in this Manual for more detail.)

It is also the responsibility of each Internal Medicine subspecialty to orient and train residents on their service in those interpretive skills and procedures that are unique to their division. All residents must regularly document the type and number of each procedure that has been accomplished. These are maintained on a master list in each resident's portfolio and are used at the end of the resident's training to verify competence in procedural medicine as set forth by the ABIM.

D. ABIM Requirements

In the final analysis, academic activities of the Department are focused on assuring the eligibility of residents to sit for the certifying examination of the American Board of Internal Medicine. The ABIM outlines both in general and in specific terms the steps necessary for a resident to become eligible for taking the examination. While a person who has finished training in Internal Medicine may legally practice medicine, that individual cannot call him/herself a specialist in Internal Medicine without passing the Boards. Attaining board certification has profound implications in all aspects of the practice of medicine.

The ABIM requires substantiation that candidates for certification are competent in clinical judgement, medical knowledge, clinical skills (medical interviewing, physical exam, and procedural skills), humanistic qualities, professionalism, and provision of medical care. Residents are expected to show competency in **understanding** indications, contraindications, and complications associated with the following procedures, as well as interpretation of results:

- Abdominal paracentesis
- Arterial line placement
- Arthrocentesis
- Central venous catheter placement
- Incision and drainage of an abscess
- Lumbar puncture
- Nasogastric intubation
- Pulmonary arterial catheter placement

Thoracentesis

Residents are expected to demonstrate competency in **performance** of the following procedures, generally at least 5 should be performed, in addition to understanding their indications and complications:

- Advanced cardiac life support
- Venous blood draw
- Arterial blood draw
- Pap smear and endocervical culture
- Peripheral IV placement

The regulations and recommendations of the ABIM are designed to ensure a minimum standard of quality throughout the nation's internal medicine training programs. The Department continually strives to exceed the requirements set forth by the ABIM to maintain the highest quality of training for its residents.

Board certification does not rest solely on passing the written examination. It also requires ongoing evaluation by an accredited residency program of the candidate's performance as a physician. This is done through a resident tracking form, which is also a part of the resident's permanent file. The ABIM requires that the Program Director attest each year that each resident is progressing satisfactorily towards competence in the practice of Internal Medicine and in attaining the knowledge base to pass the Board exam. This two-fold goal is the reason behind the comprehensive evaluation process used by the Department as well as our support of objective measures of knowledge (such as requiring all categorical residents to sit yearly for the in-service examination). The Department insists on satisfactory performance in the aggregate by each resident over the course of each program year.

The ABIM will not admit a candidate to the Board exam that has not been certified by the Program Director for each year of training.

The ABIM requires that the 36 month period of full-time medical residency education must include: thirty months of rotations in general internal medicine, subspecialty internal medicine, critical care medicine, geriatric medicine, and emergency medicine which may include a maximum of four months of non-internal medicine primary skill areas (e.g. neurology, dermatology, office gynecology, or pediatrics); up to three months of other electives approved by the internal medicine Program Director. Up to three months of leave is reserved for vacation time (or parental or family leave or illness, including pregnancy-related disabilities). Vacation or other leave cannot be forfeited to reduce training requirements. (From: ABIM Policies and Procedures, 2009)

As in the past the ABIM requires that the residency must contain twenty four months of direct patient responsibility, which may occur in either inpatient or ambulatory settings. A minimum of six months of this direct patient responsibility on internal medicine rotations must occur during the R-1 year.

The ABIM encourages documentation of direct observation of residents by faculty, chief residents, or in the case of interns, supervising residents in provision of patient care. The program requires that each resident complete four mini-CEX (Clinical Evaluation Exercises) per year. Completion of this requirement will be documented on each resident's ABIM tracking form, submitted annually by the program.

As a means of self-assessment and practice, the Department requires the ABIM in-service examination to be taken by all categorical residents each year. This test is similar to the actual Board exam. Results from this test are confidentially shared with the Chairman and Program Director. The exam is designed to show areas of strength and deficiency, and better prepare the resident physician in studying for future exams. A computer print out detailing performance in each area of internal medicine is given to the resident and reviewed with the resident by the Program Director at one of the semi-annual meetings required for each resident with the Program Director. Though the in-service exam is meant primarily as an educational tool, it does provide important objective information about a resident's medical knowledge base, and thus is taken into consideration in the resident's overall evaluation in the area of medical knowledge.

The Department makes every effort to enhance the abilities of each resident, independent of his/her competency level. The Department is proud of the quality physicians trained at the University of Kansas Hospital and continues to insist on the highest standards by teachers and trainees alike.

E. Policy on ACGME guidelines and ambulatory assignments and patient loads

All trainees are required to follow the ACGME program requirements for Residency education. The following is a complete listing of the guidelines as set forth by the ACGME and has been adopted for the Department of Internal Medicine residency training program.

1. Ambulatory Medicine

a. At least one-third of the residency training is in the ambulatory care setting.

(NOTE: In assessing the contribution of various clinical experiences with ambulatory patients to the 33% minimum, the following guidelines can be used: ½ day per week assigned to an ambulatory setting throughout all 3 years of training is equivalent to 9%; a 1-month block rotation is equivalent to 3%. Examples of settings that may be counted toward this requirement are general medicine continuity clinics, subspecialty clinics, ambulatory block rotations, physicians' offices, managed health-care systems, emergency medicine, walk-in clinics, neighborhood health clinics, and home-care visits.)

- (1) In an ambulatory setting, one faculty member is responsible for no more than four residents..
- (2) On-site faculty members' primary responsibilities include the supervision and teaching of residents. On-site supervision as well as the quality of the educational experience must be documented.
- (3) Residents are able to obtain appropriate and timely consultation from other specialties for their ambulatory patients.
- (4) There are services available from other health-care professionals such as nurses, social workers, language interpreters, and dietitians.

b. Ambulatory Medicine -- Continuity Clinic

- (1) At the Program Director's discretion, residents may be excused from attending their continuity clinic when they are assigned to an intensive care unit, to an away-elective, or to night float.
- (2) Residents attend a minimum of 130 weekly continuity clinic sessions during the 36 months of training.
- (3) The continuing patient-care experience is not interrupted by more than 6 weeks, excluding a resident's vacation.
- (4) During the continuity experience, arrangements are made to minimize interruptions of the experience by residents' duties on inpatient and consultation services.
- (5) Each resident follows patients with chronic diseases on a long-term basis.
- (6) It is desirable that residents be informed of the status of their continuity patients when they are hospitalized so the resident can make appropriate arrangements to maintain continuity of care.

c. Ambulatory Medicine -- Emergency Medicine

- (1) Internal medicine residents assigned to emergency medicine have first contact responsibility for a sufficient number of unselected patients to meet the educational needs of internal medicine residents. Triage by other physicians prior to this contact is not tolerated.
- (2) Internal medicine residents are assigned to emergency medicine for at least 4 weeks of direct experience in blocks of not less than 2 weeks.
- (3) Total required emergency medicine experience does not exceed 3 months in 3 years of training.
- (4) During emergency medicine assignments, continuous duty does not exceed 12 hours.

- (5) Residents have direct patient responsibility, including participation in diagnosis, management, and admission decisions across the broad spectrum of medical, surgical, and psychiatric illnesses, such that the residents learn how to determine which patients require hospitalization.
- (6) Internal medicine residents assigned to rotations on emergency medicine have on-site, 24-hour, supervision by qualified faculty members.
- (7) Timely, on-site consultations from other specialties are available.

2. Inpatient Medicine

a. On Inpatient Rotations:

- (1) A first-year resident is not assigned more than five new patients per admitting day; an additional 2 patients may be assigned if they are in-house transfers from the medical services.
- (2) A first-year resident is not assigned more than eight new patients in a 48-hour period.
- (3) A first-year resident is not responsible for the ongoing care of more than 10 patients.
- (4) The program has a minimum of 210 admissions per year to the medical teaching services for each first-year resident.
- (5) When supervising more than one first-year resident, the supervising resident is not responsible for the supervision or admission of more than 10 new patients and 4 transfer patients per admitting day or more than 16 new patients in a 48-hour period. (This does not apply to Night Float residents.)
- (6) When supervising one first-year resident, the supervising resident is not responsible for the ongoing care of more than 14 patients.
- (7) When supervising more than one first-year resident, the supervising resident is not responsible for the ongoing care of more than 18 patients.
- (8) First-year residents should interact with second- or third-year internal medicine residents in the care of patients.
- (9) Second- or third-year internal medicine residents or other appropriate supervisory physicians (e.g., subspecialty residents or attendings) with documented experience appropriate to the acuity, complexity, and severity of patient illness are available at all times on-site to supervise first-year residents.
- (10) On inpatient rotations, residents have continuing responsibility for most of the patients they admit. (Unless they are on Night Float or the ER rotation.)
- (11) Residents from other specialties do not supervise internal medicine residents on any internal medicine inpatient rotation.
- (12) Residents write all orders for patients under their care, with appropriate supervision by the attending physician. In those unusual circumstances when an attending physician or subspecialty resident writes an order on a resident's patient, the attending or subspecialty resident communicate his or her action to the resident in a timely manner.
- (13) There is a resident on-call schedule and a detailed checkout procedure, so residents learn to work in teams and effectively transmit necessary clinical information to ensure safe and proper care of patients.
- (14) The on-call system includes a plan for backup to ensure that patient care is not jeopardized during or following assigned periods of duty.
- (15) There is a minimum of 6 months of inpatient internal medicine teaching service assignments in the first year,
- (16) There is a minimum of 6 months of inpatient internal medicine teaching service assignments over the second and third years of training combined.
- (17) The required 12 months of inpatient internal medicine include a minimum of 3 months of inpatient general internal medicine teaching service assignments over the 3 years of training.
- (18) Geographic concentration of inpatients assigned to a given resident is desirable because such concentration promotes effective teaching and fosters interaction with other health-care personnel.

b. Inpatient Medicine -- Critical Care

- (1) Residents are assigned to critical care rotations (e.g., medical or respiratory intensive care units, cardiac care units) no fewer than 3 months in 3 years of training.
- (2) Total required critical care experience does not exceed 6 months in 3 years of training. (NOTE: When elective experience occurs in the critical care unit, it must not result in more than a total of 8 months of critical care in 3 years of training for any resident.)
- (3) All critical care training occurs in critical care units that are directed by ABMS-certified critical care specialists.
- (4) All coronary intensive care unit training occurs in critical care units that are directed by ABIM-certified cardiologists.
- (5) Timely and appropriate consultations are available from other internal medicine sub specialists and specialists from other disciplines.

3. Subspecialty Experience

- a. Clinical experience in each of the subspecialties of internal medicine is included in the training program and may occur in either inpatient or ambulatory setting.
- b. Although it is not necessary that each resident be assigned to a dedicated rotation in every subspecialty, the curriculum is designed to ensure that each resident has sufficient clinical exposure to the diagnostic and therapeutic methods of each of the recognized internal medicine subspecialties.
- c. Residents have formal instruction and assigned clinical experience in geriatric medicine. The curriculum and clinical experience is directed by an ABIM certified geriatrician. These experiences may occur at one or more specifically designated geriatric inpatient units, geriatric consultation services, long-term care facilities, geriatric ambulatory clinics, and/or in home-care settings.

F. Evaluation

There are a number of ways in which residents are evaluated. The most frequent and dependable is the written and verbal evaluation by the attending physician at the end of each month's rotation, which is subdivided into the six core competencies and placed on a nine-point Likert Scale. The Likert Scale is a rating scale measuring the strength of agreement with a clear statement. For example, an attending may be asked whether or not the resident effectively uses consult services and responds by agreeing with statements designed to assess how well the resident has succeeded in this category. Comments are encouraged to expand on the objective rating. These evaluations are necessarily subjective and are based on the faculty evaluator's own personal standards and experience with previous residents. Each evaluation must be discussed with the resident---if this does not occur, the resident should ask to meet with the attending for his/her evaluation. All monthly written assessments are screened by a residency Program Director. A satisfactory performance is required in each of these areas. A low satisfactory is cause for concern and results in counseling with the resident and close monitoring by the Program Directors and Medical Education Committee. A documented unsatisfactory, particularly following sequential or recent low satisfactory marks, makes the resident subject to probationary status, as decided by the Medical Education Committee and recommended to the Program Director (see Deficiency and Remediation section).

Residents will also be evaluated using the mini-clinical evaluation exercise (Mini-CEX). The Mini-CEX focuses on the core skills that residents demonstrate in patient encounters. It is easily implemented by attending physicians as a routine, seamless evaluation of residents in any setting. It is a 15-20 minute observation or "snapshot" of a resident/patient interaction. Based on multiple encounters over time, this method provides a valid, reliable, measure of the residents' performance. It is expected that these Mini-CEX evaluations will take place at least four times per year, for a total of twelve over the resident's three years of training..

Annually the Program Director or Associate Program Director, meets with each categorical resident individually. The purpose of these sessions is to review the resident's portfolio for completion, provide

feedback, counseling, assistance, and listen to suggestions. These meetings are informal and supportive --- they should not engender apprehension. Residents who have, however, had low satisfactory or worse evaluations can be expected to discuss these evaluations and put forth a plan for improvement.

In general, all residents have unimpeded access to the contents of their personal file, which is kept in the medical education office. Evaluations are intended to be drafted with an emphasis on constructive assistance with particular suggestions for improvement. However, if the resident feels that the evaluation is unfair, inaccurate or unwarranted, then, it is his/her right to refute the legitimacy of the evaluation with a written response. This will be reviewed by the Program Director, and further action will be taken as needed to clarify the discrepancy. The resident's written response will become part of the resident's permanent file.

In addition to regularly reviewing residents' performance, the Department's Medical Education Committee annually reviews each resident's personal file of service evaluations, clinical competency exams, ITE scores, standardized patient performance, and other performance documentation for the year. A composite evaluation is made and transferred onto the appropriate forms of the American Board of Internal Medicine. The Committee also determines if each resident is meeting or has met the Departmental requirements and expectations for promotion or graduation, and if not, appropriate remediation is implemented (see section on Deficiency and Remediation).

G. Conferences/Curriculum

Conferences are held regularly throughout all the sites participating in the Department of Internal Medicine Residency Training Program. Morning Report (MR) is held every morning except Wednesday from in the Greenberger conference room (4050 Wescoe) at the University of Kansas Hospital (KU), and in the 11th floor conference room at the Kansas City Veterans Administration Hospital (KCVA). MR also takes place at the Leavenworth VA Hospital. MR is facilitated by the chief resident at both KU and at the KCVA, with strong faculty involvement as well.

The format varies somewhat at each institution. At KU and KCVA Mondays and Fridays will be "MR Live" with informal presentations of overnight admissions, Tuesdays will be "Intern MR" presented by the chief residents and Thursdays "Formal MR" presented by senior residents. At the Leavenworth VA morning report is in a "Live" format. Emphasis is placed on the generation of a proper differential diagnosis and appropriate ordering of additional tests, followed by a general review of the disorder. Chief residents will be responsible for teaching points on "Intern MR" days and senior residents on "Formal MR" days. By having the residents read on a particular topic and make several teaching points for their peers, it is felt that the residents will become accustomed to both self-learning and teaching.

Morning Report (MR) is one of the most important teaching activities of the Department and attendance is mandatory as part of the resident's professional training. It is an opportunity to frame evidenced based learning around interesting case examples from the inpatient or outpatient setting. The atmosphere at MR is intended to be informative and non-confrontational, however, the aim is to challenge the resident selected to discuss the case by openly analyzing his/her ability to process clinical information appropriately. Faculty is well represented at MR to provide clinical experience and expertise to the discussion. Regular attendees of MR feel that it is an invaluable aid in preparation for taking the Board exam. Virtually all material on the Boards is presented at one time or another in MR. Due to the importance of attendance, repeated failure to be present may result in a letter in the resident's permanent file/warning status at the discretion of the program directors.

On a resident's continuity clinic day, he or she will attend the Pre-Clinic Conference. This conference uses the Yale curriculum, which can be found on the residency website. Conference starts at 8:00 AM or 1:00 PM depending on AM or PM clinic. Attendance is kept, and the conference counts toward the resident's attendance requirement if it interferes with the regularly scheduled conference. Core Curriculum Conference is held from 12:15-1:00 pm on Monday, Tuesday, Thursday, and an occasional Friday from 1:00-1:45 pm in Sudler Auditorium and is broadcast to the KCVA and Leavenworth. Residents are required to attend a percentage of these conferences as per requirements below. Each division in Internal Medicine is assigned

several lecture topics felt to be essential to a resident's training in internal medicine. The schedule of topics is agreed upon by the Residency Committee, and incorporates all the required subject matter areas for an accredited internal medicine residency program. Every effort is made to include all aspects of the practice of Internal Medicine, from a detailed lecture on glomerular filtration to an open forum to discuss the medical humanities. All presenters are urged to direct the conferences to the resident level (rather than faculty or student level although they certainly may attend), to present state of the art discussions, and to provide at least a one page outline. The Core Curriculum Conference is held at KU and relayed to the off site participating locations for simultaneous viewing. Tapes are made of each conference for those unable to attend or who want to revisit the lecture material at a later date.

Grand Rounds, held in the Sudler Auditorium at KU at 8 am on Wednesday mornings. Presented by faculty or visiting professors, this is the showcase Departmental conference of the week. Every effort should be made to attend. MR is not held on Wednesdays.

In accordance with hospital and ACGME regulations, monthly Patient Safety conferences and Clinicopathological conferences are held. Cases for both conferences are selected by the chief residents. Departmental House Staff meetings are held once a month. The Chief Residents prepare the agenda and the Program Directors are present to discuss items or answer questions. This is intended to be an open forum in which residents can express any concerns they have about the residency program and suggest ways to improve it. Journal Club is held once a month at both KU and the KCVA. The journal article is selected at least two weeks in advance by the chief resident and the house staff will then work on its critical appraisal with a selected faculty professor.

Each division supports its own set of conferences or seminars. While on that service, resident attendance is expected at these programs, however priority is given to the regularly scheduled morning report and core conferences.

Multiple special interest conferences are held daily on campus. These are listed on the weekly calendar at the KU website and details about the event are posted throughout the hospital.

Attendance at core conferences and morning report is mandatory. Residents are expected to willingly take part in these conference opportunities. However, in order to ensure that minimum attendance requirements are met attendance is taken at each conference. Residents must have an attendance above the specified percentage for conferences as follows: inpatient medicine (including subspecialty inpatient services) as well as primarily inpatient consult services/electives 80%, CCU/geriatrics 40%, MICU, ambulatory/night float months, primarily outpatient consult months 20%. Off-site electives/ER have no required percentage but attendance is encouraged as the resident is able. Residents will be notified of their attendance percentage on a regular basis, to allow adequate time for improvement before corrective measures are required.

If a resident or intern's attendance falls below the specified percentage at the end of one-week's time, they will be contacted by the chief resident. If their attendance falls below the specified attendance over a 2-week time frame they will be contacted for a meeting with a program director. At the end of the month if a resident fails to meet their required attendance they will be asked to compile a short teaching presentation for medical students rotating on inpatient medicine under the guidance of the chief residents.

It is important that residents make up the educational component missed by not attending conference. Those not at their required percentage will need to watch the recorded core conferences to get their attendance to goal. Conference attendance credit will be granted for viewing recorded core conferences and e-mailing the chief residents a brief summary of the topic presented. Extra credit may be available with board review hours or other conferences directed by the chief residents at their discretion.

H. Scholarly Activity

Categorical residents are required to conduct two scholarly activities during their residency; med/peds and med/psych residents are required to conduct one scholarly activity during the internal medicine component of residency. An oral presentation at a regional or national conference during both the second and third years of residency is **strongly encouraged** by the Department. This is most easily accomplished at the annual American College of Physicians (ACP) Kansas Chapter meeting held in the fall of each year in either Kansas City or Wichita. Other acceptable scholarly activities include publications, poster presentations, or other similar activity approved by a Program Director.

Each resident is expected to make several presentations during his/her residency. These may take the form of conducting a journal club, preparing an end-of-the-rotation presentation (for instance, on the Geriatrics rotation) or various other short presentations as directed by the attending physician.

An important expectation of the Department is that each resident should produce at least one case report suitable for presentation (noted above) and/or be involved in a research project that could result in a published manuscript. There are a host of opportunities to fulfill this expectation, and faculty physicians are both supportive and available to assist in this endeavor. As an academic residency training program, faculty are dedicated to preparing the residents for their future roles as lecturers, researchers and collaborating clinicians. The broad purpose of this academic exercise is to develop critical interpretive and communicative skills.

I. Electives

The Department enthusiastically supports residents who wish to engage in research projects during their training or explore electives outside of the traditional residency program.

Residents can take up to three months during their training to conduct research, provided the following criteria are met: 1.) The resident be deemed in good standing by the Program Director 2.) The resident identify a research mentor who will work closely with the resident and Program Director 3.) The resident submit a formal research plan for approval by a Program Director three months prior to the resident's scheduled research month. Again, all efforts will be made to accommodate the resident's request to incorporate research into his/her training program.

The opportunity to spend time doing an elective rotation is made available to residents. More traditional electives outside of the Department of Internal Medicine (such as radiology, orthopedics, trauma surgery, gynecology, etc...) can easily be arranged. Starting or continuing on an elective rotation is contingent upon meeting the requirements detailed below. If a resident fails to meet these requirements, he or she will be assigned to another rotation. The objective of an elective rotation is to provide residents time to meet their individual goals in an area of interest. By the completion of their elective rotation, clearly outlined goals must be met.

Each resident must submit an Elective Rotation Application three months prior to their elective rotation to formulate a plan for the month (6 months prior for an international elective). An outline of the resident's goals should be available at that time. If the resident will be doing research, a faculty mentor needs to be identified, and the faculty member must accept this role. In order to have a productive and educational month, it is crucial to have a plan in place prior to starting the elective rotation. Each resident will act very independently in creating a successful elective rotation; consequently the benefit derived from the rotation will be determined by each individual resident. It is our goal to provide direction and leadership to help our residents be successful in this individualized rotation.

While all residents will gain exposure to each of the Internal Medicine subspecialties during their training, requests for a rotation in a particular subspecialty, for example early in the second year prior to fellowship application deadlines, can usually be fulfilled. In addition, all residents will complete required rotations in geriatrics and neurology.

Another possibility within the residency program is for residents to take electives outside of the KU community, in other hospitals across the United States or even abroad. The Residency Program firmly believes that extraordinary experiences make for extraordinary human beings and supports any resident wishing to travel to other countries to do electives. The first step to establishing an international elective is notifying the Program Director of the planned rotation. Specifically, the Program Director will need to know where you will be going, what you will be doing there, who will be supervising you and how he can contact that person. The Graduate Medical Education department has a form that needs to be completed prior to your departure and it will be the resident's responsibility to check with employee health in order to receive all of the needed vaccinations and prophylactic medications necessary. One invaluable contact for those wishing to set up an international elective is Judith Reagan in the Department of International Programs at jreagan@kumc.edu who can provide you a list of willing host country sites and help guide you through the relatively easy process. As of now, the resident still receives his/her monthly resident salary while he/she is away from KUMC. Residents choosing to do an international elective are asked to share their experiences with their peers upon their return in the form of a modified core curriculum presentation. Remember; notify the Program Director well in advance of the proposed international elective so as not to miss out on this great opportunity!

J. Procedures

Internal Medicine is largely considered a cognitive specialty and internists are trained in critical and incisive data gathering, information processing, and decision making. Nonetheless, there are a wide range of procedures and interpretive skills with which internists are expected to be familiar and proficient. Hospital credentialing committees are increasingly requesting that training programs certify the ability of their trainees to have particular skills and perform certain procedures. National societies, especially the ACP, have been struggling for years to develop reasonable criteria to determine proficiency in procedures. Please refer also to the ABIM's requirements for procedural competency (II.D.)

There are an increasing number of guidelines for the demonstration of procedural competence. This is purposeful since it is difficult to define exactly how many sigmoidoscopies, for instance you must do before being "proficient." Even so, it is prudent to prepare for the day when it will be required to produce documentation of procedural experience in order to be granted credentials or privileges at a particular hospital. The first step is to become familiar with each procedure or skill before it is attempted in a controlled and supervised environment. Repetition of procedures by which proficiency is achieved is largely the resident's responsibility. Residents are responsible for documenting their procedures in our electronic record-keeping system, E*value.

Residents are expected to consent patients prior to the procedure that they are performing. Informed consent is obtained after explaining to the patient and family the indications for the procedure, expected benefits of the procedure, alternatives to the procedure and potential complications of the procedure. Residents are not expected to consent patients for procedures that they are not personally performing or assisting.

K. Honors and Awards

The Department is proud of its residents.. Outstanding residents are recognized with several honors and awards. Benefactors in the community also understand the importance of recognizing outstanding performance and have endowed some of the awards. The individuals who receive these awards are elected by a vote of the faculty.

Each year in June, the Department holds its awards breakfast where the graduating R3s are especially recognized. Every resident who has been in the Department for three years is awarded a Departmental chair embossed with the seal of the University of Kansas and personalized with his/her nameplate. The Intern of the Year award goes to a deserving R-1 for outstanding performance. Each resident (R2 and R3) selected as House Staff of the year is presented the Milton McGreevy award. These three awards consist of a plaque and an honorarium. (Once selected as House Staff of the year, you are not again eligible.)

A special honor is the Marc Beck Award. Given in memory of Dr. Marc Beck, who was tragically killed during his residency, the award is presented to the resident who displays the highest standards of caring

and compassion. This plaque rewards the humanistic aspect of doctoring and is one of the most meaningful gestures the Department can convey.

Additionally, the Pingleton Award is given to a resident felt to demonstrate exemplary service to the residency and the medical community.

Medical students who rotate through the Department at the MS3 level vote for the Outstanding Resident Teacher Award. Medical students also recognize resident teaching through the Student Voice Awards.

The Chairman sponsors a dinner the evening before the awards breakfast for graduating residents and their spouses. This evening at a fine Kansas City restaurant is a memorable, festive occasion which generally is the last time your class is together in one place.

Excellent performance outside of direct departmental functions is also recognized. The best presentations by associates are rewarded at the yearly Kansas Chapter of the American College of Physicians (ACP) meeting. House Staff have received awards at the national ACP meeting as well as meetings of specialty societies. Special note is made of these awards at faculty and House Staff meetings.

L. Impairment

Satisfactory performance includes the absence of significant impairment (impaired function of a resident to a degree that it is causing less than satisfactory performance, and/or the impaired function, if not corrected or is uncorrectable, is likely to lead to future unsatisfactory performance) due to physical, mental, or emotional illness, personality disorder, or substance abuse. Every effort will be made to reasonably accommodate those individuals with conditions or impairments that qualify as a disability under applicable law, provided that the accommodation does not present an undue hardship for the Department, the Medical School, or venues of training. Residents will nevertheless be required to satisfactorily meet the Department's performance criteria, requirements, and expectations of the Medicine Residency Program.

M. Deficiency and Remediation

Should a resident be found to be deficient in any of the criteria or parameters of performance and not meet advancement or promotion specifics, he/she will meet with the Program Director, the Associate Director, or their designee wherein 1) The expectations and deficiencies will be stated, 2) What the individual can do to improve will be explored and planned, and 3) An attempt will be made to determine if there are outside factors which may explain why a problem has developed. At this point a determination will be made of whether the resident is in good standing or is in a Performance Warning Status (PWS). The PWS will involve a period of 3 months, where the performance of the resident can be monitored more closely. PWS is designed to identify weaknesses that, if not remedied, may lead to probation or dismissal. The Program Director, Associate Program Director, or their designee will be responsible for determining the process for remediation. This meeting will be documented, given to the resident for his/her agreement of the meeting content, and a final copy will go into the resident's personal file. Unless otherwise stated, a resident in Performance Warning Status is still considered to be in good standing and does not have to report this action on future professional applications. Should, however, the resident be placed in Performance Warning Status again after the initial 3 month period, he/she is eligible to be placed on probation.

Should the resident continue to be deficient despite appropriate counseling, professional assessment and input (if indicated), and faculty efforts, a period of probation (usually 3 months) is indicated. Before being placed on probation, the resident will appear before the Residency Education Committee wherein his/her case will be discussed. The resident in question will have the right to rebuke the claims made against him/her. If his/her performance is deemed to warrant probation then a formal written letter of probation will be drafted. A written letter of probation should: 1) State deficiencies that the individual has been counseled for and document that insufficient improvement has been made, 2) State explicitly that because of this the individual is being put on probation, 3) State period of probation, 4) State what is expected during this period, 5) State what will be done to assist the individual in meeting these expectations, 6) State what the mechanism(s) will be to

determine improvement and 7) State what the consequences or options are to be if expectations are not met. The deficient resident will receive this letter and a copy will go into his/her personal file. Residents placed on probation may have difficulty with licensure in some jurisdictions.

The probationary period is intended to emphasize to the resident the importance of satisfactorily meeting the residency training requirements and expectations of the Department. The resident should clearly appreciate the meaning of expected remediation, appreciate the defined time in which this must be accomplished, and alert his/her attending faculty during this period of probation to the importance of helping the resident with defined problems. The faculty should provide an honest evaluation, and comply with requests by the Department for assessment, counseling, or assistance, should there be any possibility of personal problems, learning disability, or outside factors that may be contributory to the resident's performance. Residents on probation must achieve a satisfactory evaluation from their attending faculty on assigned clinical service rotations during their probationary period. Probationary actions will only be shared with those needing to know.

Should the resident fail the above probationary period, then at the discretion of the Department, a letter extending the probation may be issued, or a letter dismissing the resident from the program on a designated date will be issued, assuming that dismissal was a consequence of probationary failure as stated above. Accompanying this letter must be a statement of the resident's right of appeal.

A resident who may or may not have been on probation (and successfully accomplished remediation in the probationary period), but who has received intermittent low satisfactory or isolated unsatisfactory marks during the 8 to 12 months of the academic year (and particularly following a probationary period), may be asked to repeat the year. This is particularly true if the Residency Committee feels the resident can receive no better than a marginal grade on the ABIM yearly assessment and/or if the Department will in all likelihood be unable to certify the resident to sit for the ABIM examination should the resident's performance trend continue. (Please refer to the GME manual for a comprehensive section on deficiency and remediation policies.)

Resident contracts are renewed on a yearly basis. If a resident is thinking about leaving his/her position in Internal Medicine, then it is advised that he/she meet with the Program Director as soon as possible to discuss this matter. The Program extends many professional courtesies to its' residents and asks that residents be professional and alert one of the Program Directors well in advance of his/her intended date of departure. Similarly, the Program reserves the right not to renew a contract for any resident it deems as performing in an unsatisfactory manner.

N. Grievance Procedure

Grievable matters are those relating to the interpretation of, application of, or compliance with the provisions of the Resident Agreement, the policies and procedures governing graduate medical education, and the general policies and procedures of the University of Kansas Medical Center. Questions of capricious, arbitrary, punitive or retaliatory actions or interpretations of the policies governing graduate medical education on the part of any faculty member or officer of the Internal Medicine Residency Program are subject to the grievance process.

Complaints of illegal discrimination, including failure to provide reasonable accommodations and sexual harassment, are processed in accordance with the Medical Center policies and procedures that are administered through the Equal Opportunity Office.

Should a resident in the Department of Medicine have a grievance or be dissatisfied with any aspect of the Program, he/she is encouraged to initially discuss the issue with his/her attending or the Chief Residents. If this is felt by the resident to be inappropriate or the issue is not satisfactorily resolved, timely discussion with the Program Directors is highly recommended.

Documentation of the issues and a statement of dissatisfaction by the aggrieved resident may be helpful, and is also encouraged, particularly when making an appeal to the Department's Medical Education Committee.

In general, the resident will first discuss any grievance with the Chief Residents. If this fails to provide adequate closure to the grievance, then he/she is directed to speak with one of the Program Directors. Issues can best be resolved at this stage and every effort should be made to achieve a mutually agreeable solution.

If the grievance is not resolved to the satisfaction of the resident after discussion with the Program Director, the resident has the option to present the grievance, in writing, to the Office of Graduate Medical Education. In situations where the grievance relates to the Chair or Program Director, or where the resident believes that a fair resolution cannot be attained by presenting the grievance to those individuals, he/she may present the grievance in writing directly to the Office of Graduate Medical Education.

The Associate Dean for Graduate Medical Education will meet with the resident, the Program Director, the Chair and one or more of the program's Chief Residents to determine the cause and validity of the complaint and to determine the means of redress.

Should the meeting with the Associate Dean fail to resolve the grievance to the satisfaction of the resident, the resident may request that he/she be heard by the Executive Dean. Any action(s) taken in good faith by the Executive Dean addressing the grievance will be final.

III. Hospital and State Regulations

A. Kansas Licensure

A valid Kansas License is required before practicing medicine in this or any other hospital in Kansas. Materials are generally sent to prospective interns prior to orientation. For a temporary license, requirements include: graduation from an approved U.S. medical school (if an FMG, an approved foreign medical school, certification from the ECFMG and a valid visa); and supervised instruction in an approved training program. A temporary license (postgraduate permit) normally lasts for the duration of the residency (3 years). To convert to a permanent license, one must have passed Parts I, II and III of National Boards or FLEX and successfully completed a year of training in an approved program. Once a permanent license is provided, the postgraduate permit expires, and it is the resident's responsibility to ensure that his or her permanent license is renewed yearly. Residents who will be attending continuity clinic at Swope Parkway, or any other Missouri-based institution, will need to obtain a Missouri license as well.

To continue in the Program, you must have a valid license. The program and the GME office track license expiration dates, but the Kansas Board of Healing Arts (KSBHA) ultimately views license renewal as the responsibility of the resident physician. In the event of failure to renew a temporary or permanent license before its expiration, the resident may be subject to discipline by the KSBHA, including fines and/or public censure. Materials can be provided by the Medical Education office, but you do have to fill these out expeditiously. The consequence of not having a valid license is immediate suspension from the Program until one is obtained.

B. Utilization Review

Virtually all patients covered by Medicare (and many other insurance plans) have charts examined for utilization review. The purpose of this is to identify patients inappropriately admitted to the hospital. If this occurs, the hospital (i.e. the doctors) must justify the admission and if not justified, the hospital stands to lose reimbursement for that patient's care.

There are two aspects to utilization review (UR): admission criteria and intensity of service criteria. Under admission criteria, guidelines have been developed which must be met in order for an admission to be approved. The patient must have some definable problem, often supported by an abnormal laboratory, radiographic or physical exam finding. Even laboratory findings must be significantly abnormal. For example,

a Hgb of 9 gm/dl is not enough for admission criteria - the Hgb must be below 7.5 gm/dl. While these guidelines have decreased admissions of patients with poorly defined conditions, they also limit the flexibility doctors once had, leaving in limbo patients who probably would benefit from hospital care but do not now meet the admission criteria.

Intensity of service criteria refers to the frequency or extent of nursing, medical, or ancillary care once the patient is admitted. Treatments, IV fluids or drugs and interventional testing all involve intensity of services. In some circumstances, a patient may meet admission criteria, but not qualify for intensity of service; for example, a patient with CHF who is treated with bed rest and oral medications may not meet intensity of service criteria even though progress is made that was not possible before admission.

You must be aware of these concerns since much of the documentation for meeting admission criteria or intensity of service criteria is found in your notes in the chart. Suggestions in your notes that the patient may not have required admission are inappropriate. Treatment of your patient should clearly reflect the degree of illness but realize that a lack of aggressive management may result in the hospitalization stay being disapproved. The resident physician must be honest but discreet in his/her notes and seek advice should he/she have questions. The attending physician can be helpful in this regard.

C. Charts

The hospital chart is one of the most important documents the resident physician will regularly encounter in his/her personal and professional life. Don't forget that the original impetus for complete and accurate medical charting was not a legal requirement for documentation, but rather to facilitate communication to allow progress, ideas, thoughts, plans and goals to be noted for future reference. Review of a patient's previous hospital or outpatient record can yield an enormous amount of information and save time, money, delay, and inappropriate intervention. The accurate recording of the patient's hospital course is paramount to good medical care.

The hospital chart is also a legal document and the resident should understand some of these ramifications. You must comply with all HIPPA guidelines and this information will be provided during the compliance meeting. Notes must accurately record the patient's daily progress, including thoughts and plans discussed on rounds. However, gratuitous comments or negative references to other treatments are usually not useful, especially when these comments imply fault.

An admission note is required within 24 hours of admission. Usually the intern dictates or writes a complete history and physical. The resident need not necessarily record a complete H & P (though it often is hard to remember important details of the case unless this is done) but must have at least a brief admitting note which must include a history of present illness, physical exam, and assessment/ plan or a problem list. Progress notes are required daily. The students are expected to write daily progress notes with the houseofficer. A discharge summary should include the dates of admission and discharge, reason for hospitalization, physical examination, laboratory, and radiographic findings, a synopsis of the patient's hospital stay, plans for home health care and follow-up clinic visits, dismissal medicines, and note of whom the referring doctor was and who was responsible for contacting him/her. The dictating resident should spell out the name of the primary care physician to ensure that he/she receives a copy of the discharge summary.

Hospital rules demand discharge summaries to be dictated within 48 hours. Unless this is done at the time of dismissal, however, the chart can be hard to locate, resulting in a delay of the discharge summary and ultimately prompting reminders from Medical Records or the Department of Medicine staff. The habit of early completion of charting will prevent otherwise irritating intrusions into the resident's busy schedule or even a limitation on the resident's patient privileges.

It is common courtesy that a comprehensive transfer note is written when a patient is transferred from one service to another. Similarly, a very thorough off service note to your colleagues is indispensable and critical to the continued care of the patient.

D. ACLS

Advanced cardiac life support is required of all residents. This formal requirement is met through the regularly offered courses given by the hospital and Department. Unfortunately, certification only lasts for two years; you will have to renew your certification after that time to stay current. Keep your eyes open for announcements in this regard, but ultimately the resident is responsible for getting this done in a timely manner. There is a listing of available courses on the Internal Medicine Residency website.

E. Malpractice and other legal situations

No discussion of malpractice begins without the failure to foster communication with your patients. A large percentage of suits results from simple failure to keep a patient or family informed about diagnosis, prognosis, plans and realistic expectations. A relationship built on consideration and respect avoids many problems and even allows for forgiveness of mistakes and adverse outcomes. Such a relationship does require time - but this is time well spent. The hospital has patient advocates who are often approached by the patient or family with complaints or concerns. These individuals are usually able to identify problems in communication which can be expeditiously managed.

There is a Risk Management Coordinator operating out of the Office of Legal Counsel for the hospital. This person can advise you before a problem becomes serious enough to consider malpractice. Most suggestions are common-sense but worthy of implementation.

If you find yourself, a colleague, an attending or other professional person engaging in activities which may eventually be considered malpractice, it is your moral and legal responsibility to report this activity. You can approach another attending, one of the Program Directors, the Chief Residents, the risk management coordinator or the hospital lawyers. However, for the resident's own protection (as well as the involved individuals and the hospital) he/she would benefit from telling someone.

Should you be contacted by a lawyer or paralegal for comments regarding a patient's care, do not respond. Report the incident immediately to the Program Director's office. The University and GME office have counsel available to handle any questions or concerns which arise.

You may be contacted by a representative of the hospital in the event that you were involved in the care of a patient with a complication or adverse outcome. KU Hospital and the VA Hospitals are committed to a culture of patient safety, and root cause analyses are performed when rare adverse events occur. The program encourages resident involvement in these investigations as part of the training experience and to prepare residents for independent practice. However, as a trainee you should always be accompanied by an attending physician or a program leader if you are to be interviewed about a patient care concern. Residents should let the chief residents know if they are contacted to participate in such an investigation.

On occasion, you may be contacted by the news media regarding the status of a patient admitted to the hospital. Usually, they respect the patient's privacy by not badgering hospital employees who may know the health status of a particular individual. Do not answer any questions and report this to your attending, especially as a HIPPA violation may occur.

F. Ethics

With increasing medical sophistication, the ethical questions which surround a patient's care often overwhelm the medical decisions. Medical and even more so ethical complexities are commonplace in the field of medicine. Even in the most complicated ethical situation, the first and most important step is to talk with the patient and family. Only through full communication with the appropriate decision maker can the resident address honestly, thoroughly and expeditiously the issues raised.

There are other people willing and able to assist. The chaplain service consists of full-time Protestant and Catholic ministers. (In addition, these ministers each lead Sunday services for hospital patients and employees). Other denominations have clergy on call to respond to patient requests.

An excellent source of ethical advice, available 24 hours a day by pager, is the hospital ethics committee, which consists of both medical and other personnel who are available to explore and advise on major ethical concerns. Physicians on the committee are available for discussion and for consultation at any time. In addition, there is a monthly Ethics conference held by the Ethics committee in conjunction with the General Medicine division. Ethical dilemmas arising on the inpatient medical services are discussed in an informal setting and lunch is provided. Senior residents supervising an inpatient service at KU for the month are required to attend, and all other senior residents are invited.

G. Order Writing

All orders written on teaching service patients are written by the residents. Attending physicians are required to write or cosign the DNR/DNI order.

The Program requires that all residents abide by the hospital's order writing policies for physicians as outlined by the Pharmacy Department. In general, it is the resident's responsibility to ensure that his/her DEA license is up to date and that the number is provided to the pharmacy Department.

When concerns about a resident's order writing competency are raised, a resident has his/her order writing privileges suspended and must have all orders cosigned before they become part of the chart and are carried out. This is decided upon by the Program Director and his/her Assistant Program Directors and explicitly outlined for the resident in question before it takes effect. The following is a listing of abbreviations prohibited from use in chart documentation, either in the orders or in the progress notes section of the patient's chart.

Avoid Unsafe Abbreviations

Use	DO NOT USE	Reason
Write Daily or Every Day or Qday	QD	Can appear as QID or QOD
Every Other Day	QOD	Looks like QID or QD
Morphine Sulfate	MS or MSO4	Can be mistaken for Magnesium
Magnesium Sulfate	MgSO4	Can be mistaken for Morphine
Unit or Units	U or u	Looks like a number leading to overdose
International Unit or Unit	IU	May look like "IV" or "10"

Avoid trailing zero (1 mg)	Trailing zero (1.0 mg)	10-fold overdose may occur if decimal point is not noticed
Use a leading zero (0.1 mg)	Lack of leading zero (.1mg)	10-fold overdose may occur if decimal point is not noticed
mL or mL/Hr	CC	Can appear as units or additional numbers
Sliding Scale (Insulin)	SS or SS	Can appear as other numbers or symbols
mcg or microgram	µg	Overdose results if mistaken for "mg"
RIGHT	R	Can be confused with "L"
LEFT or LITER	L	Can appear to be a number

Approved by the Executive Committee of the Medical Staff
Endorsed by the Pharmacy & Therapeutics and Medical Records Committees

IV. Department Rules/Understandings

There are rules, traditions, activities, and expectations of the Department of Medicine which may not apply to other departments at the Medical Center. The following is an attempt to introduce you to a few of the more important areas.

A. Inpatient and Ambulatory Practice

The wards and clinics are where most of the resident's service commitments are and where the majority of learning occurs. It is helpful to know what will be expected of the resident in these settings.

Attending rounds are held daily. The time and place may vary with each service and it is the resident's responsibility to be at the right place at the right time. Attending rounds are a time for decision making regarding clinical and ethical problems with the patients, a time for teaching, and a time for the medical team to ask questions. Everyone on a service has responsibilities and duties without which the team cannot function effectively. It is only polite and respectful to be present for rounds or to be sure someone on the service knows if you will be absent.

In general, there are a number of responsibilities for each member of the inpatient medical team:

R-1: It is the intern's responsibility to know all the relevant clinical data for his/her patient. This includes, but is not limited to, vital signs, medications and dosages, physical exam findings, laboratory values, radiological studies, as well as pertinent family and social information. It is the intern's responsibility to arrive at the hospital early enough each morning to see his/her patient's before rounds and be able to present them in a succinct, thorough manner. It is also the intern's responsibility to communicate updates to the family. When the intern does not know how to process certain clinical information, it is his/her responsibility to seek out his/her superiors for help. It is also the intern's responsibility to take call as scheduled and notify his/her senior resident should any problems arise in the course of the rotation. Interns present at MR only at the KCVA and should seek the advice of their senior residents in selecting an interesting teaching case.

R-2/3: It is the responsibility of the supervising resident to ensure that his/her team runs efficiently and provides the best care possible to the patients on the team. The senior resident is responsible for all of the patients on the team. He/she must see all of the newly admitted patients and the acutely ill patients before rounds. When an intern is absent from rounds for clinic or a day off, it is the senior resident's responsibility to thoroughly evaluate the intern's patients before rounds and to be prepared to discuss them in detail. Senior residents are responsible for all aspects of supervision as it pertains to interns. Specifically, they are available to help with the interpretation of physical exam and laboratory findings and to guide R1s in use of system resources for discharge planning and coordination of care. It is their responsibility to communicate directly

with both the attending physician as well as consulting physicians. They ensure that plans discussed during rounds are carried out effectively. At KU they are responsible for presenting at MR when scheduled.

At the beginning of each month, the attending should orient the residents to his/her expectations for the month and give them a copy of the service learning objectives. Each attending will function somewhat differently; he/she will hold rounds in a different manner, will expect different levels of formality, will have different expectations for patient presentations and levels of decision making, and will like to consult other physicians to varying degrees. It behooves the resident to know the expectations of each attending. If this is not abundantly clear, it is the resident's responsibility to ask.

Rounds on weekends usually vary from rounds during the week, becoming more service focused as the team accommodates the necessary days off for its members. Usually the attending or senior resident will decide on when rounds will be held. Special requests can be accommodated (church services, weddings, etc.), but only if these circumstances are made apparent to the attending physician.

If a resident must be absent (personal appointments, approved absences), it is his/her responsibility to inform the attending and senior resident in advance.

Generally, ward rounds are formal. It is expected that all members of the service will respect the patient and the person speaking with attention and appropriate response. There is no special dress code for rounds although the resident is expected to look neat and well-groomed. T-shirts, shorts and athletic attire are not considered acceptable. Scrubs are not inappropriate on rounds if the resident physician has not had a chance to change. Otherwise business attire, or business casual, should be the rule.

Team sizes vary with the nature of each specific service. In general, one intern cannot carry more than 8 patients at any given time. For teams composed of 2 interns and one supervising resident, the number of patients must not exceed 16 patients. For teams with one intern and one supervising resident, the number of patients on that team is limited to 12 patients.

Services will have different expectations as to when and where residents should appear in clinics, do consults, contact consultants and carry out other details related to patient care. The resident should learn the expectations and priorities from the attending or supervisors early in the rotation.

B. Evening and Night Coverage for Inpatient Services

Inpatient services at KU and the KCVA are responsible for taking calls on and admitting patients to their own service until 7pm at night on weekdays. Inpatient teams can check out to their team's "late day" resident with the involvement of their staff at 5pm. The team's late day resident will remain in house until 7pm to take calls on their team's patient and to admit patient's to their team. Each individual team is responsible for determining the late day resident schedule. If the team's late day resident is an intern, the short call senior resident is responsible for admitting that patient with the intern between the hours of 5pm to 7pm. Teams that are one resident or one resident and one intern are an exception to this rule and take home call on their patients from 5pm-7pm; these teams' admits after 5pm will be the responsibility of the senior short call resident.

A formal checkout process will take place at 7pm each weekday evening. Residents expected to be present at these checkout sessions are the late day resident from each inpatient team, the senior short call resident, and the night float team. Checkout rounds will be held in a standardized location at each facility. The two senior residents at checkout rounds are responsible for ensuring that an effective checkout process takes place. Checkout rounds are a priority and all residents outlined above are expected to be in attendance.

As mentioned above, interns and upper level residents participate in a night float coverage system for the medicine inpatient wards at KU and the KCVA. Due to the night float coverage system, overnight call at KU and the KCVA is limited to one to two weekend calls per rotation block for interns on inpatient services. Senior residents have no overnight call while on inpatient months at KU or the KCVA.

The night float teams at KU and the KCVA are made up of an upper level resident and two interns; the night float team works Monday through Friday and has Saturday and Sunday nights off. The night float team comes on duty at 7pm and goes off duty at 8am. The night float team is responsible for all admissions and consults to medicine services (except those to the KU ICU and KU CCU) during their shift. The senior resident is involved in each admission/consult while the interns alternate helping the senior resident with admits and consults. The night float team is also responsible for all cross coverage responsibilities between 7pm and 8am. Interns take first call from nurses regarding questions or concerns on floor patients. Interns are expected to respond to calls from wards to assess patients who seem to be having problems. These calls have varying degrees of urgency and all requests to see patients should be taken seriously. Interns must respond to these calls expediently, and should always leave a note in the chart detailing the reason for the call and any action taken. The intern should have a very low threshold for calling the night float senior resident to review the case and the management plan. The resident may choose to update the patient's primary resident at home, or call him/her for any further information not explicit from the chart review.

As stated above, the night float system is not in effect on Saturday or Sunday at KU or the KCVA. Thus, inpatient interns do remain in house overnight on weekends. Interns can expect one or two weekend calls per block. Inpatient interns will take cross cover calls as well as admits patients to their own team on these weekend calls. Inpatient senior residents are assigned a Saturday or Sunday shift one or two times per block; senior residents are responsible for all admissions and consults from 8am to 8pm on their assigned shift. At 8pm, an assigned upper level consult resident will take over these responsibilities until 8am the following morning.

In the ICU and CCU at KU, night coverage is provided by a unit resident that is doing four to seven consecutive twelve hour night shifts. In the MICU these shifts begin at 6pm and end at 7am. In the CCU these shifts begin at 7pm and end at 7am. The night shift resident is responsible for all admissions to his/her respective team (up to the above defined ACGME admission limits) as well as taking all calls on unit patients. Additionally the senior resident rotating on the CV-2 team will provide 1 week of night float coverage for the CCU. During the week they are on nights, 1 resident from CCU will float to the CV-2 team. There is no short call in the MICU Monday-Friday. There is a short call system on weekends/holidays scheduled by the team. The short call resident stays from 1pm and is responsible for all ICU admissions; they will check out the patients to the night float resident at 6pm. The CCU maintains a short-call system from 5pm-7pm Monday-Friday at which time they check out to the night float resident. Short call on weekends is from the time rounds are complete until 7pm. The CV-2 resident will take home pager call on their patients from 5pm-7pm Monday-Friday and will check out to the night float resident via telephone at 7pm. When the CV-2 resident is off on the weekend, the CCU team is not responsible for coverage of their patients.

At Leavenworth VA Hospital, residents participate in a home beeper call system, but do not take any in hospital overnight call.

Each general medicine team, CCU and ICU team is responsible for their own short call schedule. Chief residents will assign intern and senior resident long calls and night float. Any changes to the chief-resident assigned schedule must be submitted in writing (email is fine) to the Chief Residents as well as bobbie fink in order to update the call schedule and notify the page operator.

Meals are provided via a meal-card for those on call as is a clean room in which to sleep.

The Department of Medicine strictly enforces the RRC's work hours regulations with which every resident should be familiar: 1) A resident cannot work over 80 hours/week as averaged over the four week block rotation, 2) Each resident must have at least 10 hours off between shifts, 3) Each resident post-call must not exceed the "24+6" rule, meaning that he/she must leave the hospital no later than 30 hours from the time he/she entered the hospital to assume call responsibilities, and 4) Each resident must be given one full day off from clinical responsibilities per week. **Any deviation from this must be reported to the Chief Residents so corrective action can be initiated.**

In accordance with the RRC-IM, the requirement of ten hours off between shifts can be shortened to eight hours for residents on inpatient services who stay in the evening for “short call” and check out to a night float resident.

Residents are expected to report their work hours, including the time that they arrive and leave the hospital for call shifts, accurately. The program leadership reviews the report of each resident’s work hours weekly to ensure compliance and to address concerns immediately before they become a pattern.

As a back-up for any potential illnesses that occur while on service, for any unforeseen circumstances related to excessive admits/consults occurring during a planned shift (great than 10 new admits or consults per senior resident) or for any additional extenuating circumstances, a jeopardy or “back-up” call system is in place with 1 intern and 2 senior residents serving usually 1-3 weeks of back-up call per year. These calls are assigned and posted on the online “Amion” scheduling website for viewing of residents and staff. A resident when on back-up call is expected to be carrying their pager at all times, as well as carrying a cell-phone for any unforeseen pager failure and to return pages. The resident should be available, within 1 hour, to be able to report to work if needed and to refrain from use of any substances including medications or alcohol which may lead to somnolence or inability to perform clinical duties if you are called upon. If a resident fails to respond to pages or phone calls when called upon for back-up or is unable/unwilling to report to work they will be assigned an additional week of back-up call and another overnight or MOD call as the chief residents see fit.

C. Leavenworth VA Medical Center

The Leavenworth training site includes a teaching ward in which selected patients are admitted. There are several KU Department of Medicine faculty who serve as attending physicians. Admissions to this ward are controlled by the chief of medicine and are managed by the residents. There is little responsibility for patient care in the rest of the hospital. A concentrated series of lectures and teaching conferences occurs each day, and nursing home facilities on site provide residents with valuable exposure to geriatrics and long term care. As stated above, residents do not take in house call at Leavenworth VA Medical Center.

D. Medicine/Pediatrics

The Med/Peds program offers another option in primary care for practitioners. Residents in this program complete four years of residency training and, according to guidelines laid out by the Boards of Pediatrics and Internal Medicine, are eligible to become board certified in both medicine and pediatrics.

In the first year, the resident spends six months on rotations in one specialty and then six months in the other. During years 2 and 3, residents alternate between medicine and pediatrics at 4 month intervals. In the fourth and final year, the 6 month rotation resumes. Schedules are coordinated between the specialties in order to avoid excessive exposure or reduplication in subspecialties.

The resident maintains a continuity clinic at the Silver City Clinic in a nearby neighborhood called Argentine. The Program Directors for Internal Medicine and Pediatrics serve as co-directors for the Med/Peds program, and there is coordination and faculty supervision by both Departments. Med/Peds residents have the same opportunities, responsibilities, and duties as medicine residents.

E. Medicine/Psychiatry

The University of Kansas Medical Center also offers a combined Med/Psych program which is a 5 year program similar in structure to the Med/Peds program, allowing board certification in both Internal Medicine and Psychiatry.

F. Ambulatory Care

The Resident’s Continuity Clinic is the most consistent experience in ambulatory medicine. Each resident is assigned to this clinic one half day per week throughout the residency. Residents may have their

continuity clinic at Silver City, or Swope Parkway, KU only, KCVA only, Westwood, or may alternate between KU and the KCVA (ending with 2011 graduating class). Preliminary residents do not have continuity clinics. The only exception to weekly attendance in these clinics is when residents are assigned to critical care months and night float, when they do not attend their clinic. An exception is when residents are assigned to the Cardiology Inpatient rotation at the KCVA, when they *will* attend clinic.

The Resident's Continuity Clinic is an opportunity to follow patients as their primary care physician. Residents follow a panel of patients for their entire three years of training. The emphasis is on creating an outpatient clinic environment replete with preventive medicine, follow up visits, as well as acute care for episodic illnesses. Patients in the resident clinic will come from a variety of sources -- walk-ins with acute illnesses, patients followed by former residents, follow-ups from hospitalizations, etc.

Residents will have their clinic on the same day each week. Pre-clinic conferences based on the Yale Curriculum are held each morning from 8:00-8:30 am (1:00 pm for residents with afternoon clinic). The resident is excused from MR on his/her clinic day but attendance is also tracked at the pre-clinic conference. These didactic sessions are facilitated by the supervising attending physicians as well as the residents in the continuity clinic. Patients are put into rooms as soon after 8:30 a.m. as possible. Generally, return patients are scheduled for 20 minutes, new patients for 40-60 minutes. All patients need to be checked out with one of the clinic attending physicians, who is ultimately responsible for the patient's management at that visit. Our goal is for each intern to see 3-5 patients, each 2nd year resident to see 4-6 patients and each 3rd year resident to see 5-7 patients per half-day of clinic.

There is a nurse manager at each hospital whose duty it is to ensure the smooth running of the clinic. This nurse should know the clinic population, and patients are encouraged to contact him or her with questions; if he or she cannot effectively solve the problem, he or she will contact the resident physician for further guidance. At KU all labs ordered on outpatients are screened by the nurse clinician and the resident assigned to Rapid Return Clinic -- any significantly abnormal results are relayed to the ordering resident. In this way, the residents are notified of major problems before the patient's next visit and can intervene quicker if necessary.

The clinic attendings are available to provide assistance in patient management decisions and are required to see all intern's patients until he/she reaches his/her sixth month of training. Often times an attending physician will choose to continue seeing the resident's patients if it is felt that the patients are complicated or acutely ill.

A resident's clinic takes priority over any other service obligation. If he/she is unable to keep the clinic date, it is imperative that he/she notify the clinic attending, the Chief Residents, and scheduling staff as soon as feasible. The scheduling staff should be contacted via email at IMScheduling@kumc.edu as well. As it pertains to vacation changes, clinics may be cancelled by the chief residents if requests are made via email to IMCHIEFS greater than 60 days prior to the expected absence. If changes are requested less than 60 days in advance they must be cleared by the designated clinic faculty as stated in the Leave Request Form on the internal medicine residency website. In this circumstance, once approved by this faculty member and the Chief Residents, the form will be forwarded to the appropriate contact persons and the resident is then expected to call all patients scheduled in his or her clinic and notify them of the cancellation. The patients should be directed to internal medicine scheduling to reschedule their appointment.

When the rotation schedule is made up at the beginning of the academic year vacations are generally included. However, if a change in vacation time is needed, the resident must fill out the necessary change of vacation form available in the Program office or from the Chief Residents. Once completed and signed by the appropriate individuals, the change will be communicated to the scheduling staff to cancel the resident's clinic. By having all of the affected personnel sign the form, it is assured that the resident's clinics will be rescheduled and the attending physician and senior resident who are directly impacted will be appropriately informed of the changes. **Continuity clinics may be rescheduled for the following reasons: Medical Education Conferences, Board Preparation Courses or USMLE/COMLEX Step 3. Continuity clinic**

can be cancelled with prior approval for the following reasons: Locum Tenens, Medical Mission Trips/International Electives. Two months advance notice is recommended to ensure that you will be able to cancel your clinic on the desired day. Dr. Stewart Babbott (KU) and Dr. Stephanie Thompson (VA) must be notified of all clinic changes and request for cancellation is subject to their approval. Clinic cancellations for any other reason must be discussed with Dr. Stewart Babbott and will be evaluated on a case-by-case basis.

Most of the specialty services and many of the general medicine rotations at both KU and KC VAH have outpatient clinics the resident will be expected to attend. This provides an excellent opportunity to see patients with specialty problems in an outpatient setting. In addition, required rotations in Neurology and Geriatrics include significant experience ambulatory experience. Between all the required clinics in general and specialty medicine, the resident will be spending at least one third of his/her residency in an ambulatory setting.

G. Pagers

The training program will assign each resident a primary pager. Residents may be asked to carry additional pagers, such as the code blue pager or a VA pager, when on certain rotations. Replacement batteries are available at different locations in each hospital and in the Medical Education office. The resident should inquire where these are distributed upon arrival at the new hospital.

Residents on consult services are frequently asked to cover or carry the call beeper for that service on a rotating basis. A resident may be called for emergent consults or simple patient questions. This educational duty tends not to be especially onerous. Responsibilities will vary depending on the particular service.

H. Communication with referring physicians

Referrals are a large and very important part of the service provided by this Department to inpatients and outpatients. Patient transfers from outside of KUMC must be accepted by the attending physician. These referrals frequently come from physicians outside KU Medical Center, in the greater Kansas City area or outlying areas in Kansas and Missouri. Timely communication with referring doctors is essential. Referring physicians are conscientious practitioners who recognize a problem beyond their abilities and appropriately send the patient to this tertiary care center for further work-up and treatment. The resident should keep in mind that all communication with the Transfer Center should be directed to the attending physician on call. A resident cannot accept or deny a transfer but is encouraged to talk to the transferring physician to get the relevant details of the patient's medical problems.

It is appropriate to contact the referring doctor upon admission of the patient. This is to let the patient's doctor know that his or her patient has arrived and to clarify any questions or priorities that may have arisen after the initial workup. It is also wise to contact the doctor periodically during a prolonged admission to keep him/her updated. On discharge, the summary is faxed to the referring doctor; hence prompt dictation of summaries is essential to continuity of care.

If a resident's primary care patient is admitted to the hospital either at KU or the KCVA, he or she should be notified via phone call, text page or email by the admitting service.

I. Special circumstances in regard to routine services, admission limits and covering non-teaching patients

At all sites where KUMC residents practice, there are no non-teaching patients seen by residents except under urgent/emergent circumstances such as a rapid response or Code Blue. Residents are not required to provide routine intravenous, phlebotomy, or messenger/ transporter services, excepting in the care of emergency. Residents' service responsibilities are limited to patients for whom the teaching service has diagnostic and therapeutic responsibility. (NOTE: "Teaching Service" is defined as those patients for whom internal medicine residents [PGY 1, 2, or 3] routinely provide care.) The admission and continuing care of patients by residents is limited to those on the teaching service. The exception is when there is an emergent

situation, and there is a request by the physician of the non-teaching patient. Care will be passed back to the primary doctor as soon as the patient's emergent condition has been stabilized

As a back-up for any potential illnesses that occur while on service, for any unforeseen circumstances related to excessive admits/consults occurring during a planned shift (great than 10 new admits or consults per senior resident) or for any additional extenuating circumstances, a jeopardy or "back-up" call system is in place with 1 intern and 2 senior residents serving usually 1-3 weeks of back-up call per year. These calls are assigned and posted on the online "Amion" scheduling website for viewing of residents and staff. A resident when on back-up call is expected to be carrying their pager at all times, as well as carrying a cell-phone for any unforeseen pager failure and to return pages. The resident should be available, within 1 hour, to be able to report to work if needed and to refrain from use of any substances including medications or alcohol which may lead to somnolence or inability to perform clinical duties if you are called upon. If a resident fails to respond to pages or phone calls when called upon for back-up or is unable/unwilling to report to work they will be assigned an additional week of back-up call and another overnight or MOD call as the chief residents see fit.

J. Absences, notification, days off

It is unrealistic to expect that a resident will not become ill, not have personal emergencies, or not have other reasons to be absent. Should any of these occur, the resident's first responsibility is to inform others on his/her team of the absence. Arrangements can be made to cover for a resident's absence.

If something arises that will require an absence from the service for a full workday or longer, the resident must also inform the Chief Resident. If necessary, the sick call resident or a resident from another service may need to be pulled to cover. Prolonged absences, as from illness, require close communication with the Chief Resident as changes in schedules invariably must be made. If a resident is medically ill for longer than 2 consecutive days, he/she is required to provide the Chief Residents with a doctor's note to be placed in the resident's file. Each resident is responsible for reporting any sick days used when he/she is filling out his time entry.

Anticipated days off should be cleared through the attending physician. If the resident will miss a clinic day, he/she needs to fill out an absence notification form available through the Program Medicine office or the Chief Residents. Clinic leadership must sign-off on these forms. Absences should be scheduled three months in advance if possible.

The Department recognizes the value of regular days off and has developed a policy in this regard. Residents are guaranteed one day off per week, averaged over a four week period. The details of arranging days off differ with each service -- generally the interns and residents arrange the schedule by themselves. If difficulties arise, discuss these with the attending and Chief Residents.

V. Benefits

With respect to your benefits, there are a number of people who can help sort through the benefits package. The business office for the Department is available at 588-6001 and can answer many of your questions. The staff in the Office of Medical Education will assist in answering your questions, or direct you to the appropriate people to do so.

A. Pay

Residents get paid every two weeks, starting two weeks after the resident completes the first pay period. A resident can choose to have the pay check mailed to his/her home or have it deposited electronically into his/her account.

B. Medical insurance

Medical insurance is paid by the University but residents do have a choice regarding particular plans. This is the same choice offered to University employees. Detailed information on the various coverage plans will be made available during the new resident's orientation.

C. Life insurance.

The Department purchases a group term life insurance policy for all of its residents without the necessity of prior examination. This includes accidental death and dismemberment protection in the amount of \$50,000. This policy is convertible to permanent life insurance within 31 days of leaving the group. This benefit should be kept firmly in mind as the training program finishes.

D. Malpractice insurance

While practicing medicine at the KU Medical Center and its affiliated hospital training sites, residents are covered by a self-insurance plan administered by the State of Kansas. This policy provides standard coverage for all activities typical to internal medicine. There is tail coverage for any suits filed after a resident has left the Department for a period of 3 years.

This policy covers residents only while practicing under approved circumstances in the KU Medical Center and its affiliated hospitals. In general, this is not confining. However, when considering issues related to moonlighting, there may not be coverage provided for non-affiliated hospitals. Residents moonlighting or doing locum tenens without the benefit of prior approval by the Programs Directors cannot be guaranteed malpractice coverage. Residents must be most acutely aware of this when moonlighting in a non-affiliated institution. Neither malpractice nor disability insurance applies to these sites. It is the resident's responsibility to know if they have coverage during moonlighting time.

E. Disability insurance

The Department insures residents should they become disabled and cannot work. The policy pays \$1000/month if benefits begin 181 days after the disability. This policy takes effect without the necessity of a qualifying physical examination.

This policy may be converted to private use, again without requiring an examination, if one decides to do so within 31 days of the termination of with the Department. This is potentially a very valuable benefit which should be considered as one approaches the end of training. There are multiple supplemental policies which will be covered in one of the orientation lectures.

F. Parking

Parking is provided by the Department in the RED lots at KU. Parking at the Kansas City and Leavenworth VA Hospitals is also provided. Parking stickers must be obtained from the Medicine office at the VA and residents should park only in designated areas.

G. White coats

The hospital provides each resident with three white coats. Residents should be aware that it is official medical school policy that white coats with name and hospital ID be worn at all times. This same policy states that no other buttons, stickers, pictures, appliques, statements, political comments etc. adorn the white coats.

H. Access to Medical Literature and Board Preparation Materials

The Archie Dykes Library for the Health Sciences is located across 39th Street north of the hospital. The library stocks the vast majority of commonly desired periodicals by the clinical and basic science staff. Books and manuals are also readily available. The library is generally open at convenient hours during the day but is not open 24 hours per day. However, access to the library's electronic journals and databases are available online through the KUMC website, both on and off campus. Any library fines are the responsibility of the resident and it is possible that a graduating diploma could be withheld until library fines are paid in full.

There are books and computers available in the Departmental resident lounge on the 4th floor of Delp at KU. Books have been provided by the Department, faculty or drug companies. They are intended to remain in the resident's lounge for all residents to use so residents are discouraged from removing them from the resident's lounge. Several divisions have texts and journals available but they request that residents use them in the divisional library only.

All the University and KCVA hospital computers have *Up To Date* on them and internet access to the Dykes library is available. In addition, a number of board review resources are available for residents' use in the chief residents' office. The department provides each resident with a copy of the MKSAP board review materials as well.

I. Vacation

All House Staff are entitled to 3 weeks of vacation per year, to be taken in one-week blocks unless a special exception has been granted, and not to exceed two weeks in a row of absence. Vacations generally start on Mondays and finish on Sundays, however some exceptions can be made based on the residents schedule. ***The weekend off before the start of vacation starts is not guaranteed and will depend on the specific circumstances of any given rotation.*** Residents who make travel plans before obtaining approval from the program leadership are not guaranteed approval of the time away and may incur a financial loss for travel expenses.

There are certain rotations, such as ICU, CCU, CV-2 and supervisory services, during which vacations are not permitted. Vacation requests are gathered during the spring prior to making out the master schedule for the upcoming year.

Under certain circumstances, requests can be granted for a change in vacation dates. These must go through the Chief Residents and be approved. As it relates to scheduled clinics, clinics may be cancelled by the chief residents if requests are made via email to IMCHIEFS greater than 60 days prior to the expected absence. If changes are requested less than 60 days in advance they must be cleared by the designated clinic faculty as stated in the Leave Request Form on the internal medicine residency website. In this circumstance, once approved by this faculty member and the Chief Residents, the form will be forwarded to the appropriate contact persons and the resident is then expected to call all patients scheduled in his or her clinic and notify them of the cancelation. The patients should be directed to internal medicine scheduling to reschedule their appointment.

Preliminary residents or graduating residents starting fellowship or employment need to notify the chief residents at least three months in advance if they will be absent for orientation, travel, or moving at the end of the academic year. Vacation days will need to be saved during the year and applied for these absences.

National holidays are defined within the hospital in which the resident is working. Occasionally there is a discrepancy between holidays observed at KU, and the Veterans Hospitals. There is no comparable time given for holidays at one hospital and not observed by the others.

J. Fitness Center

The Kirmeyer Fitness Center, located on the corner of Rainbow and Olathe across from the Med Center, is open to all employees of the Med Center. The center has exercise equipment, aerobics rooms, a basketball court, racquetball courts, a circular track and a lap pool. Some of the facilities are unavailable during the day since these are used by Rehab Med and the Sports Medicine program. However, the Center opens at 6 AM and remains open in the evening and weekends for participant use. Fees are reasonable but not covered by the Department.

K. ACP membership

The American College of Physicians was founded in the 1920s with the primary goal of providing and certifying continuing education for internists. The ACP has been at the forefront of continuing education efforts in American medicine for years. The annual ACP meeting is a remarkable conference with a variety of educational offerings. In recent decades, the organization has expanded its role to include membership benefits, clinical practice and technological assessment, public policy stands, and political representation of internist concerns. The ACP is the premier organization representing the interests of all internists. The KU Department of Medicine has had and continues to have a very high profile in the ACP, but residents are

encouraged to investigate its ideology thoroughly before deciding on whether membership is desired. It is not mandatory by any means.

Recognizing that residents and fellows are its future members and also have concerns different from the remainder of the membership, the ACP has a category termed Associate Member. Associates attend ACP meetings at a special price, order materials such as MKSAP at reduced cost receive the *Annals of Internal Medicine*, are eligible for insurance and other benefits, sit on regional and national committees and, in fact, have most of the benefits of full membership short of voting at the annual meeting. The Department pays the dues for all residents who desire associate status.

The Kansas ACP Chapter has an Associates Committee. This committee exists to represent associate (resident) concerns within the state organizational structure, provide feedback to national leadership, serve as a pool of interested persons from which appointment to regional and national committees can be made and to interact positively with medical students in an effort to better present the attractiveness of internal medicine as a career choice. Representatives from each class, at both the Kansas City and Wichita campuses, are elected by the associates to membership on the committee.

L. Sick leave

The University will provide up to 10 workdays of sick leave per year to cover personal illness or illness in the resident's immediate family (spouse or children). Sick leave cannot be accumulated from year to year. The use of sick leave must be approved by the Program Director or Department Chair. At the discretion of the Program Director or Chair, a physician's statement may be required as a condition of approval of sick leave.

For short-term illnesses (colds, flu during your residency) residents are asked to simply inform the appropriate members of their team and the Chief Residents, being certain the message reaches the attending and supervising physician. In some circumstances (supervisory services, ICU rotations), even short-term illnesses will require coverage so let the attending, supervising resident and the Chief Residents know as soon as possible. Occasionally, it may require the Chief Resident to intercede in order to ensure adequate coverage.

For any illness, which will require the resident to take a leave of absence, prompt notification to the Chief Residents and final approval by the Program Director must be obtained in writing. Should a leave of absence exceed accrued time, stipend payments will be interrupted. However, family health insurance benefits will continue as long as the resident pays the individual premium. (See the University House Staff Policies & Procedures Manual, Section 15).

The American Board of Internal Medicine allows up to one month, per year, as time away from the program. Time used beyond this one month will be required to be made up to meet the requirements for writing the Boards. The ABIM does not distinguish between vacation time or leave for illness, including pregnancy-related disabilities, and includes them as time away from the program. (Also see Section II-D in this manual, ABIM Requirements.)

M. Maternity Leave

It is important to inform the Chief Residents and the Program Director promptly upon knowledge of pregnancy. This permits necessary adjustments in the schedule. Obstetrical appointments are handled as any other medical appointment; a resident should inform the rest of his/her team.

Any unused sick leave/vacation time can be used to cover maternity leave. Should a leave of absence exceed accrued time, stipend payments will be interrupted. However, family health insurance benefits will continue as long as the resident pays the individual premium. (See the University House Staff Policies & Procedures Manual, Section 15.2). In addition, residents are required to make up time at the end of residency should they exceed their accumulated time for leave. This is subject to departmental approval, as the Department of Medicine becomes financially responsible for a resident's salary if training is completed "off-cycle," or after June 30 of the third year of training.

Elective time may be utilized for a home study project following the birth of a child. Residents are expected to meet with a Program Director to discuss the project as outlined previously in Section II. Residents are required to attend their weekly continuity clinic during this home study month.

See above section V-L (Sick Leave) in this manual for the ABIM position and requirements on pregnancy-related disabilities or leave from the Program.

N. Paternity Leave/Adoption

It is important to inform the Chief Residents and the Program Director as soon as paternity leave/adoption is anticipated. This may permit assignment to a service less likely to be adversely affected by an unexpected absence.

Any unused sick leave/vacation time can be used to cover leave. Should a leave of absence exceed accrued time, stipend payments will be interrupted and time will need to be made up at the end of residency training. However, family health insurance benefits will continue as long as the resident pays the individual premium. (See the University's House Staff Policies and Procedures Manual for more information).

See above section V-L (Sick Leave) in this manual for the ABIM position and requirements on pregnancy-related disabilities or leave from the program.

O. Moonlighting

The ability to moonlight with Departmental sanction is regulated by the Program Director. There are only a few approved sites for moonlighting; currently these include the Kansas City VA, the University of Kansas Medical Center and the Leavenworth VA, and sites arranged through KUMC's Locum Tenens program. Additional site requests must be submitted in writing to the Program Director for approval.

Moonlighting is not a right, it is a privilege. Residents must be in good standing and progressing steadily through the Department to be sanctioned to moonlight. Moonlighting is not permitted on certain rotations (ICU and supervisory services), and must not conflict with training assignment, call schedule, or patient responsibilities. In order to participate in moonlighting, residents must read and sign the policy sheet provided by the Department. All moonlighting hours are counted toward weekly work hours, which must not exceed 80 hours total.

In addition, all duty hour requirements regarding residency may apply to moonlighting as well, and must not be violated. Residents cannot moonlight if doing so brings them into conflict with duty hour requirements while performing their normal duties. Residents with J-1 or H-1B visas are not eligible to moonlight.

P. Locum tenens

One week of locum tenens is permitted during the R3 year, in addition to the resident's three weeks of vacation. Those who are interested should let the Kansas Rural Health Coordinator, Andee Ellis, know at the beginning of the year. (aellis2@kumc.edu or 588-1228) This week is not treated as vacation. If the locum tenens is arranged through the Rural Health Office malpractice coverage is generally not required. Residents may do up to 2 weeks of locums per year, but the 2nd week is counted as vacation time. Residents cannot take both vacation and locum tenens during the same rotation. Availability to accept locums depends, of course, on the resident's rotation and the approval of its attending faculty. Any locum tenens opportunities outside of the Rural Health Office here at KUMED must be accompanied by a request for House Staff Extra-Institutional Practice Privilege which must be signed by the Dean and approved by the Program Director.

Q. Meetings

The Department sponsors many CME lectures given by physicians during the course of a year. These all are open to House Staff and usually are free or have a minimal charge. As with any meeting, it is best to pre-register with Continuing Education (Student Center Building) but if that is not done, one can frequently

register at the door. As with all absences from a rotation, clearance should be obtained from the attending physician and the supervising resident if applicable.

The Department is very involved in the yearly Kansas chapter ACP meeting. This meeting rotates between Kansas City and Wichita. It is an excellent opportunity to fulfill the scholarly activity required in the resident training program.

Up to five days per year may be taken to attend national and regional conferences and will not be counted as vacation time, but may need to be counted as the resident's days off for the month. Absences beyond five days in a given year will need to be in accordance with approved vacation time.

For those elected as resident representatives to local or national organizations (e.g. ACP, AMA etc.), attendance at these required meetings is readily permitted and encouraged, but the resident must work closely with program leaders and chief residents to ensure that their absence is not burdensome to their colleagues.

An individual is encouraged to use part of their educational fund to attend a conference such as ACP.

R. Educational Fund

Categorical residents in good standing with the program have access to educational funds as follows: Year of Training No. 1 - \$300.00 allowed, Year of Training No. 2 - \$300.00 allowed, Year of Training No. 3 - \$600.00 allowed.

This money may be accumulated over a period of time for use as a lump sum, or in small amounts each year. Example:

Year 1 - \$300 available.

Year 2 - \$300 added to balance from year 1.

Year 3 - \$600 added to balance from years 1 and 2 (if any balances remain).

This money must be used for approved educational purposes only, and residents must be in good standing to access it. This includes, but is not limited to books, journals, educational CDROMs, medical supplies, medical license, DEA number, ABIM certification examination, USMLE Step III, computers, palm pilots, conference attendance, etc. Note: Combined program residents (e.g. Medicine/Pediatrics, Medicine/Psychiatry) have slightly different allotments and the resident should check with his/her Program Director for the actual allowance.

VI. Other

A. Social

One of the great attractions of the Department of Medicine's training program is the camaraderie amongst the House Staff. Residents generally get along well, regularly pitch in and help out when needed (often without asking), and enjoy being together. Throughout the course of the year there are planned or impromptu social events such as softball, golf tournaments, boating excursions, or spectator sport events. The Department of Medicine has donated a fund available to residents on the House Staff Appreciation Fund Committee in which to sponsor many of these activities. Activities are announced well in advance via email and available to all medicine residents and sometimes spouses/families based on budget. Any resident is able to participate in the planning of these activities as a part of the committee.

There are other regular social events on the Department calendar. The Chairman or Program Director has a welcoming party for incoming interns shortly before the internship begins. The Chairman also sponsors a reception for the visiting Departmental Professor and dinner for graduating R3s held at a fine Kansas City restaurant. Attending Faculty may acknowledge the end of a rotation by taking the team out to lunch or otherwise expressing appreciation.

One of the most enjoyable events occurs on a (typically) dreary Saturday in the middle of winter. This is the Departmental Quiz Bowl. Started in the early 1980's, the Quiz Bowl pits House Staff against faculty in a non-medical test of trivia, replete with lunch and adult beverages at a local pub. Spirits are high, facts are loose, and fun is had by all.

B. House Staff recruitment

The process by which House Staff are selected is one which involves all members of the Department. The invited applicant's interview day is designed to provide potential interns the widest possible exposure to our Department. Attendance at morning report, orientation by the Chief Residents, ward rounds, meetings with residents over lunch and faculty interviews comprise a full morning for applicants.

One of the most important aspects of the interview day is the applicant's interaction with our residents. Whereas some programs appear to shelter applicants from residents, we are pleased to have them meet with all of our residents, and residents are an instrumental part in the Department's recruiting drive.

Potential incoming interns are our resident's future colleagues. It is critical that any feedback our residents may have be conveyed to the Chief Residents or the Program Director/other members of the Residency Education Committee. Recruitment season is long but essential to continue the long tradition of exemplary residents in internal medicine.

Our resident's appraisal of the applicant, along with our faculty's impressions and assessments, combined with the applicant's letters of recommendation, medical school dean's letter, and personal statement makes up the file for each applicant. All files are then carefully reviewed by all members of the Medical Education Committee, and a match list is compiled for the computerized national match of R-1's.

C. Fellowships

Traditionally about half of the residents have gone on to complete subspecialty fellowships. Graduates of the program have been remarkably successful in attaining positions in this Department as well as at the most competitive programs in the country. The process begins early. Interviewing for fellowships usually begins in the spring of the R2 year. Before then the resident is encouraged to talk with the division director of the subspecialty in which he/she is interested.

Interviewing occasionally presents problems. It can be complicated to juggle demands of a service with the need to interview. In general, fellowship interviews are held in March or April. Residents are encouraged to plan their vacation time around the months they are likely to interview and it is possible to break up one of your weeks of vacation for interviews if needed; you may also use regularly scheduled days off for interviews. Once interview dates are confirmed, it is the interviewee's responsibility to coordinate service coverage while he/she is away to interview.

The Department realizes that some specialty areas, such as cardiology, pulmonary, and gastroenterology, are more competitive than others are and often demand numerous interviews. Service duties can be met, however, with generous doses of flexibility, consideration, and prudent planning. However, failure to plan ahead may limit realization of expectations. As soon as you have accepted/scheduled an interview that may conflict with your service responsibilities, please let the Internal Medicine Chiefs know. There needs to be a minimum of 2 weeks notice prior to interviewing, preferably more. This is to allow appropriate coverage and rescheduling if needed. If attending more than 7 interviews, you must meet with an Internal Medicine Program Director and have your schedule approved. Approval by the Internal Medicine Program should be done prior to scheduling plan flights, hotels, etc. as you run the risk of having to cancel and there will be no reimbursement from the Internal Medicine Program.

D. Practice opportunities

Most residents begin to think about their futures early in their residency. Decisions to do fellowships, to stay in general internal medicine, to pursue academic, private practice, or administrative medicine and to line up adequate pay-off positions (e.g. military, PHS, KMS) should be considered early in training. Faculty in the

Department is more than happy to assist in identifying pros and cons, i.e., to act as sounding boards and meetings with the faculty mentor are strongly advised. For those interested in academic positions, contact should be made early on with the division director in the area of interest.

For residents interested in the private practice of general internal medicine, jobs are readily available. Residents are urged to check in their R-2 /R-3year with the Program Directors. Residents are often asked if their names can be given to individuals or organizations seeking practitioners. Many opportunities come directly to their offices and can quickly be sent to interested residents.