



North
Brooklyn
Health
Network

WOODHULL MEDICAL & MENTAL HEALTH CENTER

GME Policies & Procedures
INSTITUTIONAL GUIDELINES

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Approved by GMEC	1996					
Revised/Reviewed /Approved	April 2001	June 2002	Jan 2003	July 2004		

A
NORTH BROOKLYN HEALTH NETWORK
INSTITUTIONAL STATEMENT
OF
COMMITMENT TO GRADUATE MEDICAL EDUCATION

In keeping with the Health and Hospitals Corporation's (our parent corporation) resolution on Graduate Medical Education approved in February 1988, Woodhull Medical & Mental Health Center/North Brooklyn Health Network (WMMHC/NBHN) is committed to providing an organized program in Graduate Medical Education. The program provides guidance and supervision of the residents, facilitating the resident's professional and personal development while ensuring safe and appropriate care for patients.

WMMHC/NBHN is committed to providing the leadership for this effort through Graduate Medical Education Committee, individual department chairs, program directors and coordinators.

WMMHC/NBHN is committed to providing essential financial and human resources needed to achieve substantial compliance with the Institutional Requirements of the Accreditation Council for Graduate Medical Education (ACGME) and American Dental Association (ADA).

WMMHC/NBHN is committed to providing essential financial and human resources needed to enable the educational programs to achieve substantial compliance with the ACGME and ADA Program Requirements in an ethical and professional environment.

WMMHC/NBHN is committed to assessing the quality of the educational programs on a regular basis.

Approved by GMEC (August 15, 2001)
Re-approved by GMEC (January 2003)
Re-approved by GMEC (July 2004)

B
Woodhull Medical and Mental Health Center
Guidelines for Resident Selection Process

The residents are selected carefully from an initial pool of a vast number of applicants.

I. RESIDENT CORE SELECTION COMMITTEE

A Core Selection Committee (CSC) is appointed in order to oversee the resident selection process.

Responsibilities of the CSC:

- Participation in the initial and final screening of applications for interview
- Participation in the interview process
- Selection and ranking of candidates

II. RESIDENT ELIGIBILITY

Applicants with any one of the following qualifications are eligible for appointment to the program (as outlined in “The Institutional Requirements” published by the ACGME committee).

1. Graduates of medical schools in the United States and Canada accredited by the Liaison Committee on Medical Education (LCME).
2. Graduates of medical schools in the United States and Canada accredited by the American Osteopathic Association (AOA).
3. Graduates of medical schools outside the United States and Canada who meet one of the following qualifications:
 - a) Have received a currently valid certificate from the Educational Commission for Foreign Medical Graduates **(or)**
 - b) Have a full and unrestricted license to practice medicine in a US licensing jurisdiction.
4. United States citizen graduates from medical schools outside the United States and Canada who cannot qualify under 3b above, but who have successfully completed the licensure examination in a US jurisdiction in which the law or regulations

provide that a full and unrestricted license to practice will be granted without further examination after successful completion of a specified period of graduate medical education.

5. Graduates of medical schools outside the US who have completed a Fifth Pathway program provided by an LCME accredited medical school.

III. SELECTION CRITERIA FOR INTERVIEW:

After a careful review of the applications, residency candidates are selected for an interview not on the basis of any one criteria but rather on how well they do in a number of areas which include (but are not necessarily limited to) excellence in the following:

- a. USMLE scores.
- b. Our attempt to maintain diversity in the residency program.
- c. Post-graduate training.
- d. Post graduate training in areas other than they have applied for.
- e. The length of time away from clinical experience.
- f. Communication Skills.
- g. Special background or experiences which may contribute to the strength and diversity of the program

The faculty members participate in both the screening of the applications for interviews and in the interview process itself.

IV. INTERVIEW PROCESS

The interview process spans the period from early December until late January. Each candidate is interviewed by two faculty members who document their assessment of the candidate in our "Interview Evaluation Form."

After the completing the interview process, the candidates are offered a tour of the hospital by our Chief Resident or one of our senior residents. During the tour they get a chance to meet with the head nurse and other residents (which will hopefully give them more of an opportunity to further assess our program and how it will best suit them).

Prior to completing the interview process each candidate receives information on the following:

- Description of the Program, including goals and objectives
- Salary
- Vacation time
- Family Leave

- Sick Leave
- Professional liability insurance
- Health Insurance and other insurance benefits
- Meals, Laundry, Living Quarters

V. NRMP

As a crucial part of the resident selection process, our program participates in the National Resident Matching Program (NRMP). The “core selection committee” plays a role in the selection of both the "In Match" & “out of match” positions. By the first week of February, the NRMP ranking list is prepared and mailed to the NRMP. While candidates selected “out of match,” will most likely have been given their contracts prior to the Match, those who have participated in the match will receive their contracts after the matching results are published.

During the week of June immediately preceding the start of their formal residency training, the newly selected candidates must attend the hospital-wide new employee and departmental orientation programs. They are also expected to complete the hospital required BLS course and Laboratory Information System training course before they start in July.

VI. DURATION OF APPOINTMENT

Duration of appointment is for one academic year. Academic year usually begins in July and ends in June.

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C
Woodhull Medical & Mental Health Center
Guidelines For Evaluation Of Residents, Faculty And The Program

I. RESIDENT EVALUATION

1. The performance of individual resident's during clinical rotations is assessed by the Attending Physician monthly using a form that separately addresses the following areas: general fund of pediatric/ medical knowledge, ability to integrate basic knowledge and clinical findings, up-to-date knowledge and close following of clinical concerns of patients, independent learning, technical skills, ability to work with coworkers, ability to relate to patients and their families, and teaching/supervisory skills.
2. To assess the progress of each resident, a committee of full time faculty staff meets semi-annually to review the individual monthly evaluations and other relevant data, including physician activity profiles generated by hospital wide and departmental QA activities.
3. If the committee described in item 2 [above] uncovers any problems with the progress of any resident, he/she will be counseled by the preceptor and in some cases by another designated staff member based on the recommendations of the committee. If necessary a more detailed plan of intervention will be developed.
4. A summary report of each resident is written and, along with the monthly evaluations is filed in the resident's confidential file.
5. The resident's preceptor meets at least semi-annually with the resident to give feedback on overall performance and to counsel if necessary. Attending physicians are encouraged to give individual feedback of performance to residents at the end of each monthly rotation.
6. Procedural competence is documented in a Procedure Log for individual residents. Certain procedures, such as sedation analgesia, and the performance of off site laboratory procedures, as part of Woodhull policy will have additional forms of documentation and monitoring of competence. High volume procedures such as lumbar punctures, supra-pubic taps, and umbilical catheterizations are permanently monitored in the Department's ongoing CQI process on a provider specific basis.

7. Residents are required to take the annual In-Training Examination of the respective Board. The results are used for evaluating the strengths and weaknesses of residents, as well as for evaluating the entire program.

II. FACULTY EVALUATION

1. Residents complete an evaluation form assessing his/her Attending Physician, at the end of each monthly rotation. Areas focused on include: teaching ability, availability for consultations, fund of knowledge, and ability to relate to patients and their families. These forms are confidential and anonymous. These evaluations are reviewed at least annually by the Chairman of the Department, who uses this information as part of the annual evaluation conducted for each attending. If necessary, appropriate feedback is given to the faculty.

III. PROGRAM EVALUATION

Evaluation of the Training Program is accomplished in several ways utilizing a variety of resources:

- a. Results of the annual In-Training Examination is used to assess the effectiveness of the residency training program in any specific area.
- b. Results of the Board Examinations.
- c. Various confidential evaluation forms (monthly forms used by residents to assess individual attending physicians, the Exit Evaluation Form- completed by resident at time of departure from the Program).
- d. Suggestions and comments made by residents and attendings at the Departmental Medical Education Meeting.
- e. Recommendations made by the hospital-wide Graduate Medical Education Committee (GMEC).
- f. Recommendations made by the GMEC subcommittee which independently assesses every Training Program using the Program Evaluation Tool approved by GMEC. See IV.

IV. INTERNAL PROGRAM REVIEWS

- **Review Committee**
 - Internal Reviews of the ACGME/ADA accredited programs will be carried out by a GMEC Sub-Committee **at approximately the mid-point** between the ACGME/ADA program surveys using a GMEC approved review tool.
- **Review Committee Composition:**

- The sub-committee will be composed of faculty members, administrator and resident representative.
- **What the Committee does?**
 - The sub-committee will assess the residency program’s compliance with its program standards.
 - In addition, the sub-committee will also assess:
 - ✓ The educational objectives of the program.
 - ✓ The adequacy of educational and financial resources to meet these objectives.
 - ✓ The effectiveness of each program in meeting its objectives.
 - ✓ The requirements concerning the General Competencies i.e.:
 - a) *To assess whether each program has defined, in accordance with the relevant Program Requirements, the specific knowledge, skills, and attitudes required and provides educational experiences for the residents to demonstrate competency in the following areas: patient care skills, medical knowledge, interpersonal and communication skills, professionalism, practice-based learning, and systems-based practice.*
 - b) *To provide evidence of the program's use of evaluation tools to ensure that the residents demonstrate competence in each of the six areas.*
 - c) *To appraise the development and use of dependable outcome measures by the program for each of the general competencies.*
 - d) *To appraise the effectiveness of each program in implementing a process that links educational outcomes with program improvement.*
 - ✓ The effectiveness in addressing the citations from previous ACGME/ADA site visits and Internal Reviews.
- **Material & Data**
 - Sub-committee will use the following materials and data in the program review process.
 - ✓ Letters of Accreditation from previous ACGME/ADA reviews.
 - ✓ Reports from previous internal reviews.
 - ✓ Interviews with program director, faculty & peer-selected residents.
- **Review Report**
 - The sub-committee will present its Report of the Internal Program Review to the GMEC for review.

V. RESTRICTIVE COVENANTS

- WMMHC/NBHN will not require residents to sign a non-competition guarantee.

VI. NONRENEWAL AND TERMINATION OF RESIDENTS' CONTRACTS

Every attempt is made to identify areas of deficiency as early as possible in the resident's training career so that the individual resident can be informed of the deficiencies or concerns. The assigned faculty preceptor will meet with the resident periodically to work on specific areas of difficulty. If there is no improvement the resident will be informed in writing about the consequences which can include non-renewal or termination of contract, or repeating the year of residency.

If a resident performs at a marginal level consecutively for 2 years, he/she will be asked to repeat the last year of marginal performance. If a resident's performance has been unsatisfactory, his/her contract may not be renewed. He/she will be informed of that in writing by December of that year.

If a resident's contract needs to be terminated prior to the expiration of his/her contract, he/she is entitled to go through the appeals mechanism (grievance) provided by the Committee of Interns and Residents (C.I.R.) Contract.

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D
Guidelines for
General Policies and Procedures for Residency Programs

I. FAMILY LEAVE

All residents are entitled for 12 weeks of leave for family and medical purposes as per the Family Leave Bill. The leave does not have to be taken at one time, but may be taken in increments. The leave time does not carry over from year to year. Covered by the Family Leave Bill, is leave related to:

1. Birth of a child
2. Placement (adoption or foster care) of a child
3. Serious medical condition of a spouse, child or parent
4. Leave for personal serious health condition
5. Death in the family

a. Procedure for requesting leave

The resident must give notice of intent to take leave if foreseeable, 30 days prior to taking leave or as soon as practical. Because of the need for scheduling coverage for an absent resident, the earlier the notice is given, the better. The notice should be addressed to Residency Coordinator of Program in writing.

b Length of leave allowed

Residents are eligible for 12 weeks of leave.

c Category of time used

The time used for family leave, may come from vacation and/or sick time. The resident can carry over unused vacation or sick time to use as a family leave.

d. Pay and benefits during family leave

The resident will be paid fully if vacation and/or sick time is used for family leave.

e. Cumulative night call

The resident will not have more frequent night calls during the time not on leave to make up for the night calls during family leave.

II. BOARD ELIGIBILITY

The Boards stipulate the following: *“The duration of training is 36 months. Absences in excess of three months whether for vacation, sick leave, maternity leave etc, must be made up. If the program director believes that an absence of more than three months is justified, a letter of explanation should be sent for review by the Credentials Committee of the respective Boards.”*

The resident must make up the time absent from the program (excluding vacation time) to fulfill the requirements for Board certification. This should be done either at the end of the PGY-3 year or at the end of the leave year (by adjusting the vacation time for the following year).

III. RESIDENTS’ ABSENCE - NOTIFICATION

The resident is responsible for making the necessary arrangements for patient coverage (including Continuity Clinic coverage) in his/her absence (interviews, religious observances, etc.). The Department Office must be notified of these changes.

It is imperative that the Department Office and the Chief Resident are informed of any changes that will ultimately affect the schedule.

Procedure to follow when arranging for interview (fellowship position/primary care position) or calling in sick or late.

a. Interview

If any absence is contemplated by the resident for attending an interview permission will have to be requested from the Program Coordinator, in writing either two weeks prior to the interview or as soon as interview has been approved. Sick leave cannot be used for attending an interview.

b. Calling in Sick/Late

- The resident should notify the Chief Resident and the Department Office with an explanation as soon as possible.

- The Department Secretary/Chief Resident should enter the information in the Residents’ Log for absenteeism.

- The Chief Resident and Department secretary should inform each other immediately whenever they are the first to become aware that any resident will be absent that day.

- The resident should also notify the Physician in charge of his/her area of assignment. If unable to contact the physician, the resident should request the Chief Resident to inform that physician.

- The Chief Resident should arrange for appropriate patient coverage.
- Whenever the resident calls in sick on the day of his/her continuity clinic, he/she is responsible for
- The attending on service should keep track of all resident absences and document them in the appropriate space on the resident monthly evaluation form.

IV. EXCHANGE OF SCHEDULE

When a resident exchanges his/her scheduled on call day with another resident, he/she must notify the Chief Resident.

V. BACKUP PATIENT COVERAGE FOR RESIDENTS' SICK CALLS

When a resident calls in sick, his/her night or weekend call will be assigned to a fellow resident. When the resident returns to work, he/she should cover the fellow resident's night/weekend call. If a resident's original illness lasts long enough for him/her to be unable to pay back the night/weekend calls, moonlighting service will be arranged whenever feasible so that the remaining residents will not be overburdened with excessive calls.

VI. UNAUTHORIZED LEAVE OF ABSENCE

Any unauthorized leave of absence must be made up to fulfill the requirement for the Board certification.

VII. EXCESSIVE SICK CALLS

Residents' sick calls will be closely monitored. If found excessive, the resident involved will be subjected to disciplinary action.

VIII. PROFESSIONAL COUNSELING & RESIDENT STRESS

Individual professional counseling will be provided for residents who are stressed, depressed or suspected of abusing alcohol or drug. The program director will ensure strict confidentiality in this matter and work in consultation with the Director of Psychiatry [Dr. L.Urcuyo]. Referral to the Employee Assistance Program (EAP) is also available.

IX. MOONLIGHTING

In compliance with New York State Public Health Law 405 and ACGME Institutional Standards, programs will:

- a. Limit all residents to no more than 12 consecutive hours on duty while rotating through the Emergency Department.
- b. Limit all residents to an average of 80 hours/week over a four week period and no more than 24 (+3) consecutive hours.
- c. Provide at least 10 non-working hours between scheduled on duty assignments.
- d. Provide at least one 24 hour non-working period per week.

Residents are not required to moonlight. The Program Directors/Chairmen will determine the resident eligibility for moonlighting. It is imperative that the residents are in compliance with 405 Law, during their moonlighting activities. Every resident must notify the Director of the Department of all moonlighting activities outside Woodhull Medical and Mental Health Center.

Residents who have worked the maximum number of hours permitted will be prohibited from working additional hours as physicians providing professional patient care services.

Competent PGY-2s and PGY-3s may be allowed to moonlight in the Emergency Service or on the Inpatient Unit including at Woodhull Medical and Mental Health Center; provided they are in compliance with the 405 regulations and ACGME requirements. The Attending physicians, Residency Coordinators and Chief Residents are responsible for monitoring the moonlighting activities. The monitoring activity will be reported to GMEC by the program director or his/her designee.

Residents not in compliance with the moonlighting policy will be counseled as needed.

X. RESIDENTS' DUTY HOURS AND WORKING ENVIRONMENT

Residency training is a full time responsibility. Activities outside the education program must not interfere with the resident's performance on the educational process.

It is important that the residents have a keen sense of personal responsibility for patient care. Their obligation to patients is not automatically discharged at any given hour of the day or any particular day of the week. The residents are not relieved of duty until the proper care and welfare of the patients have been ensured by the presence of a suitable professional replacement.

Work hours for the residents start at 7:30a.m. while in the inpatient service. They go off duty after sign out rounds, held at around 4:30 p.m., and after completion of their assignments. On call duty occurs with a monthly average of every fourth (4th) night.

When averaged over 4 weeks, the residents should spend no more than 80 hours per week in hospital duties, with at least 1 day out of 7 without assigned duties.

Emergency Department shifts should not exceed 12 hours, and other shift should not exceed 24 hours, with consecutive shifts separated by at least 10 hours.

In the event that a resident is unable to fulfill the assignment, a fellow resident will be scheduled to have back up call schedule and to provide patient coverage.

RESIDENCY CLOSURE/REDUCTION

In case of residency closure/reduction:

- WMMHC/NBHN will notify all the residents immediately. WMMHC/NBHN will allow all the residents to complete their education or help enroll in other ACGME/ADA accredited program to continue the education.
- WMMHC/NBHN will notify the ACGME/ADA immediately.

QUALITY ASSURANCE

- WMMHC/NBHN carries out formal Hospital-wide and Departmental Quality Assurance Programs where complications and deaths are reviewed.
- All residents are required to participate in the Departmental QA program.
- Departments are required to request autopsies for adequate educational experience for residents.

XIII RESIDENT RESPONSIBILITIES

• General Conduct

- Residents should strive for excellence in all aspects of patient care delivery, learning, and teaching. This implies professional demeanor and conduct both in direct patient care and in communication with family members and other health care professionals and support staff.

- It is expected that wherever residents are working, courtesy, respect and collaboration will characterize the environment. It is the responsibility of all residents to participate in the creation and maintenance of this environment. No resident should exhibit insubordination toward his or her clinical supervisor. However, if the resident thinks that a directive given by the supervisor is unethical, incorrect, or dangerous, it is his/her responsibility to discuss the issue rationally with the supervisor. If the matter is not resolved at that level it may be taken to the program director and/or the department chair. If the matter continues to be unresolved, the GME Committee will consider it.

- Maintenance of patient confidentiality is an integral part of good clinical care. A discussion of patient-specific information within hearing of other patients or visitors not only violates patient confidentiality but also may lead to serious medical-legal problems.
- When a transfer of care occurs, the resident is expected to ensure that patients under his or her care have ready access to care. Confidential or proprietary information is to be used properly and with appropriate maintenance of confidentiality. Confidential information, including information in the hospitals' computer systems, will only be released to authorized persons.
- No resident should falsify institutional or personnel records; use or be in possession of prescription drugs not prescribed for him/her; or steal, remove, or be in unauthorized possession of hospital, NBHN, or other persons' property. Residents shall not use alcohol or any drugs that might adversely affect safe clinical performance when they may be called upon to provide direct patient care or advise those providing direct care (for example, when on call). Use of such drugs is incompatible with safe clinical performance. Violation of any of the foregoing is grounds for termination.
- Residents shall not provide patient care under circumstances of possible physical, mental or emotional lack of fitness that could interfere with the quality of that care. It is the responsibility of residents, upon identifying a situation in which another physician is impaired to the potential detriment of patient care, to notify the program director or Department Chair in order to arrange for alternative patient care coverage.
- The GME Office will survey residents about their working hours periodically. Residents are expected to complete the surveys accurately;
- International Medical Graduates and Visas: Residents who are not U.S. citizens must have permanent residency status or a visa with work authorization.
- During the time of residency training, residents have many professional responsibilities, including (but not limited to) the clinical care of patients, improving their own educational preparation, and teaching those with whom they work.

Clinical care - Residents are expected to provide competent, compassionate patient care; to work effectively as a member of the health care team. This implies professional demeanor and conduct both in direct patient care and in communication with family members and other health care professionals and support staff. They are responsible to the department chair or designee to whom they have been assigned for all matters pertinent to the professional care of

patients. They are responsible to the medical director of the health care facility of their current assignments, for all matters of administrative policy and procedures. Within the residency program itself the order of rank is Chief Resident and residents in descending order by year of training (e.g. PGY-3, then PGY-2).

Residents participate in the care of all patients (subject to the jurisdiction indicated above) and perform other assigned duties of a professional nature. In addition to regular duties, all residents have miscellaneous duties; for example, they see patients who appear at unusual hours, sign medical papers of various kinds, determine whether visitors should be permitted, interpret uncertain orders left by residents who are not present, and so forth.

Residents will adhere to the schedule announced in the roster of duty compiled by the department chairperson or designee at the beginning of each change of service. Requests for changes to rotation schedules must be made through the Departmental office. In cases where residents are unable to adjust schedules through Department offices (e.g., nights, weekends, holidays), changes must be approved by the resident's immediate supervisor (i.e. chief resident), with notification of the program coordinator at the earliest possible opportunity. The resident is also responsible for notifying all relevant hospital and university offices (page operators and call centers) of changes to the schedule. Residents and clinical fellows will report promptly, completely and accurately their duty and on-call hours when requested to do so by their residency Program Director, or the Graduate Medical Education office. Paperwork and payroll records must reflect actual resident locations.

Upon each arrival for rotation to an affiliate Hospital, the resident must report to the appropriate office to complete paperwork, receive unique hospital I.D. numbers, and be added to the time report where necessary.

During the Graduate Medical Education's June Orientation for new residents, all individuals are provided with copies of all relevant hospital by-laws, rules and regulations, and GME policies approved by the GME Committee. All residents are expected to abide by all such regulations. In addition, the NBHN GME policies are also available through GME office (ext. 8715) and your department and all residents are expected to be familiar with these policies.

Learning and Education - A primary responsibility of resident trainees is to meet the educational goals of their specific programs. Residents are recognized as adult learners, and ultimately the acquisition of knowledge, skills, and professional attitudes is the responsibility of each individual. The Institution and the residency programs will provide an ample selection of educational offerings. The expectation is that residents will make every effort to benefit from the education offered, by attending educational conferences and by participating in

the planning of conferences as required for each program. An essential component of learning is the development of life-long learning skills - all physicians must practice disciplined, ongoing acquisition of medical knowledge.

A. ACGME General Competencies - the ACGME (www.acgme.org) has defined six areas as General Competencies*, and stipulates that programs require their residents to develop them to the level of a new practitioner, by the completion of residency training.

- Patient care
- Medical knowledge
- Practice-based learning and improvement
- Interpersonal and communication skills
- Professionalism
- Systems-based practice.

Following are adapted from the ACGME:

1. Patient Care - Residents must be able to provide patient care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health. Residents are expected to:

- communicate effectively and demonstrate caring and respectful behaviors when interacting with patients and their families
- gather essential and accurate information about their patients
- make informed decisions about diagnostic and therapeutic interventions based on patient information and preferences, up-to-date scientific evidence, and clinical judgment
- develop and carry out patient management plans
- counsel and educate patients and their families
- use information technology to support patient care decisions and patient education
- perform competently all medical and invasive procedures considered essential for the area of practice
- provide health care services aimed at preventing health problems or maintaining health
- work with health care professionals, including those from other disciplines, to provide patient-focused care

2. Medical Knowledge - Residents must demonstrate knowledge about established and evolving biomedical, clinical, and cognitive (e.g., epidemiological and social-behavioral) sciences and the application of this knowledge to patient care. Residents are expected to:

- demonstrate an investigatory and analytic thinking approach to clinical situations
- now and apply appropriate basic and clinically supportive sciences

3. Practice-Based Learning and Improvement - Residents must be able to investigate and evaluate their own patient care, appraise and assimilate scientific evidence, and improve patient care. Residents are expected to:

- analyze practice experience and perform practice-based improvement activities using a systematic methodology
- locate, appraise, and assimilate evidence from scientific studies related to their patients' health problems
- obtain and use information about their own population of patients and the larger population from which their patients are drawn
- apply knowledge of study designs and statistical methods to the appraisal of clinical studies and other information on diagnostic and therapeutic effectiveness
- use information technology to manage information, access on-line medical information; and support their own education
- facilitate the learning of students and other health care professionals

4. Interpersonal and Communication Skills - Residents must be able to demonstrate interpersonal and communication skills that result in effective information exchange and teaming with patients, patients' families, and professional associates. Residents are expected to:

- create and sustain a therapeutic and ethically sound relationship with patients
- use effective listening skills and elicit and provide information using effective nonverbal, explanatory, questioning, and writing skills
- work effectively with others as a member or leader of a health care team or other professional group

5. Professionalism - Residents must demonstrate a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population. Residents are expected to:

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

gender, and disabilities

6. Systems-Based Practice - Residents must demonstrate an awareness of and responsiveness to the larger context and system of health care and the ability to effectively call on system resources to provide care that is of optimal value. Residents are expected to:

- understand how their patient care and other professional practices affect other health care professionals, the health care organization, and the larger society and how these elements of the system affect their own practice
- know how types of medical practice and delivery systems differ from one another, including methods of controlling health care costs and allocating resources
- practice cost-effective health care and resource allocation that does not compromise quality of care
- advocate quality patient care and assist patients in dealing with system complexities
- know how to partner with health care managers and health care providers to assess, coordinate, and improve health care and know how these activities can affect system performance

B. Discipline-specific Education

In NBHN sponsored GME programs, the residency program director is responsible for the organization and implementation of discipline-specific educational objectives. The resident is expected to manifest active involvement in learning, and has responsibility for the following:

- familiarity with program's educational objectives and residency curriculum
- experience with quality-assurance/performance improvement, including the tracking of autopsy results for patients for whom he/she has treated
- development of competence in the areas listed in A. above
- development of a personal program of learning to foster continued professional growth

C. Other Educational Requirements

- Residents are also expected to teach and mentor junior residents and medical students. Collaborative learning is an important part of graduate medical education, and residents' involvement with the education of other members of the health care team is vitally important.
 - All residents must provide data on their educational experience to their Program Director. The provision of regular feedback on faculty, program, and overall educational experiences, via confidential written or electronic evaluations,

is an essential part of the continuous improvement of the educational programs within our institution, and is required by the ACGME.

- Active participation in hospital and departmental committees is an opportunity for residents to become familiar with administrative aspects of health care, and such experience, particularly involving those which relate to patient care review activities should be sought.

XIV. Responsibilities of the Residency Program Director

According to the ACGME Institutional Requirements, "the purpose of graduate medical education (GME) is to provide an organized educational program with guidance and supervision of the resident, facilitating the resident's ethical, professional, and personal development while ensuring safe and appropriate care for patients." In NBHN-sponsored GME programs, the residency program director is responsible for the organization and implementation of these program-specific objectives. Specific responsibilities may be delegated by the program director, but he/she is responsible to the GME Committee and the Designated Institutional Official for the timely and accurate completion of all tasks. In addition to the ACGME, a number of other regulatory bodies impose requirements on our GME programs. These agencies include (but are not limited to) the NYS Department of Health, NY State Board of Medical Examiners and Joint Commission on Accreditation of Healthcare Organizations. Compliance with these requirements is the responsibility of the program directors, working in concert with the institution.

Physicians-in-training include residents and fellows, who, for the purposes of this policy, will be referred to as "residents" (see GME General Policies). GME programs may be characterized as:

- ACGME accredited - for which there are specific ACGME program requirements
- Non-ACGME-accredited - for which there are no specific ACGME program requirements

Responsibilities of the residency program director include all of the following:

1. Participation in the Institutional governance of GME programs (I-A-1)
 - Compliance with NBHN GME Policies
 - Knowledge of and compliance with ACGME Institutional and Program Requirements - www.acgme.org)
 - Participation in GME Committee, subcommittees and task forces, and Internal Review panels as requested including representation at all GMEC meetings
 - Prompt cooperation with requests by the GME Office and/or GME Committee for information, documentation, etc.

2. ACGME accreditation (Residency Review Committee) matters (I-B)
 - Prompt response to RRC requests for information and maintenance of files
 - Preparation of the Program Information Form (PIF) prior to RRC site visits
 - Preparation of documentation of Internal Review materials and reports as required by the GME Committee protocol
 - Development of action plans for correction of areas of noncompliance as identified by the Internal Review, RRC site visit, and/or other mechanisms

3. Educational Aspects of the Program
 - Development and periodic review/revision of an educational curriculum as defined in the ACGME Program Requirements for the specialty (I-B-3-d-3-a) or, if a non-ACGME accredited program, periodic review/revision of the educational curriculum
 - Provision of instruction and experience with quality-assurance/performance improvement, including the tracking of autopsy results for patients cared for by the program's residents (I-E-1)
 - Use of dependable measures to assess residents' competence in the "General Competencies" of patient care, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice (I-B-3-d-3-e)
 - Use of dependable measures to assess residents' competence in other areas as defined in the ACGME Program Requirements for the specialty
 - Implementation of a process that links educational outcomes with program improvement (I-B-3-d-3-f)
 - Insurance that each resident develop a personal program of learning to foster continued professional growth (II-B-2-a)
 - Facilitation of residents' participation in the educational and scholarly activities of the program, and insurance that they assume responsibility for teaching and supervising other residents and students (II-B-2-b)
 - Assistance to residents in obtaining appointment to appropriate institutional and departmental committees and councils whose actions affect their education and/or patient care (II-B-2-c)
 - Procurement of confidential written evaluations of the faculty and of the educational experiences by the residents, at least annually (II-B-2-d)
 - Insurance of residents' attendance at educational offerings required by the institution and the agencies listed in the second paragraph.

4. Administrative and Oversight Aspects of the Program
 - Oversight and liaison with appropriate personnel of other institutions participating in the residency training (I-B-3-b)
 - Creation, implementation, and periodic review of program-specific

policies consistent with NBHN GME policies for the following:

- ✓ Resident selection (I-B-3-e, II-A)
- ✓ Resident evaluation (I-B-3-e)
- ✓ Resident promotion (I-B-3-e)
- ✓ Resident dismissal (I-B-3-e)
- ✓ Resident duty hours and periodic survey of such (II-D-2)
- ✓ Moonlighting policy and written documentation for any resident participating in moonlighting (II-C-11)
- ✓ Insurance that non-eligible residents are not enrolled in the program (II-A-3)
- ✓ Insurance that all applicants are informed in writing of the terms and conditions of employment and benefits including a copy of the resident contract (II-C-2)
- ✓ Insurance that written notice of intent not to renew a resident's contract is provided no later than four (4) months prior to the end of the resident's current contract, unless there are extenuating circumstances (II-C-4)
- ✓ Supervision of residents so as to allow progressively increasing responsibility by the resident, according to their level of education, ability, and experience (II-D-1)
- ✓ Manage clinical scheduling of residents including, but not limited to
 - Creating clinical rotation and on-call schedules
 - Structuring on-call schedules to provide readily available supervision to residents on duty, and that appropriate backup support is available when patient care responsibilities are especially difficult or prolonged (II-D-2-a)
 - Structuring duty hours and on-call time periods so as to focus on the needs of the patient, continuity of care, and the educational needs of the resident, and to comply with limitations as set by the institution and the appropriate RRC (II-D-2-b)
 - Revising schedules at each cycle completion (e.g., monthly) and communicating the revised schedule to the NBHN Reimbursement Specialist and the GME Office to enable accurate IRIS reporting

XV. Security Background Checks for Resident Applicants

Introduction: It is the policy of the NBHN to require a Security Background Check (SBC) on applicants for graduate medical education (GME) positions sponsored by NBHN, in which there is:

- responsibility for the care, safety or security of humans
- direct access to, or responsibility for, pharmaceuticals, select agents, or controlled substances
- access to medical records
- unsupervised access to the Health Science Center

For the purposes of this policy, the term 'resident' is used to include fellows as well. Specific required checks include:

- criminal history record information check
- sanction check
- selective service check
- driver's license check.

The criminal history record information check, sanction and selective service checks must be accomplished before a resident is enrolled in a training program.

XVI. RESIDENT FATIGUE

The institution and the GMEC are sensitive to the fact that overly tired residents can pose a danger to patients even if they don't exceed the work hour limitations.

“**Fitness for duty**” is a more useful measure than “duty hours” for fatigue.

A. Factors that can lead to fatigue on duty

➤ **Acute sleep loss**

Include non-work related issues such as trouble at home, too much partying on days off or being sick. Pay attention when the residents say they had a day off but did not get much sleep for whatever reason.

➤ **Cumulative sleep loss**

Spotting of cumulative sleep loss is more difficult. It can creep on the resident so that he/she gets used to being tired as just the normal state of being.

➤ **Length of continuous wakefulness**

It is important to pay attention to how long has the resident actually been awake before the shift started.

➤ **Time of day and circadian pattern**

The primary sleepiness window is 3 am to 6 am but the performance can be degraded

from midnight to 8 am. Fatigue can strike in those time periods without many other risk factors being present.

B. Signs of “dangerous” fatigue levels

➤ **Inconsistent performance**

Any deviation from the residents’ usual performance level is considered a warning sign of fatigue

e.g.: Inattentiveness in a normally attentive resident, difficulty with a task that he/she has done several times before.

➤ **Overt sleepiness and fatigue behaviors**

e.g.: Yawning, nodding off during quiet moments, staring, repeated blinking of eyes

➤ **Other people’s observations and concerns**

Do not trust the residents to self report or admit fatigue. People tend to be very poor judges of their own level of fatigue.

➤ **Admission of fatigue**

Since residents are usually reluctant to admit being fatigued, anyone who says he/she needs rest time should be taken seriously. They may have reached the point where they are posing a real danger to the patients.

The fatigued residents are apt to make serious errors in judgment or physically injure a patient during a procedure. They may have difficulty in communicating clearly and working as part of a team. They may also pose a driving risk

As a hospital staff, if you get the signal that a particular resident is fatigued, trust your perception and gut instinct and do not take the resident’s word that “everything is alright”.

C. Recommendation

1. Encourage residents and other hospital staff to be on the look out for fatigued residents and to report any concern promptly to the Senior Resident, Chief Resident or Attending physician
2. Institute a culture in which the residents feel comfortable in saying that they are really tired and have to take a brake.

3. Teach residents about optimizing naps and caffeine

Research has shown that a nap for 26 minute improved the performance by 34% and alertness by 54%. Sleeping any longer can put you in a deep sleep that leaves you groggy upon waking.

Caffeine can be a potent antidote to fatigue and help a resident to get through the shift if it is used properly. 100 mg to 200 mg caffeine is required to improve alertness and cognitive performance. A typical cup of coffee has 135 mg of caffeine, a cup of tea has 30- 40 mg and cola drinks contain 35 – 45 mg of caffeine per serving. The caffeine will not usually kick in for 30 minutes and then the effect lasts for three or four hours

If caffeine and nap are to be combined one should ingest the caffeine before taking a short nap, not after.

4. Address the dangers of fatigued driving in a direct way

Educate the residents that there is a dramatically increased risk of accidents when driving home fatigued. The use of antihistamine or any drug with a sedative effect or driving on a long boring stretch of road can increase the risk.

The warning signs of drowsy driving like head nodding, difficulty focusing on the road, not remembering the last section you drove, drifting out of your lane, missing your exit and falling asleep briefly at a stop sign or red light, should be taken seriously.

The residents should drink coffee immediately upon finishing the shift followed by a nap for 20 minutes. The caffeine should be taking effect just as the resident wakes from the short nap, optimizing alertness for the drive home.

XVII. GME Core Curriculum

In addition to the discipline-specific proficiencies that residents must develop, the ACGME has identified a set of generic educational requirements that must be provided in all the residency training programs. Following are the learning goals for each generic requirement:

Ethics

- Residents should develop an understanding of basic ethical principles.
- Residents should understand and protect patients' rights.
- Residents should understand their ethical responsibility to society.

- Residents should understand the principles of ethical research.

XVII. Scholarship and Lifelong Learning

- With the assistance of mentors and colleagues, residents should establish personal standards for their behavior, attitudes, skills, and knowledge.
- Using external and subjective evaluative methods, residents should assess their learning/development needs and establish a plan for self-improvement.
- Residents should develop an ability to assess the medical literature critically.
- Each resident should apply the basic principles of the scientific method in his/her practice setting.
- Residents should participate in scholarly activities.

Physician as Communicator and Teacher

- Residents should demonstrate the effective communication skills essential to the practice of medicine.
- Residents should lead and work with others in creating an educational environment and in caring for patients.
- Residents should become competent in teaching clinical skills and professional attitudes and behaviors.

Personal and Professional Development

- Residents should be altruistic, putting the interests of the patient and the community before their own.
- Residents should be accountable to both patients and the community.
- Residents should deal with patients, families, and colleagues with honesty and integrity.
- Residents should strive to achieve excellence in all aspects of their academic and professional endeavors.
- Residents should show respect for others.
- Residents should develop the skills that will help them balance a demanding career with a fulfilling personal and family life.

Medical Practice Issues

- Residents should understand basic legal terms and concepts related to the practice of medicine, especially their legal obligations regarding patient information and the provision of end-of-life care.
- Residents should be knowledgeable about the basic concepts, principles, and language of health care economics, including the variety of reimbursement systems and the mechanisms for assessing quality of care.

- Residents should understand how governmental regulatory and independent accreditation agencies monitor individual medical practices and health care organizations.
- Residents should understand the "business" aspects of managing a medical practice, including appropriate selection/employment of medical personnel.

XVIII. GENERAL POLICY OF RESIDENT SUPERVISION

Section A. Introduction

Careful supervision and observation are required to determine the trainee’s abilities to perform technical and interpretive procedures and to manage patients. Although they are not licensed independent practitioners, trainees must be given graded levels of responsibility while assuring quality care for patients. Supervision of trainees should be graded to provide gradually increased responsibility and maturation into the role of a judgmentally sound, technically skilled, and independently functioning credentialed provider.

Section B. Definitions

The following definitions are used throughout the document:

Resident – a professional post-graduate trainee in a specific specialty or subspecialty

Licensed Independent Practitioner (LIP) – a licensed physician, dentist, podiatrist, or optometrist who is qualified usually by board certification or eligibility to practice his/her specialty or subspecialty independently

Medical Staff – an LIP who has been credentialed to provide care in his/her specialty or subspecialty by a hospital

Staff Attending – the immediate supervisor of a resident who is credentialed in his/her hospital for specific procedures in their specialty and subspecialty that he/she is supervising

Section C. Purpose

This policy will establish the minimal requirements for resident supervision at NBHN. Individual training programs may have more requirements for their attendings and trainees.

Section D. PROCEDURE

- a. Residents will be supervised by credentialed providers (“staff attendings”) who are licensed independent practitioners on the medical staff at the NBHN. The staff attendings must be credentialed in that hospital for the specialty care and

diagnostic and therapeutic procedures that they are supervising. In this setting, the supervising staff attending is ultimately responsible for the care of the patient.

- b. Each NBHN Program Director will define policies in his/her discipline to specify how trainees in that program progressively become independent in specific patient care activities in the program while still being appropriately supervised by medical staff. A program's resident supervision policies must be in compliance with JCAHO policies on resident supervision. The policies will delineate the role, responsibilities and patient care activities of trainees and will delineate which trainees may write patient care orders, the circumstances under which they may do so, and what entries if any must be countersigned by a supervisor. Each NBHN Program Director will complete a listing of resident clinical activities that are permitted by year of training, the required level of supervision for each activity, and any requirements for performing an activity without direct supervision. *Program Directors of ACGME-credentialed programs will submit their listing of clinical activities by postgraduate year to the Graduate Medical Education Committee (GMEC) for review.* Yearly, each NBHN Program Director will review the job descriptions and listing of resident clinical activities and make changes as needed. *Program Directors of ACGME-credentialed programs will submit the new job descriptions and their updated listing of clinical activities by postgraduate year to the Graduate Medical Education Committee (GMEC) for review.*
- c. The Program Director will ensure that all supervision policies are distributed to and followed by trainees and the medical staff supervising the trainees. Compliance with the NBHN resident supervision policy will be monitored by the Program Directors.
- d. Annually the Program Director will determine if residents can progress to the next higher level of training. The requirements for progression to the next higher level of training will be determined by standards set by each Program Director. This assessment will be documented in the annual evaluation of the trainees.

Section E. Supervision of Trainees in the Inpatient Setting

- A. All lines of authority for inpatient care delivered by inpatient ward or ICU teams will be directed to a credentialed staff provider. The attending staff provider has the primary responsibility for the medical diagnosis and treatment of the patient. Trainees may write daily orders on inpatients for whom they are participating in the care. These orders will be implemented without the co-signature of a staff physician. It is the responsibility of the resident to discuss their orders with the attending staff physician. Attending staff may write orders on all patients under their care. Trainees will follow all local teaching hospital policies for how to write orders and notify nurses and will follow verbal orders policies of each patient care area.
- B. General job descriptions of trainees by year of training are available from the GME Office. The general job descriptions may not apply to all programs, such as

subspecialties which do not have PGY1 or PGY2 levels. Program Directors have the discretion to use or modify these descriptions as appropriate to their specialty or subspecialty.

- C. Staff supervision of care for hospitalized patients must be documented in the inpatient record. Documentation requirements for inpatient care are outlined below.

Documentation that must be performed by staff and by trainees

Documentation, in writing, by staff of concurrence with the admission, history, physical examination, assessment, treatment plan, orders concurrence with major therapeutic decisions, such as “Do Not Resuscitate” status, when any major change occurs in the patient’s status, such as transfer into or out of an intensive care unit must be in accordance with hospital policies.

Documentation, in writing, by trainees must also be in accordance with hospital policies.

Section F. Supervision of Trainees on Inpatient Consult Teams

All inpatient consultations performed by trainees will be documented in writing, with the name of the responsible staff consultant recorded. The responsible staff consultant must be notified verbally by the trainee doing the consult within an appropriate period of time as defined by the particular consulting service. The consulting staff is responsible for all the recommendations made by the consultant team.

Section G. Supervision of Trainees in Outpatient Clinics

All outpatient visits provided by trainees will be conducted under the supervision of a staff provider. This staff provider will interview and examine the patient at the staff’s discretion, at the trainee’s request, or at the patient’s request. The staff doctor has full responsibility for care provided, whether or not he/she chooses to verify personally the interview or examination.

Section H. Supervision of Trainees in the Emergency Department

The responsibility for supervision of trainees providing care in the Emergency Department (ED) to patients who are not admitted to the hospital will be identical to that outlined in the schema for outpatient supervision above. The responsibility for supervision of trainees who are called in consultation on patients in the ED will be identical to that outlined in the schema for consultation supervision above. Consulting staff should be notified appropriately of ED consultations.

Section I. Supervision of Trainees in Interpretive Settings

It is the responsibility of each training program/department in these areas to establish supervisory regulations in compliance with JCAHO & RRC requirements.

Section J. Supervision of Trainees Performing Procedures

A trainee will be considered qualified to perform a procedure if, in the judgment of the supervising staff and his/her specific training program guidelines, the trainee is competent to perform the procedure safely and effectively. Residents at certain year

levels in a given training program may be designated as competent to perform certain procedures without direct supervision, based upon specific written criteria set forth and defined by the Program Director. In this instance, trainees may perform routine procedures that they are deemed competent to perform (such as arterial line placement) for standard indications without prior approval or direct supervision of staff. However, the resident's staff of record will be ultimately responsible for all procedures on inpatients. In addition, residents may perform emergency procedures without prior staff approval or direct supervision when life or limb would be threatened by delay. All outpatient procedures will have the staff of record documented in the procedure note, and that staff will be ultimately responsible for the outpatient procedure. Program Directors will designate the PGY level at which each procedure in their specialty can be performed. Some Program Directors may choose to identify only the requirements for residents to perform certain clinical activities without direct supervision since not all procedures may easily be categorized by PGY level.

Section K. Specialty-Specific Additions or Exceptions to This Policy

As noted in Section E of this document, Program Directors will delineate the job description of each level of training by postgraduate year. This document may be used as the basis for such a document. Annually, each Program Director will review the levels of supervision for the clinical activities of the residents in his/her program. As noted above some Program Directors may choose to identify only the requirements for residents to perform certain clinical activities without direct supervision since not all such activities may easily be categorized by PGY level. Any additions or exceptions to this policy for the specialty should be submitted as part of the job descriptions. *Program Directors of ACGME and non-ACGME (ADA, AOA) credentialed programs will submit the job descriptions and their listing of clinical activities by postgraduate year to the Graduate Medical Education Committee (GMEC) for review.*

Job Descriptions of Trainees by Year of Training

1). Postgraduate year 1 (PGY1) resident

A PGY1 resident will take a complete history and physical examination (H&P) on all new admissions to the teaching service requiring an H&P and will document them on the approved hospital forms in the patient's chart or in a computerized clinical record. After discussion with the attending physician and supervising resident, the PGY1 will write an assessment and initial management plan and institute a therapeutic intervention. The PGY1 resident, under the supervision of the senior resident and attending physician, will participate in daily rounds and write daily progress notes which include an interim history and physical exam, laboratory and radiographic data, and an assessment and plan. If a significant new clinical development arises, there will be timely communication by a member of the resident team with the attending. The house staff and attending must communicate with each other as often as is necessary to ensure the best possible patient care. The PGY1 resident may be responsible for completion of discharge summaries. Transfer notes and acceptance notes between critical care units and floor units, when

required, can be written by the PGY1 resident. Such transfer notes shall summarize the hospital course and list current medication, pertinent laboratory data, active clinical problems, and physical examination findings. The supervising resident and the attending must be involved to ensure that such transfer is appropriate. All PGY1 residents, when leaving an inpatient team, must write an “off-service” note summarizing pertinent clinical data about the patient. The new resident team must notify the attending physician of the change in resident teams and review the management plan with him/her.

2). *Postgraduate year 2 (PGY2) resident*

PGY2 residents, when assigned to the service, will take responsibility for organizing and supervising the teaching service in concurrence with the attending physician and will provide the PGY1 residents and medical students under his/her supervision with a productive educational experience. In this role, they work directly with the PGY1 residents in evaluating all new admissions and reviewing all H&Ps, progress notes, and orders written by the PGY1 resident daily. They will also supervise, in consultation with the attending physician, all procedures performed by the PGY1. PGY2 residents may perform any of the PGY1 tasks outlined above at the discretion of the attending or patient care area policies. PGY2 residents must maintain close contact with the attending physician for each patient and notify the attending as quickly as possible of any significant changes in the patient’s condition or therapy. All decisions related to invasive procedures, contrast radiology, imaging modalities, and significant therapies must be approved by the attending.

3.) *Postgraduate year 3 and above (PGY3) residents*

PGY3 residents will follow all responsibilities of the PGY2 outlined above when acting in a similar supervisory capacity. PGY3 residents may perform any of the PGY1 or PGY2 tasks outlined above at the discretion of the attending or patient care area policies. They will also be available to provide assistance with difficult cases and provide instruction in patient management problems when called upon to do so by other residents. They will assume direct patient care responsibilities when needed to assist more junior residents during times of significant patient volume or severity of illness.

XIX. RESIDENT WORK HOUR EXCEPTIONS Request Protocol:

- The ACGME work hour rules allow exceptions in the weekly limit on duty hours up to 10 percent or up to a maximum of 88 hours.
- Programs must submit the work hour exception request to the GMEC.
- All exceptions requested must be based on a sound educational rationale.
- The GMEC will evaluate, discuss and approve/disapprove the request for work hour exception.
- The GMEC Chairman will present the work hour request to the Medical Board (where the DIO is a member) for final approval.
- In case of disapproval of the work hour request:

- ✓ The program director can resubmit the work hour exception request with revised educational rationale to the GMEC.
- ✓ The program director can also appeal to the DIO and Medical Board.

XX. PRIOR APPROVAL for Submissions To ACGME/ADA

All requests/submissions by programs to ACGME/ADA, as listed below, must be presented for prior approval by the GMEC, DIO and the Medical Board:

- a. all applications for ACGME/ADA accreditation of new programs and subspecialties;
- b. changes in resident complement;
- c. major changes in program structure or length of training
- d. additions and deletions of participating institutions used in a program;
- e. appointments of new program directors;
- f. progress reports requested by any Review Committee;
- g. responses to all proposed adverse actions;
- h. requests for increases or any change in resident duty hours
- i. requests for "inactive status" or to reactivate a program;
- j. voluntary withdrawals of ACGME/ADA-accredited programs;
- k. requests for an appeal of an adverse action; and,
- l. appeal presentations to a Board of Appeal or the ACGME/ADA.

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