

2014-15 GENERAL INTERNAL MEDICINE HANDBOOK

INTRODUCTION

It is our purpose, as well as our obligation, to provide you with an education that will lead to the greatest development of your skills in preparation for a lifetime of personal and professional success, and to certification by the American Board of Internal Medicine. To do so requires that all of us, you as trainee, the faculty, and the administrative personnel of the Department are all proactive and prepared to participate in the patient care and educational environment. Within this residency, a team approach to patient care and education will help everyone achieve their goals. Please solicit the help of the large number of people and resources who are available to you. The line of responsibility and authority extends from the Junior House officer to the Senior House officer through the Chief Resident to the respective Chief of Service of each hospital and eventually to the Chairman. These same individuals should be used to assist you in the solution of problems in any area. They need your help to identify the problems and solutions.

We are obligated to follow the rules set forth by the Department of Graduate Medical Education, the American Board of Internal Medicine, and the Accreditation Council for Graduate Medical Education. We adhere to those guidelines as strictly as possible in order to assure the integrity and continuity of the program in the institutions as the process of serial review is carried out by these agencies.

The fact that we are engaged in training does not relieve us of the responsibility to be a physician in the true sense. We must be cognizant that a patient's welfare should be our first priority. In addition, a significant portion of our daily obligation is to educate ourselves, our colleagues, and other learners. In the educational-academic structure of a college of medicine the primary individual to whom we owe that obligation is the medical student. It is conceded by all knowledgeable in medical education that the medical House Officer is probably that most important single teacher for the medical student. The most enjoyable and rewarding moments of your training will likely be moments where you will be teaching your colleagues and learners. We need to ensure the succeeding generations of physicians are competent.

The respect and esteem inherent in being a physician is earned through the period of your training and the remainder of your professional lifetime.

John Sinnott, M.D.
Professor and Chair
Department of Internal Medicine

Cuc Mai, M.D.
Associate Professor and Program Director
Department of Internal Medicine

*Please note: Although approximately 40% of the housestaff are female we refer to housestaff in this manual as "he" for ease of reading.

Internal Medicine Administration

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GENERAL POLICY

A. Patient Care

1. The team (Staff Physician, Chief Resident, Resident and student) is responsible for each patient's care. Quality care for the individual patient is the ultimate goal of the team and each of its members.
2. The PGY I Resident has the primary responsibility for patient care. He should evaluate the patient, write the necessary orders, perform the primary patient care procedures and act as the primary care physician. This is a relationship, which is established not only with the patient but also with the patient's family. The PGY I Resident has the primary responsibility for all of the patients on his service.
3. The PGY II and PGY III Resident is an active participant in the patient's ongoing daily care. He is intimately acquainted with all of the details of the patient's problems and maintains continuity in daily rounds and examinations with the PGY I Resident. He serves as the senior advisor to junior members of the Housestaff team providing direction and explanation. In this senior position an admission note is required and at the time of discharge, a summary of the patient's illness must be entered in the record. As the senior member of the team, the PGY II & III Resident is responsible for the education of the medical student and the Junior House Officer. The senior resident should inform the Attending of any significant, unexpected deterioration in a patient's condition resulting in transferring that patient to a critical care unit. All deaths on the Ward team must be discussed in depth with the Attending physician.
4. The Attending Physician is also actively engaged in patient care and rounds on all patients. He is responsible for providing guidance and experience in all facets of the patient's care. Rounds are made Monday through Friday and the Staff Physician will be available on call both at night and on weekends for consultation. Each patient will be staffed within 24 hours or sooner after admission.

The attending physician should be contacted promptly for any sudden changes in the patient's condition, death of a patient or transfer of the patient to the ICU. This also includes immediately notifying the attending or attending on call for any errors in patient care.

5. There are patients who will come under your care who have an illness and a constellation of other medical problems. Decisions may be required concerning the application of unusual intervention (i.e. resuscitation) in such cases. There should be specific efforts to consult the patient's family (particularly the legal next of kin) to determine their attitudes and decisions in such instances. If the course of action agreed upon is not to resuscitate (DNR), a note should be written in the chart in the Progress Notes and the situation and circumstances discussed with the Attending.

At the VA, DNR orders can only be written and signed by the Attending. The order should be explained in the progress notes.

At Tampa General Hospital, the DNR order can be written by the resident but must be co-signed by the attending within 24 hours.

B. Housestaff Relations to the Student (Clinical Clerk)

1. The resident will assist the student in developing his skills and knowledge in the field of Internal Medicine. Please see the goals and objectives for the students for the third year internal medicine clerkship.
2. Among the many components of this responsibility are the following:
 - a. Instructing the student in the development of a logical approach to clinical problems.
 - b. Instructing and assisting the student in development of good patient care and treatment, practices and attitudes. Serve as a role model to the student in the humanistic approach to medical care.
 - c. Teaching the student the requisite patient care procedures.
 - d. Encouraging the student's reading in general medicine texts and providing the student with selected review articles on topics concerning patients.
 - e. Reviewing each of the student's "work-ups" and providing constructive criticism. Every history and physical examination (H&P) must be written and in the chart within 24 hours of admission and countersigned by the Senior Resident within 24 hours.
 - f. Ensuring that students attend all conferences.
 - g. Resident members of the team are to provide ongoing evaluation of the student's progress, pointing out, as objectively as possible, both weaknesses and strengths. Upon the completion of the student's rotation a final written evaluation is required. This must be discussed with the student and completed without delay.
 - h. The students will be assigned a maximum of 6 patients.

C. Nursing Staff

1. The nurses are an integral part of the health care team and it is obvious that personal and professional courtesy should be extended to them at all times. They will make ward rounds with the teams when possible and they should be advised of changes of plans, special requests or anticipated problems.
2. Housestaff are responsible for a significant contribution to the education of the Nursing Staff. Such education is vital in assisting them to take better care of your patients. Explanation and thoughtfulness in matters of patient care and ward practices should be routine.
3. A simple "pick-up-after-yourself" practice will allow the nursing staff more time with the patients.

D. Pharmacy Staff

1. The pharmacist is another vital member of the health-care team. He is responsible for all medications dispensed in the hospital; He is also a ready source of information on the various therapeutic agents, their dosages, compatibilities, toxicity, administration forms and combinations.
2. It is his legal and professional responsibility to ensure that the intent of your orders is fulfilled. when he questions an order, he is doing so to ensure that you and the patient receives the agent prescribed.
3. The pharmacy operates under strict guidelines which each House officer should know and understand. When in doubt, ask!

E. Social Service & Dietetics Personnel

1. These individuals must be involved as early as possible in the planned management of the patient.
2. PredischARGE planning is the hallmark of good total care and impossible without their professional skill and assistance.

F. Administrative Professionals

1. The goals of the administrative professionals, admitting personnel, ward clerks, etc. are the same as yours - good patient care.
2. Their problems are different from yours although you have common interests. Your ability to listen and comprehend their problems will result in better patient care and a more harmonious hospital experience.

SPECIFIC POLICIES

A. Appointments

1. All appointments to the Department of Internal Medicine are for one (1) year only. This is in accord with national academic policy.
2. Each applicant shall be considered for each successive year according to individual merits and the positions available within the Department.
3. Appointments for Medicine PGY I training positions are made through the National Resident Matching Program (NRMP).
4. Notification of acceptance or rejection for an additional year of training will be made by the Chairman of the Department. This date will be in accordance with the Uniform Announcement Date agreed upon by all Chairmen of the Departments of Internal Medicine.

B. Dress Code

1. All Housestaff should be neatly dressed and clean at all times. The full length clinical coat with the seal of the University is to be worn in all patient contact areas by all residents. All male residents shall wear collared shirts during duty hours. Bare abdomens and open toe shoes are unprofessional.
2. Departmental identification name tags are to be worn at all times.
3. Scrub suits are **NOT** acceptable during regular duty hours on the Internal Medicine Services or during continuity clinic. They are acceptable when on unit months, on call or immediately post call. They should never be worn outside of the hospital.

C. Evaluations

1. There will be a semi-annual and summative evaluations of each House officer by the Program Director. This will include a review of the resident's portfolio. The portfolio will include evaluations, mini-CEX's, procedural clinical logs, 360 degree prospective inpatient/outpatient assessments, semi-annual self assessments and any letters of support or concern.
2. Each House Officer will evaluate their attending after each monthly inpatient rotation. In addition, the outpatient continuity attending will be evaluated on a semi-annual basis.
3. The overall program will be evaluated by residents, former graduates and clinical faculty annually. This data will be included in the annual program review.
4. Each resident is evaluated by his Attending Physician and the residents and students who constitute the ward team (see enclosed samples).
5. The Senior Resident will be responsible for the evaluation of the Junior Resident upon the completion of the rotation, and similarly the Junior Resident will evaluate the Senior Resident.
6. Each House officer's performance is reviewed quarterly by the Residency Competency Committee of the Department of Internal Medicine.
7. The Chair of the Residency Competency Committee, or his designated alternate, will meet with individual members of the Housestaff to discuss any problem identified by the process of evaluation.
8. Residents will be evaluated routinely by nurses and patients both in the inpatient and outpatient settings.
9. Also included in the individual evaluation folder will be inpatient and outpatient 360 degree prospective evaluation forms randomly selected by supervising faculty. These will also be used in the evaluation process.
10. During the first year of training, all PGY I residents will be observed in the performance of a complete history and physical examination (American Board of Internal Medicine Clinical Competency Examination) by faculty members/senior residents. This must be completed in a satisfactory manner or re-examination will be required. Minimally 8 mini-CEX's should be completed/reviewed in the PGY I year.
11. During each year of training all PGY I-III trainees will take the American Board of Internal Medicine Resident Self-Assessment Examination. The cost for the examination will be defrayed by the Department.
12. Results from In Training Exams (ITE) and SMART will be included for self evaluation.

D. Duty Hours

The continuity of patient care required for good medicine mandates attention to hospital routine which must run smoothly. A regular schedule of hours is necessary to implement this routine. As the most critical member of the care team - the individual with primary responsibility - the example that you set is critical to a well run service.

1. Duty hours for all Housestaff in all hospitals are 7:00 a.m. – 4:00 p.m. (Monday through Friday)

2. Weekend and Holiday duty hours begin at 7:00 a.m.
3. On average, a resident should have no hospital duties 1 day per week.
4. Normal duty hours will include the published on-call schedule hours in accordance with RRC guidelines. This schedule may be amended only through the Chiefs of Service.
5. On average, residents will not work more than 80 hours per week. Examples of the time commitment can be found in the appendix. Specific duty hours are as follows:
 - a. Tampa General Wards and VA Wards, 7:00 a.m. – 4:00 p.m. Monday through Friday when not on third short (TGH) or long call (VA). At the VA and TGH, when on third short (TGH) or long call (VA), the team may leave at 8:00 p.m., and admissions after that will be taken care of by the night overflow resident.
 - b. Residents are expected to leave promptly on weekends and holidays after checkout to the covering residents. This will enable housestaff to have appropriate time off.
 - c. ICU rotations for PGY II/III will be 12 hours in duration Sunday through Friday, Saturdays are off and are cross covered by residents on elective rotations.
 - d. ER rotations at Tampa General Hospital will be roughly three 12-hour shifts per week.
 - e. Residents on Consult Services shall be allowed to leave at 4:00 p.m. so that they can assume night time coverage when appropriate.
6. When on call, the resident will NOT admit any new patients after 24 hours and have a maximum of 4 additional hours for continuity care and didactics.
7. Residents should attend minimally 130 continuity clinics over their three years of training. Continuity Clinics are canceled during unit (CCU/MICU) and during night float rotations. Continuity Clinics will be attended during ER rotations. When residents are on elective rotations there should be an attempt to minimize conflicts with continuity clinics.
8. All residents must document their duty hours on-line every two weeks in New Innovations.
9. Subspecialty residents, including emergency medicine and psychiatry PGY I's, will start on first of the month. All other PGY I's including categorical and medicine/pediatric residents will start on the 3rd of each month.
10. Any resident who fails to show up for cross coverage or sick pull without advanced notice will
 - a. Work on Sunday for the person (upper level) or Friday night for house officer coverage (intern) who was on days who had to stay over AND
 - b. Do a cross cover for the person covering sick pull who had to come in

E. Stress Management

There are many times during postgraduate training when significant stresses may affect the House Officer. The PGY I resident is making the transition from medical student to physician, the PGY II resident is making the transition from being supervised to supervising, while the PGY III resident has concerns of not only academic and intellectual growth but also deciding future plans. Stress may be related to those uncertainties, severely ill patients, increased workload, sleep deprivation, loss of a patient to whom one had been attached, family and/or marital problems and anxiety. The Department is committed to trying to work with the House officer to understand these problems and help in stress management. It is of utmost importance that the resident cares for not only his/her physical health but

also mental health. Problems may be addressed by speaking with faculty advisors, Chiefs of hospital services, the Program Director or the Chair.

Where to Get Help

The Resident Assistance Program (RAP) is an assessment, counseling, and referral service, by mental health and substance abuse treatment professionals who can provide confidential help to USF Medical Residents experiencing personal problems. To receive assistance simply call the RAP hotline @ 813/870-3344, 24 hours a day, seven days a week. This service is provided as a benefit of your education and residency at no cost to you. A link directly to RAP is available on the homepage of the USF GME office.

Sexual Harassment Policy

USF Health Morsani College of medicine is committed to the maintenance of a supportive, productive and safe environment for faculty, House Staff, staff and students. To ensure that such an environment exists, all inappropriate professional behavior is not permissible. In an attempt to clarify and unify policy and procedures related to inappropriate professional behavior, namely sexual harassment, the College of Medicine has adopted policies and procedures.

Sexual harassment is any unwelcome, out of context sexual reference or conduct, be it verbal gestures, or pictorial, which can create a hostile environment. All individuals may experience sexual harassment by members of the opposite or same gender. Sexual harassment whether by peers or across hierarchical lines (academic, administrative or patient care) is unwelcome, illegal, and creates an unhealthy learning or working climate. For further information regarding this Sexual Harassment Policy please refer to the House officer Policies and Procedures manual issued by the office of Clinical Affairs.

Impaired Physicians Act (Florida Statue #458.3315)

It is important in the residency program that both residents and faculty recognize a potential problem of physician impairment. The Florida Medical Practice Act (F.S. 458), Legislature, Department of Professional Regulation, Board of Medicine and medical profession continue to affirm their commitment to public safety by continuing to authorize the Florida Impaired Practitioners Program (FIPP). Identical impaired practitioner provisions also govern the professions of Osteopathic medicine, Pharmacology, Podiatry, and Nursing. The legislation provides, in some cases, therapeutic alternative to disciplinary process. In other cases therapeutic intervention and treatment are concurrent with disciplinary action legislatively sanctioned. Recognition that illness and recovery are mitigating factors in Board disciplinary proceedings gives a licensee an opportunity to re-enter practice after satisfactorily completing treatment and progressing satisfactorily in recovery. This opportunity also provides increased incentive for early interventions and treatment. Information on the Physicians Recovery Network (PRN) and its program can be obtained @ 800-888-8PRN or by writing to P.O. Box 1881, Fernandina Beach, FL 32034.

Mentorship

A mentorship assignment will be arranged between each PGY I resident and an assigned faculty member in their area of interest. The purpose of the program is to assist with career planning and development, as well as subsequent practice selection. In addition, this will allow the sharing of life experiences in regards to the training experience and enculturation into the medical profession. The mentoring process will be confidential and should take place, minimally, at least twice in the PGY I year. Also, a mentorship assignment will be arranged between each PGY I resident and PGY II or III resident to allow for smooth transition from being a medical student to a resident physician.

F. Leave

Consult the GME Housestaff Handbook which accompanied your contract for complete data concerning leave policies. Housestaff appointed to the University Affiliated Hospitals Training Program on a 12 month basis and who are part of the Common Pay Source shall be entitled to paid leave according to the provisions in this section:

1. Vacation Leave

- a. Vacation leave is designed to provide periodic opportunities for relaxation & personal refreshment. It is expected that each House Officer will plan for and take all vacation leave days available each appointment year. Each House Officer shall be credited with 15 weekdays per year of residency. **Advanced Subspecialty Residents** use of vacation leave must be requested and approved in advance by their Program Director. In general, vacation leave is to be taken in increments of a full week with no more than 2 weeks in a single rotation. Vacation leave days may not be carried over from one appointment year to the next, and no payment for unused leave days will be made upon terminating a training program.
- b. **INTERNAL MEDICINE RESIDENTS** vacation time should be planned IN ADVANCE! Vacation cannot be taken on ward, unit, or night months, TGH Team F, TGH Med Consults, the ambulatory month, or the VA women's health month. On subspecialty services the request should be first submitted to the Chief Resident, followed by the Education Coordinator. Requests are considered based upon the adequacy of patient care coverage, and must be made 45 days prior to the first day of a rotation for vacation time. Any time away from regular duties that are not specified as sick leave, family/medical leave, child care leave, or maternity/paternity leave should be specified as vacation time, including time away for interviews.
- c. All administrative responsibilities (dictation summaries, signatures, etc.) must be completed or leave approval will be denied.

2. Sick Leave

- a. Each House Officer shall be credited with 9 workdays (Monday through Friday) of sick leave at the beginning of each appointment year. In addition, at the beginning of each year 1 workday of sick leave per House Officer will be credited to a sick leave pool. Sick Leave Pool credits may be used only after exhaustion of accrued sick leave and all but five days of vacation leave. The Sick Leave Pool may only be accessed through request by the Program Director and approval of the Associate Dean for Graduate Medical Education. Sick leave day(s) should be reported promptly to Julie DeHainaut at 974-3532.
- b. Sick leave is to be used in increments of not less than a full day of any health impairment, which disables an employee from full and proper performance of duties (including illness caused or contributed to by pregnancy when certified by a licensed physician). Sick leave may be used in half-day increments as needed for personal appointments with a physician, dentist, or other recognized health care practitioner. In case of death in the immediate family, sick leave may be used in reasonable amounts as determined by the program director. Immediate family includes spouse, parents, grandparents, brothers, sisters, children or grandchildren of both House Officer and spouse. A House Officer suffering a personal disability necessitating use of sick leave without prior approval must notify the supervisor as soon as possible.
- c. In accordance with the USF Sick Leave policy, after three (3) full or partial days of absence for medical reasons (consecutive or non- consecutive days) in any 30 calendar day period, a House Officer must provide a medical certification from a health care provider before any additional absence for medical reasons will be approved.

3. Compensated Maternity/Paternity Leave

Compensated maternity/paternity leave may be clarified as follows:

- a. Annual leave for PGY I, II, III, and nine days of sick leave may be used for the purpose of maternity/paternity leave.
- b. A total of 2 weeks of additional compensated time is provided for parental leave.
- c. The Program Director must be notified in advance to request compensated maternity/paternity leave. This absence must be made up in order to fulfill the requirements for completion set forth by the ABIM.

4. Family and Medical Leave

A total of 12 weeks (60 work days, Monday through Friday) of uncompensated Family and Medical Leave may be allowed for House officers. However, ABIM does not allow more than a 1 month break in training without an extension of the residency training. Preapproval by the Program Director and ABIM is necessary.

Family and Medical Leave, including maternity leave, in general employment policies, is uncompensated time; however, when certified by a licensed physician, sick leave credits may be used for any illness caused or contributed to by pregnancy or delivery. Vacation leave credits may also be used in conjunction with childcare leave.

5. Child Care Leave

Uncompensated leave for child care purposes of six months shall be approved upon written request, to begin no more than two weeks before the expected adoption, placement for adoption, or delivery date. When certified by a licensed physician, sick leave credits may be used for any illness caused or contributed to by pregnancy or delivery. Vacation leave credits may also be used in conjunction with child care leave.

6. Uncompensated Leave

- a. Upon written request of a House Officer, the Program Director may grant a leave of absence without pay for a period not to exceed six months, if it is determined that granting such leave would be in the best interest of the University and House officer. Approval of such leave is discretionary.
- b. Any uncompensated leave will require a corresponding extension of the duration of residency. House Officers are not guaranteed that funds will be available for salary or benefits for such extended time periods. This is to be determined by the Program Director.

7. Military Leave

Leave may be granted to active duty training in the United States armed forces, reserves or national guard not to exceed 17 calendar days per year. Physicians on inactive duty training are compensated by the military and not by the University during this period; however, benefits are continued.

Administrative leave, compensated and with full benefits, may be granted for House Staff Officers ordered to active duty or ordered to appear for pre-induction examinations. Such administrative leave may not exceed 30 calendar days per year at the end of which time

employment will cease. Such termination of employment is deemed a COBRA "qualifying event" which permits the employee and dependents to elect continuation of benefit coverage under a group plan at personal expense for up to 18 months. All such military leave must be validated by copies of orders which stipulate the dates of reporting and separation from the military.

8. Jury Duty

If you receive a summons for jury duty, please forward a copy of the summons to the Program Office, 17 Davis, Suite 308. Residents cannot be formally excused from jury duty.

G. Holidays

Housestaff shall be entitled to observe all official holidays observed by the affiliated hospital where clinical duty is assigned. Education Coordinators at each affiliated site will be responsible for changes to clinical duties during holidays and will notify residents accordingly.

H. Communication: Addresses, Paging System and Computers

1. There are many instances in which communication with you is necessary by a variety of mechanisms. To facilitate this, certain rules apply.
 - a. The Department must have your current address, telephone number and emergency contact information. If this information changes, please notify us promptly.
 - b. Your Chief Resident should be informed of any emergency that takes you beyond the usual system of communication.
 - c. The emergency preparedness policy pertaining to the USF Internal Medicine Residency Program is as follows:
2. A paging system is operated in each hospital and you are provided with units. Certain general rules apply:
 - a. Only the individual to whom the unit and number are assigned should carry that unit. You are prohibited from loaning or transferring the system. Medical students carry their own pagers.
 - b. Please respond as promptly as possible to your pager.
 - c. Try to maintain the unit in the best operating order. Particular attention should be paid to the charge state of the battery.
 - d. Be courteous to the telephone operators; they are trying to facilitate communication with you.
 - e. At the end of the residency, please return the pager to the proper office.
3. Pager Assignments
 - a. TAMPA GENERAL HOSPITAL
 - (1) All residents will be assigned a pager at the beginning of their residency. You will be required to sign a liability form if lost or damaged through your negligence.
 - (2) When in on-call quarters please notify the operators of the room and extension number. This is of particular importance in the event of a code call.
 - b. JAMES A. HALEY VETERANS ADMINISTRATION HOSPITAL

There are three code pagers assigned to the CCU Team (one to the PGY I's and the others to the PGY II's or III's). At night the PGY I loans that pager to the night call PGY I covering special medical wards. One of the other pagers is loaned to the on-call CCU resident.

c. LEE MOFFITT CANCER CENTER

See above. Moffitt pagers are issued by the Moffitt GME Office.

4. In all of the hospitals in which you will be trained, computer data retrieval systems are operational. Each of these systems will have intrinsic differences which require specific knowledge if you are to access the available data. Specific courses of instruction are required.

5. USF INTERNAL MEDICINE RESIDENCY EMERGENCY PREPAREDNESS

a. RESIDENCY PROGRAM STAFF

In the event of an emergency, the Program Director will contact the residency program staff, via access to home/cell phone numbers or emergency contacts for each staff member to advise them of the emergency circumstances and whether there is a need to report for administrative duties.

b. RESIDENTS

Should an emergency situation develop residents will be contacted via home phone/cell phone or emergency contacts by the Program Director or administrative staff. This is separate from a process of a code DAVID emergency generated by the hospital in the event of an emergent hurricane readiness preparation, a minimum of two general ward teams as well as the MICU and CCU teams will be available at Tampa General (should the Board decide not to evacuate). Since there will be at least two teams available, a resident will not work greater than a 24 hour shift during an emergency situation. Therefore, plans will be in place for at least the initial 48 hours of coverage or until deemed safe for transportation to and from the hospital. In addition, to phone contact, the overall residency program can maintain an updated status by viewing emergency information on the University of South Florida web site.

Should an emergency situation occur and a hospital facility become temporarily inaccessible or unusable for training purposes, then residents at that hospital will be assigned to one of our other two hospital sites. An additional group may also participate in faculty supervised medical care at emergency shelters coordinated by the Hillsborough County Health Department. For instance, if approximately 25 residents are affected at a given facility then approximately one third of those will be shifted to hospital number 1, another third to hospital number 2 and another third participating in faculty supervised patient care at emergency shelters. Given the experiences from Katrina, the ABIM has approved up to three months of residency training in a setting of emergency shelters that are supervised by clinical faculty. Experiences are predominately direct patient care managing conditions both seen in the outpatient and inpatient arenas.

Should loss of one of the facilities be anticipated for a long term process, then residents might need assistance obtaining completion of their training at other sites. This could be accomplished by coordinating with the ACGME/ABIM and utilization of the APDIM list serve.

I. Moonlighting

1. Moonlighting should not interfere with the goals and objectives and work hour regulations for your residency training. Moonlighting hours have to be documented in New Innovations and total residency and moonlighting hours cannot exceed ACGME work hour limits.

2. House Officers may not accept outside employment or engage in other outside activity that may interfere with the full and faithful performance of clinical responsibilities. Violation of this policy may lead to disciplinary action up to and including termination.
3. You must consult with the Program Director prior to assuming such extramural activity and get written approval. You must not in any instance involve yourself in a position which requires continuity of care or will infringe upon your assigned day or night duty.
4. The Department is aware of the economic status of most trainees in an inflationary economy with large debts incurred for their education. Outside professional activity should, however, be undertaken only to fulfill needs and to a degree commensurate with your inherent educational requirements. A valid Florida license is an absolute requisite for such activity. Your training malpractice coverage does not extend to any professional activity outside the Program. The basic guide should be "common sense," for excesses will reduce your ability to attain competence.

J. Medical Licensure

1. The Professional State Regulatory Agency requires that all House Officers who do not possess an active Florida medical license register immediately with them. Registration of Unlicensed Physicians forms are available in the Education Office of the Department of Internal medicine. Unlicensed residents may not participate in patient care until their registration has been approved by the Board of Medicine.
2. Individuals applying for the USMLE Part III will pay total cost of applying for both license & Part III. GME mandates that all second year residents should pass USMLE Part III by March 1st prior to beginning of their third year. Failure to pass will result in non-renewal of the residency contract.
3. For USMLE tentative test dates and additional information for Step III contact **FSMB** directly at 817/868-4000 or go to their website at www.fsmb.org.
4. You, not the Program, must apply for licensure. Listed below is the address:

Department of Health
Medical Quality Assurance
Florida Board of Medicine
4052 Bald Cypress Way BIN #C03
Tallahassee, Florida 32399-0770
Telephone: 850/488-0595

5. The College of Medicine regularly provides courses in both HIV education and Domestic Violence which are available to all residents. To obtain your license, you must have the required three hours of HIV education and 1 hour domestic violence. You are excused as a trainee from all other postgraduate education requirements. You are also excused from payment to the Neurologically Impaired Children's Fund by letter requested of the Chair.

K. Initiation of Contract Dispute Procedure

The Professional Dispute Resolution Procedures addendum to the contract with the College adequately describes the "due process procedure" for Housestaff. There are, however, a number of specific events that will initiate procedures by the Residency Competence Committee.

1. Failure to maintain academic standards and educational requirements of the Department.
2. Repeated violation of Departmental rules after counseling by faculty, the Residency Competency Committee members and the Chair.
3. Failure to be present during duty hours or when on-call.
4. Patient neglect resulting in injury or harm to the patient.
5. Falsification of medical records.
6. Failure to respond to an emergency call or code.
7. Performance of invasive procedures without appropriate authorization except in definite life-threatening situations.
8. Intoxication or imbibition of alcohol or drugs while on duty or on-call.
9. Conviction of a misdemeanor or violation of federal, state or local narcotics laws.
10. Falsification of data on application.

Please see the GME grievance policy available at the following web address:

<http://health.usf.edu/housestaff/new/GME%20P&P/Grievance%20Policy%20&Procedure.pdf>

L. Housestaff Evaluation of Attending

In an endeavor to constantly monitor and improve the quality of your education, a routine system of evaluation of your Attending is established. Program improvement can come from your careful assessment of your experience with each assigned teacher.

1. At the end of each monthly rotation, the Resident will receive an evaluation notice from New Innovations by email for online completion.
2. Please complete the evaluation within 30 days of the end of the rotation. This provides important feedback that is reviewed confidentially on an annual basis with each faculty member.
3. Outpatient attendings will be evaluated by their continuity residents on a semi-annual basis.

M. Presentations

One of the most important duties inherent in an educational program is the presentation of case reports and scientific data at Morning Report and at a wide variety of meetings and conferences. During your presence in the training program you should become more familiar and at ease with these "public appearances." Learn to condense the essential information, refine your language and style. You will thus be able to minimize the "waste of time" inherent in a rambling, confusing presentation. Your evaluation as a House Officer will include an assessment of your communication skills as reflected in all of your presentations.

Each PGY III resident will organize and present a noon conference on a subject of their choice which will be scheduled by the program administrators office for the internal medicine residency program at the VA. This conference is mandated scholarly activity.

Patient performance data must be reviewed with the faculty preceptor in the form of a practice based learning improvement project approved by the preceptor.

Resident portfolio should be maintained and reviewed with the program director twice annually. Portfolios should include a curriculum vitae, New Innovation Evaluations, logs including procedure case logs, letters from patients or the residency competency committee, scholarly activities and references, practice based learning improvement projects, self assessment forms, CME documentation and any modules that have been completed. Portfolios are a measure of professional development and can be used for fellowship or private practice

WARD MEDICINE

A. Inpatient Medicine Policies

1. A minimum of 1/3 of time in the three year training program will be spent in inpatient internal medicine teaching service assignments.
 - a. A minimum of 6 months of internal medicine inpatient teaching assignments in the first year
 - b. There must be a minimum of 6 months of internal medicine teaching service assignments over the second and third years of training combined.
 - c. The required 12 months of inpatient internal medicine include a minimum of 3 months of inpatient general internal medicine teaching service assignments over the three years of training.
 - d. Every attempt will be made to have a geographic concentration of inpatients assigned to any given resident. This is desirable because such promotes effective teaching and foster interaction with other health care personnel.

B. Inpatient Medicine Critical Care Policy

1. Residents must be assigned to critical care rotations, MICU/CCU, no fewer than three months in three years of training.
2. Total required critical experience must not exceed six months in three years of training.
3. All critical care training must occur in critical units that are directed by ABMS certified critical care specialists.
4. All coronary intensive care unit training must occur in critical care units that are directed by ABIM certified cardiologists.
5. Timely and appropriate consultations must be available from other internal medicine specialties and specialists for other disciplines.

POLICY LIMITING THE NUMBER OF ADMISSIONS PER ADMITTING DAY TO RESIDENTS ON INPATIENT SERVICES

Inpatient Services Tampa General Hospital

The following is the policy limiting the number of admissions per admitting day per the following services:

General Medical Wards, MICU, CCU, Private Teaching Service and Chronic Care Service

PGY I: The residents will not be assigned more than five new patients per admitting day; an additional two patients may be assigned if they are in-house transfers from the medical services

PGY II/III: The supervising resident must not be responsible for the supervision or admission of more than ten new patients and four transfer patients per admitting day.

Inpatient Services at the VA Hospital

General Medical Wards, MICU, CCU, Hospitalist Service

PGY I: The residents will not be assigned more than five new patients per admitting day; an additional two patients may be assigned if they are in-house transfers from the medical services

PGY II/III: The supervising resident must not be responsible for the supervision or admission of more than ten new patients and four transfer patients per admitting day.

Inpatient Services at the Moffitt Cancer Center

Hematology Ward, Oncology Ward, Hospitalist service

PGY I: The residents will not be assigned more than five new patients per admitting day; an additional two patients may be assigned if they are in-house transfers from the medical services

PGY II/III: The supervising resident must not be responsible for the supervision or admission of more than ten new patients and four transfer patients per admitting day.

POLICY LIMITING NUMBER OF PATIENTS UNDER RESIDENT'S CARE

For all training services at Tampa General, James Haley VA, H. Lee Moffitt Cancer Center the following policy is in place limiting the number of patients under the care of each resident.

PGY I

1. The first year resident will not be assigned more than 8 new patients in a 48 hour period.
2. A first year resident will not be responsible for the ongoing care of more than 10 patients.

PGY II/III

1. When supervising one first year resident the supervising resident must not be responsible for the ongoing care of more than 10 patients.
2. When supervising more than one first year resident the supervising resident must not have the responsibility for ongoing care of 20 patients

POLICY ON ORDER WRITING

All Teaching Services

1. Residents are to write all of the orders, diagnostic and therapeutic on patients for whom they have primary responsibility. Orders need not be countersigned by the attending. In an emergency situation a resident may write an order for a patient for whom they are not responsible, however, once the patient is stabilized every effort should be made to contact the primary attending to communicate continuity of care for patient responsibility.
2. When any doubts exist regarding writing an order, consultation with the supervising resident or attending is mandatory, particularly regarding the appropriateness of drugs or doubt about the dose, time interval or route. Any issue should be resolved before the order is signed.
3. Any orders written by a medical student must be countersigned by the responsible resident.
4. All orders must be written clearly, designating the dose, unit of measure, route of administration and timing. No abbreviations should be used when designating the drug or unit of measure or timing. When applicable an interval regimen can be written so that drugs are not continued for any length of time inappropriately.
5. If a nurse or pharmacist questions your order for any drug, accept the question in a constructive manner. Determine the reason for the question and resolve the dilemma for the protection of both the patient and yourself.
6. Prescriptions should be handled with similar rules. In the State of Florida, the drug name should be written out without abbreviations. The quantity should be written and spelled out in parenthesis, for instance #180 should also be written (one hundred eighty). In addition, the route of administration and timing should be written clearly. The physicians name should be written and signed for clarity and any refills noted. Please pay particular attention to individual patient formularies and make sure that the drug will be available to the patient at the time of pharmacy pick-up. Please double check dosages and how the drug is supplied and refer to pharmacy databases when necessary. Prescriptions must be printed on tamper resistant hospital provided paper or on hospital provided prescription pad.
7. Until a license to practice medicine has been granted to you by the Department of Professional Regulation of the State of Florida, the hospital's DEA number covers your orders for controlled substances (narcotics) for prescriptions filled in the hospital pharmacy. Outside pharmacies will require a DEA from the Office of Diversion and Control US Department of Justice Drug Enforcement Administration. Therefore, you can not write a prescription for any controlled drug outside the training program until licensed.** For prescription outside the hospital that require a DEA number, the attending should sign the prescription. You are eligible for medical license after a successful completion of your first year of training. It is highly recommended that you apply immediately upon completion of your PGY I year. The department of medicine will not complete the application for you. We will provide you with the information necessary to successfully apply for your license and subsequently for your DEA number.

NON-TEACHING PATIENT RESIDENT POLICY FOR ALL RESIDENT TRAINING SITES

Resident service responsibilities will be limited to patients for whom the teaching service has diagnostic and therapeutic responsibility. The internal medicine teaching service is defined as those patients for whom internal medicine residents routinely provide care. The only responsibility residents have for non-teaching patients is under emergent conditions when the private physician is unable to be located. Under such conditions the emergent problem can be evaluated and managed by a resident, under appropriate supervision, until such time the private physician can be appropriately notified for subsequent care and orders.

A. Invasive Diagnostic and Therapeutic Procedures

1. The American Board of Internal Medicine and the hospitals in which you will eventually practice after the completion of training require an increasingly detailed list of procedures performed during training. This Program is also required to certify your professional competence in these procedures. Procedures are documented in New Innovations.
2. After initial observation and training, the Housestaff may perform the following procedures without supervision by the Chief Resident, a Senior Resident, Subspecialty Resident or Attending in either the Intensive Care Unit or on the wards, subject to individual hospital policies. PGY I residents must be credentialed via the Program Director to the designated institutional official in the GME office prior to initiation of their PGY II year. PGY I's must obtain at least three supervised procedures to obtain proficiency for internal credentialing. PGY III residents must have a minimum of five procedures to document proficiency at the end of their training. **However, all procedures should be logged in New Innovations as the requirement for credentialing for privileges in these procedures is evolving.** A summary statement for PGY III procedures will be maintained in their file at the completion of their training.

Knowledge, Understanding, and the Ability to Provide Informed Consent is required in the following procedures per the ABIM. Additionally, procedures with an asterisk need to be performed competently by the ABIM.

- a. Abdominal paracentesis
 - b. Advanced cardiac life support *
 - c. Arterial line placement
 - d. Arthrocentesis
 - e. Central venous line placement
 - f. Drawing venous blood *
 - g. Drawing arterial blood *
 - h. Electrocardiogram
 - i. Incision and drainage of an abscess
 - j. Lumbar puncture
 - k. Nasogastric intubation
 - l. Pap smear and endocervical culture *
 - m. Placing peripheral venous line *
 - n. Pulmonary artery catheter
 - o. Thoracentesis
3. All procedures listed below shall be performed only under the direction and supervision of a Staff Physician of the Department of Internal Medicine, Advanced Subspecialty Resident, or

Internal Medicine Resident that has been given supervision role. All procedures should be logged for future credentialing requirements.

- a. Central venous (subclavian or jugular) puncture with or without insertion of a swan-ganz catheter
 - b. Arterial puncture and catheter insertion
 - c. Drainage tubes to the GI tract (excluding Sengstaken-Blakemore tube)
 - d. Drainage tube to the urinary tract
 - e. Bone marrow aspiration and/or biopsy
 - f. Defibrillation
 - g. Cardioversion - emergency, life-threatening situation
 - h. Liver Biopsy
 - i. Renal Biopsy
 - j. Lung Biopsy
 - k. Bone Marrow Biopsy
 - l. Skin biopsy (punch)
 - m. Bronchoscopy
 - n. Esophagoscopy, Gastroscopy, Duodenoscopy
 - o. Hemodialysis
 - p. Pacemaker insertion
 - q. Pericardiocentesis (except during a code)
 - r. Temporary transvenous cardiac pacemaker (except during a code)
4. Prior to all elective procedures appropriate laboratory studies must be obtained.
 5. A consent form and other forms per hospital protocol must be signed by the patient and appropriately witnessed before any invasive procedure list is undertaken. (Subject to hospital policies).
 6. The operative permit must be signed before administration of a sedative, hypnotic, narcotic analgesic, or other agent which might impair the level of consciousness or judgment. The language and description of the procedure to be undertaken must be such that the patient can comprehend.
 - a. The next of kin or legal guardian may sign for the patient if he is physically or mentally unable to sign permission for the procedure.
 - b. If no relatives are available and an emergency exists, the Chief of Service, or the designate of the Chief of Staff, should be notified in order to obtain permission.

B. Patient Charts

1. The patient's chart is the only legal record of your activities in the care of the patient.
2. A complete history and physical examination is to be written or dictated by the PGY I Resident. That document must be countersigned by a PGY II-III Resident indicating its completeness and accuracy. Such a signature indicates legal concurrence and should be completed as early as possible after the admission of the patient.
3. A Senior (PGY II/III) Resident Accept note must be on every admission.
4. There must be a note by the Attending Staff on every chart. Follow-up notes by the Attending are dictated by the complexity of the care and medical events occurring during the period of hospitalization.

5. A date and time should be included on all orders.
6. All signatures must be legible and contain appropriate identification: either M.D. or M.S.
7. The following applies to the discharge summary (subject to hospital policies):
 - a. The discharge summary is to be entered into the medical record or dictated by the Senior Resident prior to the patient's departure and a note of such dictation made in the chart.
 - b. The discharge note should absolutely contain the following information: clinical summary, diagnoses, discharge medications (frequency, strength), important clinical findings or events and patient disposition.
 - c. Failure to complete timely discharge summaries reflects poorly on the professionalism competence and may result in being referred to the Residency Competency Committee.
8. Other resident hospital activities that are monitored are use of appropriate abbreviations in written or electronic orders, documentation of medication reconciliation forms, utilization of university protocol forms (operative permits) for each procedure performed on a patient, appropriate avoidance of violation of HIPAA policies, (particularly in relation to confidential patient information). This information should not be moved or transferred from the patient file for completion at other sites in the hospital. Such information could become lost and patient confidentiality could be violated.

C. Transfer of Patients

1. Residents service responsibilities must be limited to patients for whom the teaching service has diagnostic and therapeutic responsibility.
2. Patients may be transferred to the Internal Medicine Service by an Internal Medicine Resident in consultation with the Chief Resident.
3. A complete transfer note must be written before any patient is sent to another service.
4. There must be a Medicine Staff note on each chart prior to transfer to another service except in the instance of an acute emergency problem. In such situations the Chief Resident may make such a note if Staff are not available.

D. Administrative Duties

Every physician throughout his practice lifetime is required to perform a variety of administrative duties. No patient is completely or adequately cared for if charts and discharge summaries are not expeditiously completed: this includes dictation, correction of errors and signature. The introduction of Diagnostic Related Groups (DRG) into the practice of medicine in all of our affiliated hospitals requires prompt chart completion. The time intervals for such completion are mandated by the reimbursement rules and the various agencies which accredit the program, the hospital and the school.

In the hospitals in which you will train, you will be notified of chart delinquencies. The chart must be completed or disciplinary action may be taken by the Residency Competency Committee.

1. Dictate all summaries before the patient leaves the ward and complete all of the details including the face sheet, leaving only the discharge summary for later signature.

2. Check and play back your dictation to be sure it is recorded. Before you sign the Discharge Summary, correct all spelling errors in dictation; a signature makes them yours.
3. Timely completion of Death Certificate, if at all possible, at the time of the final progress note. If it cannot then be signed, respond to the administrative personnel immediately upon their request for such.
4. Routinely check with the hospital record room or electronic signature system, so that a significant number of delinquencies against your name do not occur.
5. Ensure all orders in the medical record are reviewed and signed.

E. Dietetic Staff

Clinical dietitians are responsible for the nutritional care of all patients. Upon admission, all patients are screened for potential nutritional risk. Dietitians then provide nutrition education, attend ward rounds with the teams and contribute information and expertise regarding diet therapy, nutritional assessment and enteral/parenteral nutrition. You are encouraged to consult with the dietitian for management of patients identified at nutritional risk, having feeding problems or requiring enteral/parenteral nutrition.

You are responsible for writing the diet order but the dietitian may make recommendations or question ambiguous or confusing orders. A complete diet order should be written each time the order is resummarized or changed. Each new diet order negates the previous one. A Diet Manual is available to assist you in ordering diets, tube feedings and supplements.

AMBULATORY MEDICINE

- A. The required experience in ambulatory medicine is met with an assignment of one half day per week at the VA outpatient clinics, USF Medical clinics or Hillsborough County Health Plan Clinics.
- B. One half-day per week rotated through each unit is allotted to this experience with a panel of patients assigned to each trainee.
- C. It is expected that attendance to scheduled Clinic assignments be carried out regularly, **ON TIME** and without any exceptions. In the event of illness, notify your clinic attending.
- D. At least 1/3 of the residency training will be in the ambulatory care setting. This will include, in addition to your continuity clinics, blocked time in ambulatory care, subspecialty clinics and emergency medicine. Computation of this may be found in the appendix.
- E. Residents must attend a minimum of 130 weekly continuity clinic sessions during the 36 months of training. Residents are excused from clinic during unit or night float rotations.
- F. The continuity of patient care experience will not be interrupted by more than one month excluding vacation.

- G. Every attempt will be made to insure that residents will be informed of the status of their continuity patients when they are hospitalized so that residents may make appropriate arrangements to maintain the continuity of patient care.
- H. Performance data in the ambulatory clinic should be reviewed with the faculty receptor twice annually and should result in a practice based learning improvement project.

TEACHING CONFERENCES

- A. The Department teaching curriculum includes both general and subspecialty conferences. A complete schedule for the Program is published a week in advance.
 - 1. Housestaff are required to attend all scheduled teaching conferences, (Morning Report, Board Review, Noon Conferences, Grand Rounds, Journal Club and Morbidity/Mortality Conference) unless their presence is required for a patient's immediate need. A minimum attendance of 75% is required, for the following education sessions, this includes board review, noon conference and grand rounds. Failure to meet the 75% level may result in additional call during subsequent elective months, additional educational assignments, and/or additional disciplinary action by the Residency Competency Committee.
 - 2. The attendance at subspecialty conferences is required when assigned to a subspecialty elective or subspecialty ward. All Housestaff are also encouraged to attend these conferences, when possible, as an integral part of their education.
- B. There will be a weekly conference schedule published for each hospital. These schedules will be distributed to the staff and Housestaff in their individual mailboxes. Grand Rounds is a mandatory conference for all Housestaff with the exception of those involved with critical patient care.
- C. Conferences constitute a major portion of the Department's teaching program. The attendance of the Housestaff and the students for whom they are responsible at these conferences is interpreted as an index of their participation in the educational process of the Department. **Repeated and obvious failure to attend these conferences will be considered as a lack of interest in self-education and will constitute a reason for counseling.** Certification of your participation in these activities is required by the American Board of Internal Medicine.

BOARD REVIEW POLICY - PGY II & III RESIDENTS

A Board Review will occur at all institutions two to three times weekly (Tampa General/James Haley VA/Moffitt). Clinical questions will be reviewed from the current MKSAP during each session. In addition to MKSAP other resources will include, Med Study, Mayo or Cleveland Clinic Review as deemed appropriate. A curriculum time line is followed at each institution in parallel. **Attendance by PGY II & PGY III residents is mandatory. Attendance by PGY I's is optional.** Attendance will be taken at each site for residents on rotation at that site for the given month. Seventy-five percent (75%) of the board review should be attended in a given month. Excuses will only be given for vacation time or patient care emergencies. Attendance will be taken both at the Tampa General and VA sites for residents on rotation at that site for the given month.

There are several concepts that reflect the importance of these board reviews:

1. Passage of the ABIM is of critical importance in obtaining hospital privileges and managed care contracts.
2. The Board Review will be more successful if given by dedicated faculty members on a regular basis with appropriate attendance. The review should not interfere with other education programs such as Morning Report or Noon Conference.
3. The review should be a non-punitive process and such review should be deemed important and valuable by the PGY II/III residents. The actual assignment of extra call will, hopefully, approximate zero.

TRANSITIONS OF CARE POLICY

In the course of patient care, it is often necessary to transfer responsibility for a patient's care from one physician to another. The information communicated during a hand-off must be accurate and sufficiently complete in order to ensure the continuation of safe and effective patient care. Hand-offs must follow a standardized approach (per hospital policy) and include the opportunity to ask and respond to questions. Training in written and verbal handoff procedures is done at orientation. This process is monitored through an evaluation of the interns while on inpatient medicine wards by their upper level. The chief residents and multiple faculty members have the opportunity to observe this transition of care and this is evaluated as a group. In addition, patients admitted to the hospitals should have their H&Ps and discharge summaries sent to the primary care physicians in a timely manner and/or the care plan should be verbally communicated to the primary care physicians. Finally upon transition from one rotation to the next, residents need to communicate care plans to the next group of residents who will be assuming care of the patients.

SUPERVISION POLICY

The program uses the classification if supervision is recommended by the most recent ACGME rules and regulations effective 7/1/11.

Direct Supervision:

The supervising physician (attending/senior resident) physically present with the resident and patient

Indirect Supervision:

1. With direct supervision immediately available, the supervising physician is physically in the hospital or other site of patient care and is immediately available to provide direct supervision.
2. With direct supervision available, the supervising physician is not physically present within the hospital or other site of patient care but is immediately available by means of telephonic and/or electronic modalities as available to provide direct supervision. It has been a hospitalist policy that physicians should be available, if not physically present within 60 minutes to provide patient care if over site is required or needed by the resident. In these situations, the supervising resident particularly PGY 2/PGY 3 may serve as the most immediate form of direct supervision available. They can serve in the supervisory role of junior residents in recognition of their progress towards independence and it meets the needs of the patients and the skill of the individual resident or fellow. Situations that demand direct communication with the attending

physician are discussed at the goals and objectives at the beginning of each rotation. Ultimately, these cover areas such as; unexpected deaths, and changes in conditions requiring transfer to the ICU. Clinical responsibilities are based on the PGY1 level, patient's condition and safety, level of resident education and severity and complexity of the ongoing illness as well as the available support services. All competencies are measured using the competency grid instruments to determine the level of resident education and ability to function in an independent supervisory role.

3. Attendings should be notified for all (1) critical changes in a patient's condition such as code scenario, death, transfer to the intensive care unit (2) any trainee feels that a situation is more complicated than he can manage (3) at the request of any ancillary staff or patient. Any discharge from the hospital or transfer to another unit should also be discussed with the attending.

FATIGUE MITIGATION AND ALERTNESS MANAGEMENT POLICY

Monitoring is part of the daily process of patient care. Attending physicians are trained on understanding the physical and mental evidence of fatigue. Back-up systems exist should individual resident fatigue be documented so that appropriate coverage can be in place as assigned by the Chief Resident. Residents are personally educated on fatigue, recognition and management through overall program orientation, direct interactions with attending physicians orientation at goals and objectives, utilizations of AMA modules which focus on fatigue mitigation and alertness management.

MULTIDISCIPLINARY WORK POLICY

Each of the institutions has a multidisciplinary team approach in most clinical situations at this current time. This includes:

- A. Moffitt Cancer Center, (hematology ward/oncology ward)
- B. VA Hospitalist Services and CCU/MICU
- C. Tampa General Wards and Unit Services including the MICU and CCU

The multidisciplinary team can include; the attending residents, acting interns, MS 3 students, pharmacy, social work, psychology/psychiatry, nutrition and physical therapy. There are also multidisciplinary team meetings that occur separately from patient care, that meet weekly that focus on risk/benefit, cost containment and methods to maximize quality patient care.

PD NOTIFICATION IF GOING OVER WORK HOURS

If a resident, PGY1 (over 16 hours) or PGY2/3 (over 24 + 4 hours), decides to stay over work hours for learning purposes or patient care continuity, they must notify and seek approval from the PD in writing (email Ok) explaining the circumstances. Please note that this should be a rare occurrence.

MEDICAL LEGAL PROFESSIONAL PROCEDURES

- A. It is a serious error to regard yourself as set out from the existing medical legal environment simply because you are in training. As an individual with a doctor of medicine degree (MD), you are as vulnerable as any physician. The academic structure with its obligation to supervise you and oversee your actions is a strong and supportive one which, however, has its limitations. The most important component of that structure is the patient's chart, for which you are responsible. It should reflect your logic and reasons for your diagnostic and therapeutic decisions. It should reveal clearly why you did not choose to pursue discordant data or to take a course of action that may have been advised in consultation. The chart must have Attending notes, for this is the evidence that someone other than you was actually involved in the critical decisions. **The notes should never reflect a personal conflict with others involved in the care, for these statements can be very damaging in the instances of any legal action.**

Quite clearly, many actions arise out of our failure to communicate adequately and appropriately with the patient and the family. The time you take to do this will serve to obviate considerable difficulty. The chart should have notes that clearly reflect the substance of these consultations, risk/benefit explanations and the attitude of the involved persons. If an untoward event occurs there should be a note with the details clearly set forth. Considerable care should be taken to note not only the sequence of the event, but the actual time as well. **Under no circumstances should you alter any prior note or insert data or a note out of their actual sequence.** All unusual events and your concerns should be communicated to your Chief Resident, Chief of Service and your Attending.

- B. USF Morsani College of Medicine residents are immune to personal liability for negligence when acting within the course and scope of their employment with the College. As a member of the University of South Florida Morsani College of Medicine, you are provided with professional liability protection by the Malpractice Self-Insurance Program (SIP) for the benefit of University of South Florida Health, its faculty, students, and other employees. In connection with this protection, residents have certain significant responsibilities, including full compliance with the SIP staff and SIP committee in the investigation, defense, and settlement of claims made against individual residents, USF Health faculty and employees, and the Florida Board of Regents.

It is essential to the proper operation of SIP that residents give immediate notice when they become aware of any incident that may expose themselves and SIP to any loss. The failure to provide prompt notice of incidents is a prime contributor to being named in malpractice suits that should have been resolved well in advance of litigation. Timely notice of incidents enables SIP to gather information while it is still "fresh" and arrive at an early determination of the merits of the claim or possible claim. If a claim is meritorious, attempts can be made to settle and prevent litigation.

Please refer to the Graduate Medical Education Housestaff Handbook for a complete description of SIP and reportable incidents. SIP can be contacted directly at 813-974-8008.

1. **PLEASE NOTE!** Adverse incidents should not be discussed with or among staff, including personnel of the institution or facility at which the incident occurred, (including hospital committees, risk managers, administrators or attorneys) except with the presence of either your USF department Chairperson or his/her designee, a representative from SIP or a University attorney.
2. Upon contact by any hospital personnel, advise the person to contact SIP, who may arrange an appropriate meeting. If the contact is in writing, immediately forward such written communication to SIP.

- C. Upon completion of the PGY I year, immediate application **SHOULD BE MADE** for a license in the State of Florida if you are to continue training here. Application is obtained by writing to the State Board of Medical Licensure. The address is located in a previous section of this manual (Licensure).
- D. Each hospital has its own system of internal numbering for prescriptions (DEA numbers). Prescriptions written with these numbers can be filled only in the pharmacy of that hospital and are not legal documents for prescriptions outside of the hospital. After having achieved a valid Florida license, Housestaff may apply for the Federal DEA number allowing the prescription of controlled substances in any pharmacy.

CODE 15

Every hospital in the State of Florida is required to have a Quality Analysis/Risk Management Program which is registered and reports to the Agency for Health Care Administration (AHCA). This entity within the hospital must annually report all "adverse or untoward incidents."

However, certain incidents must be reported within 15 calendar days after its occurrence - hence the term Code 15. The law defines a reportable incident as follows (Florida Statutes 395.0199 (1993): "An adverse or untoward incident, whether occurring within the licensed facility or arising from health care prior to admission in the licensed facility resulting in

- a) Death of the patient,
- b) Brain or spinal damage to the patient,
- c) The performance of a surgical procedure on the wrong patient; or
- d) A surgical procedure related to the patient's diagnosis.... wrong site or wrong procedure surgeries and procedures to remove foreign objects remaining from surgical procedures."

Such Code 15 reports almost inevitably result in the physicians involved in the incident being quickly contacted by an investigator for AHCA.

If you receive such a notice, report it immediately to the USF Self Insurance Program (Risk Management) office (974-8008) and to your Chairman. Under no circumstances should you talk to the investigator without the lawyer provided for you by the Self-Insurance Programs. The results of such investigations can seriously threaten the status of licensed physicians, as well as that of any presently unlicensed physicians to eventually obtain a medical license in Florida and possibly in other states.

TRAINING RELATED HEALTH INCIDENTS

For training related (employment) health incidents (injury, exposure, etc.) all Housestaff must follow the state and federal regulations for Worker's Compensation. Each institution affiliated with USFCOM has an employee health unit to which Housestaff should report as expeditiously as possible following any injury. All units require that an "incident report" be filed. Many subsequent benefits, including long-term hospitalization, disability compensation and others, depend upon your response and cooperation. Contact employee health units for the major institutional affiliates listed below. Training related incidents that occur at any of the other affiliated institutions may be primarily managed at that institution.

NOTE: All House Officer injuries or exposures requiring the completion of institutional incidence or occurrence reports must be reported to your Department Chairman (974-2271) or to the Office of Health Administration, Linda Lennerth, RNMSN., (974-3163). Refer to orange exposure cards for further details.

**Tampa General Hospital
Employee Health**

Where: Employee Health

Ph: (813) 844-7649

When: 7:00am – 4:30pm, Mon. – Fri.

After Hours: Emergency Rm (813) 844-7100 or page evening/night supervisor

Who: John Sinnott, MD, Medical Director; JoAnn Shea, ARNP, Manager; Linda Carter, ARNP; Patrick Lark, ARNP; Bridget Pugh, ARNP

**H. Lee Moffitt Cancer Center
Employee Health**

Where: Employee Health

Ph: (813) 745-4276, option 1

When: 8:00am – 4:00pm, Mon. – Fri.

After Hours: Administration Coordinator

Who: Anyone in the Employee Health Office

**James A. Haley Veterans Administration Hospital
Occupational and Employee Health**

Where: Occupational & Employee Health, 6N, Rm 650

Ph: (813) 972-7628 or (813) 972-7199

When: 8:00am – 4:00pm, Mon. – Fri.

Other hours: Emerg. Rm. (813) 972-7226

Who: Anyone in the O&E Health Office

USF Medical Clinic

Where: Health Administration/Infectious Disease Ctr

Ph: (813) 974-3163 or (813) 974-4403

When: 8:00am – 5:00pm, Mon. – Fri.

Who: Linda Lennerth, RN, MSN, Director, Medical Health Administration

LIBRARY SERVICES

A. Tampa General Hospital

1. Hours: Monday through Friday 8:00 a.m. - 5:30 p.m.

2. After hours, the library will be opened for physicians and students to obtain information necessary for patient care. Access is gained through the Security Officer. There is a log to sign in and out at the Circulation Window. Books taken from the library must be signed out. The card, with the physician's name clearly printed on it, is to be placed at the Circulation Window.
3. MEDLINE Search capabilities are available through the computer systems in the libraries and call rooms.

B. James A. Haley Veterans' Hospital

1. Hours: Monday through Friday 8:00 a.m. - 4:30 p.m.
2. Key may be obtained from Medical Administrative Assistant 24 hours a day by Housestaff or students with proper identification. Books taken from the library must be signed out. The card is to be placed on the sign-out desk. Instructions are on the counter.
3. MEDLINE Search capabilities are available through the computer systems in the libraries and call rooms.

C. H. Lee Moffitt Cancer Center

1. Hours: Monday through Friday 8:00 a.m. – 4:30 p.m.
2. After hours, the library can be accessed through Security. However, no books may be checked out.
3. MEDLINE Search capabilities are available through the computer systems in the libraries and call rooms.

D. University of South Florida Medical Library

1. Hours: Monday thru Friday 7:30 a.m. – 11:00 p.m.
 Saturday 10:00 a.m. – 11:00 p.m.
 Sunday 12:00 noon – 11:00 p.m.
2. OVID, Pub Med, and Up to Date are available for resident use at no cost. The cost is paid by the Department of Internal Medicine and the GME office.

MEALS

A. Tampa General Hospital

1. The cafeteria is available to the Housestaff for meals.
2. The cafeteria is open during the following intervals:

Breakfast - 6:15 a.m. to 8:15 a.m. and 9:00 a.m. to 10:00 a.m.
 Lunch - 11:00 a.m. to 1:30 p.m.
 Dinner - 4:15 p.m. to 7:00 p.m. , 11:00 pm to 2:30 am

3. The housestaff are given a meal card at the beginning of each year to use for their meals while on call.
4. McDonald's is open daily from 6:00 a.m. to 3:00 a.m. and is on the first floor in the south wing.
5. A refrigerator and microwave are available in the Housestaff Lounge on the fourth floor for storage of food brought from home.

B. James A. Haley Veterans Administration Hospital

1. Meals are provided for the Housestaff on the days which they are on call, Monday through Friday (supper meals); Saturday, Sunday and holidays (breakfast, lunch and supper meals).
2. Each physician must complete a form in the Resident's Lounge before 3:00 pm to be picked up by Dietitians. Food will be delivered to the Resident's Lounge after 6:00 pm.
3. Weekend breakfast will be served between 7:00/8:00 am in the Resident's Lounge.
4. Refrigerator is available in the Housestaff Lounge (7th floor) for storage of food brought from home.

C. H. Lee Moffitt Cancer Center and Research Institute

1. Dinner is provided for the night on-call and breakfast on the following morning.
2. All meals are served in the Cafeteria, which has a copy of the night call schedule. Meal cards will be issued through the Graduate Medical Education at Moffitt.
3. Lunch is provided for residents on-call on weekends and Cancer Center holidays.
4. Cafeteria hours are:

Breakfast - 6:30 a.m. to 10:30 a.m.

Lunch - Grill 11:15 a.m. to 1:30 p.m., hot foods 11:15 a.m. to 1:30 p.m.

Dinner - Grill 2:00 p.m. to 6:30 p.m., Hot foods 4:00 p.m. to 6:45 p.m.

ON-CALL FACILITIES

Adequate On-call facilities have been provided by the major institutions in which housestaff will take night call. These rooms are designed to afford privacy, safety and a restful environment so that the residents can rest and/or sleep when their services are not required. All attempts have been made to optimize the safety of the residents while on call. While there have been no problems in the past, security personnel are available in case any problems arise. The resident should become aware of available exits in case of a fire.

PARKING

A. Tampa General Hospital

Parking transponders are issued by the Tampa General Hospital Housestaff Office for the parking lot. Out of-state license tags will have ten days to purchase Florida tags or be subject to ticketing.

B. James A. Haley Veterans' Hospital

Parking cards are available from the Security office.

C. Lee Moffitt Cancer Center and Research Institute

Housestaff are to purchase a USF student parking pass which will be reimbursed by USF GME. Park in the usual student designated parking areas. You must adhere to USF traffic rules and regulations. Housestaff are not authorized to use the complimentary patient valet.

D. USF College of Medicine and Medical Clinics/Morsani Clinic

Parking for residents and medical students is available on the 4th floor of the Laurel Street Garage. Housestaff are not to park in patient designated areas. Pay for parking areas are also available nearby.

STIPENDS

Effective July 1, 2013:

PGY	I	\$47,410
PGY	II	\$49,187
PGY	III	\$50,978
PGY	IV	\$52,568
PGY	V	\$54,094

Payroll days are every two weeks on Fridays. Paychecks are drawn from a Common Pay Source, regardless of which hospital you are rotating through.

PHOTOCOPIES OF MEDICAL OR PROFESSIONAL LITERATURE

- A. Photocopies of library material only, one copy per article (no page limitations) is available in the Tampa General Hospital Medical Library.
- B. A copier is available in the Tampa VA Hospital on the 7th floor. Hours are from 8:15 a.m. to 4:15 p.m.
- C. The privilege of copying should not be abused, for while you do not pay for it, someone does! Copyright laws are absolutely violated by book copying. Journal articles are somewhat less proscribed but abuse can lead to legal action.

PUBLICATIONS

- A. Each resident is encouraged to prepare clinical case reports, original articles and reviews to be submitted to primary or specialty internal medicine journals or general professional journals.
- B. An indication of intent to prepare such a paper should be made through a full-time faculty member, the Chief of Service or the Chairman of the Department.
- C. Any paper submitted for publication must be reviewed by a full-time faculty member.
- D. The Department will assist the resident in obtaining the requisite illustrations and typing and preparation of the paper in final form.

RESEARCH

- A. Residents may elect to schedule a research month during their training cycle. This month must be approved by the Program Director and the research mentor must be assigned. The mentor must specify what project the resident will be working on in letter form. The mentor must also complete an evaluation at the end of the research month.
- B. All residents and fellows are encouraged to engage in research. If the research is to be conducted according to a specific protocol, that protocol must be cleared by the Chief of the Division and the Chairman of the Department. In addition, this research must be approved by the University of South Florida Human Resources Committee and the respective Chairmen of the Research Committees of each hospital. Informed consent, protocol, data tabulation and statistical methods must be prepared and submitted for approval prior to the performance of any research.
- C. In any Department of Medicine there are a variety of clinical research projects being conducted as part of our professional obligation to augment medical knowledge. Your cooperation and participation in these projects is solicited. You should consult personally with the responsible investigator for the project so that you understand the objectives. You should, in addition, review the segment of the protocol that involves your participation. All of these projects have been approved by the committees and process alluded to in A above.
- D. Procedures and the use of medication for purposes not approved by the FDA, and consequently not of accepted efficacy, constitute experimental use. If there is any question concerning the use of an agent or the performance of a procedure, refer the matter to the respective hospital Chief of Service.

COMMITTEES

- A. The hospitals and College of Medicine have assigned Housestaff to various standing committees of the hospital. This will allow the selected residents the opportunity of actively participating in hospital and College affairs and provide a beneficial educational experience for him/her.
- B. It is assumed and recommended that those selected to serve on these committees be diligent in their attendance and participation. Appropriate feedback and peer communication are anticipated.

- C. Those residents wishing to serve on a particular committee are encouraged to discuss this with the Chief of Service in order for him to make the appropriate nominations to the respective Chief of Staff. Those residents wishing to serve on a particular committee are encouraged to discuss this with the Chief of Service of the hospital and/or the Program Director.

AMERICAN COLLEGE OF PHYSICIANS

Upon entering the program you were given an application for Associate Membership in the American College of Physicians (ACP). Upon payment of the annual membership fee, you will receive the monthly issue of the Annals of Internal Medicine. In addition, you are entitled to join the insurance program of the ACP, attend postgraduate courses and the annual meeting at reduced rates. Reduced rates are also available for the MKSAP board certification/recertification education course. The governance of the Florida Chapter of the American College of Physicians includes Associates selected from each program in the State. It is the purpose of such representation to effect greater participation of all Associate members of the College in the educational activities of the College. Membership as an Associate is required if you are to receive the current MKSAP in the second year of your training.

TAMPA GENERAL HOSPITAL

A. Emergency Room

1. Internal Medicine residents assigned to emergency medicine will have first contact responsibility for a sufficient number of selected patients to meet the educational needs of the resident. Triage by other physicians prior to this contact is unacceptable.
2. Internal Medicine residents will be assigned at least four weeks of direct experience. Such will not exceed three months in three years of training. During these assignments, continuous duty will not exceed twelve hours.
3. Residents will have direct patient responsibility in participation and diagnosis management, admission decisions across a broad spectrum of medical, surgical and psychiatric illnesses so that they learn how to determine which patients require hospitalization.
4. Residents will have 24/7 supervision by qualified ER faculty. Timely on site consultations will be available from other specialties
5. The emergency room attending has the final decision on all admissions. The evaluation of emergency room patients and their admission is an educational opportunity. However, if there is evidence of recurrent disputes with emergency room attendings, then this may result in disciplinary action by the Resident Evaluation Committee.
6. Any problems should be brought to the attention of the Program Director, or to the Chief Resident or the Director of the Professional ER Physicians.

B. General Admissions

1. There are five (5) teams composed of one resident and two interns. The sixth (6th) team composed of 2 residents is available to care for overflow patients to maintain appropriate team census within the ACGME guidelines.

2. Patients admitted through the ER or through the Clinic before long call will go to the appropriate short call team regardless of whether a bed is immediately available or not. The patients can be examined in the Clinic or in the ER. Under no circumstances should an examination conducted in this area constitute a delay in the admission of the patient.
3. Elective or scheduled admissions constitute another source of patients for the short call team. These patients have had their bed availability established.
4. All emergency admissions to the medicine service are conducted through the medicine resident or Emergency Room Attending Physician. They are responsible for care until it is assumed by the Ward Team. Any questions for which team the patient should be admitted to can be clarified by the ER via contact with the Chief Resident at Tampa General.
5. NO private physician's patient is to be admitted to the medicine Service without his and the patient's expressed consent.
6. If you are unable to locate the private physician, any problem of an emergent nature will be evaluated and treated until such time as he is appropriately notified.
7. Residents should have continuing responsibility for most of the patients that they admit. Residents from other specialties must not supervise internal medicine residents on the inpatient rotations.

C. Cardiac Intensive Care Unit (CCU)

1. Candidates for the Cardiac Intensive Care Unit are those with suspected myocardial infarctions, those with life-threatening arrhythmias, new onset heart failure and other cardiac disorders.
2. The admissions to CCU are evaluated for acceptance by the Senior Cardiology resident or Fellow/Attending.

D. Medical Intensive Care Unit (MICU)

1. Admission to this unit is to the MICU team with its own Attendings/Fellow.
2. All patients admitted to this unit will be discussed with the Attending/Fellow. Appropriate documentation of this discussion will be written in the chart. The Attendings are to see their patients and write frequent follow-up notes in accord with the unit procedures.

E. Cardiac Arrest

Patients with cardiopulmonary arrest will receive maximal resuscitation efforts under the direct supervision of the Emergency Room or senior medicine resident for an appropriate duration as dictated by clinical history and examination.

JAMES A. HALEY VETERANS' HOSPITAL

A. Admission Policy

1. There will be three short call teams and one long call team scheduled daily Monday through Friday. Only one team, a long call team, will be assigned to call for weekends and holidays.
2. Admissions are the responsibility of the physicians assigned to the Ambulatory Care Service or to the ER receiving ward. There is no authority given to the ward teams to reject such admissions.
3. The rules for the Coronary Care Unit and Medical Intensive Care Unit described for Tampa General Hospital in the preceding section apply.
4. If there is a problem with exceeding admission limits, the Chief Resident should be notified immediately so he/she can ensure the complete compliance with these criteria and also assure adequate backup for patient care.
5. The long call team will admit patients only until 7:00 p.m. on Monday through Friday after which the night overflow resident will admit patients.

B. Medical Intensive Care Units

1. Direct admissions immediately become the responsibility of the unit team.
2. A transfer to these units from a general or subspecialty ward team will remove that team from the responsibility for the patient's care while in the units. A transfer out of the unit will be to the original team.
3. The discharge assignment of a patient who has been directly admitted to the unit will be made to the appropriate transfer team, Monday through Friday or at the discretion of the Chief Resident on weekends.
4. Any patient listed under step down status, but boarding in the ICU must be converted to ICU status.

H. LEE MOFFITT CANCER CENTER

A. Admission Policy

1. Medicine Housestaff are organized into two teams, a Hematology ward team and an Oncology ward team. Admissions to the ward teams, are at the discretion of the faculty or fellow member for that team. Admissions to the H. Lee Moffitt Hospitalist service, is at the discretion of the Hospitalist attending. Patients primarily assigned to this service are patients whose underlying hematologic/oncologic disorders are stable but have medical complications from their disease.
2. All patients will have a complete initial workup completed prior to presentation at Morning Report (Monday-Friday).
3. Patients admitted for procedures (short stay) will not be the responsibility of the ward teams.
4. In accordance with the expectations of the ACGME, similar to that documented under mission policies, the Moffitt policies are identical to those policies as documented previously in the house staff manual for Tampa General and the James Haley VA Hospital.

B. Patient Responsibilities

1. Patients on the medicine Service are to be seen daily by an Attending Physician.
2. Daily progress notes and appropriate flow sheet entries are to be made by the Housestaff.
3. All Housestaff are to be present for daily rounds (Monday-Friday).
4. All Chemotherapy orders are to be written by the Medical Oncology Attending and/or Fellow.

AUTOPSY REPORTS

Residents are encouraged to attend any autopsies on their patients. Residents involved in an autopsy case should receive a written or electronic report of the patients autopsy, preferably within ninety days of completion of the autopsy report to include both gross and tissue/histological findings. While autopsy reports are available electronically at the VA, Tampa General and Moffitt autopsy reports are collected quarterly by the Chief Resident and then reviewed and signed off by the involved residents. An autopsy log is maintained in the Program Administrators office.

INTERNAL MEDICINE RESIDENCY OVERALL GOALS AND OBJECTIVES

- A. To educate residents that internal medicine is a discipline encompassing the study and practice of health promotion, disease prevention, diagnosis, care and treatment of men and women, from adolescence to old age during health and in all stages of illness. To assist residents in the learning of scientific knowledge and scientific method of problem solving, evidence base decision-making, commitment to life long learning and an attitude of caring that is derived from humanistic and professional values.
- B. To assist residents in the gradual development of a graded responsibility. Obtaining an increasing level of proficiency and competency in the core competencies as defined by the ACGME. Residents should develop an increasing level of independence and confidence in the management of care of their patients in the inpatient and outpatient arenas.
- C. Residents should obtain the following competencies as defined by the ACGME:
 1. Patient care
 2. Medical Knowledge
 3. Practice Based Learning
 4. Interpersonal and Communication Skills
 5. Professionalism
 6. System Based Practice
- D. The internal medicine residency program will:
 1. Provide an atmosphere supporting scholarly and research activity.

2. Educate faculty on appropriate teaching and management work rounds in order to meet resident needs including, work hour limits.
 3. Provide at least 130 outpatient clinic opportunities in their continuity clinics with a wide spectrum of clinical disease pathology. Patients should also represent a wide variety of ages and both genders.
 4. Be responsible for the presentation of didactic conferences including; Morning Report, Noon Conference, Emergency Medical Series, Practice Management Series, Practice Management seminars, Grand Rounds, Journal Club, Morbidity and Mortality Conferences. Such conferences will cover the basic medical management education series as well as the interdisciplinary topics as defined by the ACGME. Such topics will be repeated often enough that the residents have an opportunity to attend or review most of the core conferences. Such topics may also be recorded electronically (webcast) and made available on the internal medicine residency web site.
- E. Residents will be given the opportunity to have exposure to a number of subspecialty experiences in each of the internal medicine specialties, in either inpatient or ambulatory settings.
- F. Residents will be instructed on indications, contraindications, complication, limitation, interpretations of technical proficiency in those procedures specified by the ACGME including; ACLS, thoracentesis, paracentesis, arthrocentesis, central line placement, lumbar puncture, nasogastric intubation and pap smear. Such exposures may include an opportunity to achieve competence in additional procedures such as; cardioversion, intertracheal intubation, skin biopsies, joint injections, temporary pacemaker placement, exercise stress testing and removal of skin lesions.
- G. Formative evaluation including the measure of :
1. Objective assessment of competencies in patient care, medical knowledge, practice based learning, and improvement in interpersonal and communication skills, professionalism and system based practice.
 2. Use of multiple evaluations, faculty, peers, patients, self and other professional staff.
 3. Document progressive resident performance improvement appropriate to educational level.
 4. Provide each resident with documented semi-annual evaluation of their performance with feedback by the Program Director or Associate Program. Such evaluation will be available to the resident in their residency file.
 5. Summative evaluation will be included by the Program Director for all graduating residents documenting the following:
 - a. Documenting the residents performance during the final period of education.
 - b. Will verify that the resident has demonstrated sufficiency competence to enter practice without direct supervision.
 - c. Annual evaluation will include a written notation of clinical competence for each resident and the degree to which the resident has achieves the level of performance expected in each competency as defined by the ACGME.
 6. The program will provide, minimally, annual feedback to the faculty reflecting their teaching ability, commitment to the educational program, clinical knowledge, professionalism and scholarly activities. Such evaluation will include, annual written confidential evaluations by

residents. The program will provide for faculty development including performance improvement opportunities through teaching and learning evaluation seminar given annually by the program. Residents will also be given the opportunity for (minimally) annual confidential evaluation of the Program.

7. The program will provide a mechanism to review resident performance, faculty development, graduate performance through review of ABIM certification results and post-graduate surveys as well as via internal resident surveys. When deficiencies are found the program will provide a written plan of action to document initiatives to improve performance.
8. The program will review document and maintain the work hours within those limits as specified by the ACGME in regards to the 80 hour work week, one (1) day off in seven (7), 24/4 rule, and 8 hours off between working shifts.
9. The program will insure resident supervision at all participating sites.
10. The program will complete all required documentation for the ACGME and ABIM as well as the Graduate Medical Education Office.
11. The program will insure compliance with the grievance and due process procedures as set forth by the institutional requirements.
12. The program will provide verification of residency education for all residents.
13. The program will provide a mechanism for emergency procedures involving residents and program faculty/personnel should an emergency situation develop.
14. The program will monitor resident stress including mental or emotional conditions that may inhibit performance or learning, including drug or alcohol related disfunction. Situations that demand excessive service or consistently produce undesirable stress in residents will be evaluated and modified.
15. The program will develop appointment criteria to select residents for the program.
16. The program will insure that the residency does not place excessive reliance on residents for service as opposed to education.
17. The core program will also monitor the internal medicine subspecialty training programs to insure compliance with the ACGME accreditation standards.
18. The program will assign the Program Director, the Associate Program Directors, key faculty, and education subspecialty educational coordinators based on resident compliment within ACGME guidelines.
19. The program will provide appropriate resources as is defined by the ACGME in regards to inpatient/outpatient facilities, support services, space and equipment, assess the libraries, appropriate call rooms, medical information access, etc.
20. The program will insure that the overall educational goals for the program will be distributed to residents and faculty on an annual basis, either in written or electronic format.

21. The program will insure that competency goals and objectives for each assignment at each educational level be distributed to residents and faculty annually either in written or electronic format. These goals and objectives will be reviewed by the residents at the start of the rotation.

ADDITIONAL GOALS AND OBJECTIVES

GOAL 1

Our curriculum in the three-year residency is constructed to afford the trainees the opportunity to achieve the highest level of professional competency in general internal medicine to which they aspire. Simultaneously, the curriculum provides to those contemplating subspecialization a base of general knowledge and understanding so that they are not isolated intellectually and functionally from the mainstream of internal medicine.

GOAL 2

The fundamental principle controlling the curriculum throughout the three years of training is that of "graded responsibility". The attainment of that objective is determined by careful, ongoing evaluation of each trainee. It is only by such attention to individual progress that it can be determined whether they are ready to assume the next level of responsibility with its inherently greater authority and accountability.

GOAL 3

The curriculum, in addition, emphasizes and attempts to inculcate in the trainee the fundamental qualities of ethical behavior and humanistic attitudes.

GOAL 4

Separate and distinct is the attempt within the three years of training to stimulate and develop through recognition in each trainee of the necessity to actively strive to continue to learn throughout his or her professional lifetime.

DESCRIPTION OF LINES OF RESPONSIBILITY

General Concepts Regarding Graded Responsibility

- A. The Program will advance residents to positions of higher responsibilities on the basis of satisfactory demonstration of achievement of program developed mile stones in the competencies.
- B. The Program will insure, with each year of training, that each resident has increasing responsibility in patient care, leadership, teaching and administration.
- C. Each resident will be assigned at least 24 months of the 36 months of residency education settings for the resident personally provides/supervises junior residents, providing direct patient care. Each of these assignments will include development of diagnostic strategies, planning, record keeping, order, prescription writing, management of discharge summary preparation and decision making, measure it with resident abilities and appropriate supervision by the attending physician.

POSTGRADUATE YEAR I

In the PGY I year the resident will be more closely observed by faculty and senior house officers supervision with the assumption of responsibility is appropriately progressive. Training experience will include rotations in the Critical Care Units, (MICU, CCU), general wards services at Tampa General and the VA, one Moffitt Hematology/Oncology service and two to three elective months, one month in the Emergency Room is also a possibility. The resident will also attend their outpatient continuity clinics, one half day clinic at the VA Continuity Clinics, USF Medical Clinics, or the Hillsborough Health Plan Clinics. A 50% minimum of competency should be achieved in the PGY I year.

GOALS AND OBJECTIVES FOR PGY I'S

1. Performance of a complete history and physical examinations
2. Formulation of appropriate differential diagnosis
3. Writing orders for appropriate diagnostic procedures and laboratory test
4. Writing orders for appropriate therapy
5. Writing progress notes that are concise, timely and descriptive the patients condition
6. Development of interpersonal skills to interrelate with patient and family concerning the present illness, prognosis, proposed interventions and physco-social consequences of their disease
7. Ascertain whether a consultation is indicated and request such expeditiously and maximize communication with consultants
8. Learn how to function as a participating member of the health care team working harmoniously and effectively with peers, nursing, other involved personnel and administrators
9. Learn how to perform under supervision and independently those procedures necessary to the care and management of general internal medicine patients
10. Attendance of didactic conferences including at least 75% of didactic conferences including morning report, noon conferences, journal club, morbidity/mortality conferences and Grand rounds
11. Goals and objectives will be distributed to residents at the beginning of each rotation and the objectives will be evaluated utilizing New Innovations at the end of each month by their senior resident and attending
12. Other evaluations will include CEX's, inpatient/outpatient prospective reviews. It will also include a procedural review in the PGY I year, with video review of common procedures including thoracentesis, paracentesis, lumbar puncture and central line placement
13. Each PGY I resident will also rotate through the Ultrasound Lab as directed by a faculty member board review of Ultrasound guided technics for central line, thoracentesis and paracentesis access

POSTGRADUATE YEAR II

The curriculum in internal medicine is a continuum which requires the resident physician to establish sound learning habits; that each rotation imparts greater skills and maturity, and that their abilities develop to a level commensurate with the level of responsibility they are asked to assume. The objectives of PGY I are not discarded but rather assume greater or lesser significance and consequently greater or less time in their refinement and achievement. In addition, new objectives emerge; many of which are formulated by the role as "team leader".

GOALS AND OBJECTIVES FOR PGY II's

1. Writing notes that are complete yet succinct, focusing on principle problems outlining the most appropriate and cost effective diagnostic and therapeutic approaches
2. Serve as the leader of the team identifiable to all (medical students, PGY I residents, hospital personnel and patients/families) as the individual “in charge” i.e., the organizer. Such should be affected in a model style of decisiveness, concern, consideration and humanism.
3. Assume responsibility as a teacher of medicine, identifying deficiencies appropriate to an individual level of training-student or PGY I resident. Some “spoon feeding” is acceptable but the process should be in great part stimulating to think for themselves.
4. Identify a subject or area of interest which you can “research or develop as an area of scholarly interest”. This can be achieved through participation in presentations at regional meetings of the American College of Physicians, presentations at the Southern General Internal Medicine Meetings, publications of case reports, presentations at morning report, morbidity and mortality or journal club.
5. Identify with the help and assistance of faculty and mentors as early as possible whether your career interest leads you into a primary internal medicine (outpatient versus hospitalist or whether you intend to sub specialize).
6. Gain proficiency in procedural skills with the thorough understanding of their indications, contraindications, complications and limitations.
7. Attendance at required didactic conferences, including those as outlined as a PGY I and Board Review.
8. Goals and Objectives will be distributed to the residents at the beginning of each rotation.
9. Subjects will be evaluated by the attending physicians and PGY I residents via New Innovations which will be discussed with the resident.

POSTGRADUATE YEAR III

As the completion of three years of training is contemplated the process should involve, with faculty advise, and assessment of “what is needed” to implement whatever career choice has been made. The objectives of the two preceding years should have been attained in varying degrees. Since there are more elective rotations, it is an ideal time to fine tune clinical opportunities in learning. PGY II resident should achieve a minimum of 75% of the ACGME competencies.

GOALS AND OBJECTIVES FOR PGY III'S

1. Learn to be and serve as an effective consultant within internal medicine and to other medical and surgical disciplines.
2. Further develop and enhance your teaching skills and attain a higher level of general competence in elective rotations of your choice.
3. Set aside time and attend the preparation sessions dedicated to complementing and completing your knowledge base in readiness for the certification of the American Board of Internal Medicine.
4. Present a scholarly conference on a topic of your choice during the noon teaching series.
5. Complete present and hopefully submit for publication any areas or subjects or interest chosen in the preceding years of training.
6. These objectives will be evaluated by the attending physician and junior residents at the end of each rotational experience with the completion of evaluations on New Innovations. The evaluation will be discussed with the resident. There will also be a summative evaluation

completed on each graduating resident by the Program Director. PGY III residents should achieve 100% of the ACGME competencies.

SPECIFIC ROTATIONS AT EACH FACILITY

TAMPA GENERAL HOSPITAL ROTATION GOALS/OBJECTIVES

- A. Five general ward teams with one resident and two interns per team, one ward team with two senior residents
 - 1. The PGY I residents will be primarily responsible for the admission process for patients admitted to the general ward service with appropriate supervision by the senior PGY II/III resident and attending.
 - 2. Attending rounds will be conducted each weekday and weekends when the team is post call or on overflow.
 - 3. To insure the responsibility and general wards are limited to patient on the teaching service has diagnostic and therapeutic responsibility.
 - 4. Patients cared for on the general service may be on the general medicine ward floor, step down unit or on telemetry.
- B. Cardiac Care Unit
 - 1. Residents will care for patients in the cardiac care unit who have suspected myocardial infarction or those with new onset congestive heart failure or atrial/ventricular arrhythmias or other cardiac disorders.
 - 2. Admissions to the CCU are evaluated for acceptance by the senior cardiology resident, PGY II/III after discussion with the cardiology fellow or attending.
 - 3. The PGY I resident rotating through the cardiac care unit will take primary responsibility for the day to day care of patients in the CCU, via supervision by the senior resident PGY II/III (and cardiology fellow/attending).
 - 4. The CCU attending or appropriate coverage will round with the team or cross coverage on a daily basis in the CCU.
- C. Medical Intensive Care Unit
 - 1. Residents caring for patients in the MICU include those with hypotension, secondary to sepsis or hypovolemia, drug overdoses requiring ICU care, respiratory conditions requiring close observation, or intubation or any severe medical condition requiring close observation in the ICU setting.
 - 2. The PGY I resident will be responsible for the day to day care of the ICU patients with the appropriate supervision by the senior (PGY II/III) resident and pulmonary critical care fellow/attending.

3. The MICU attending or appropriate coverage will round with the primary team six days weekly and the cross covering resident the seventh day.

D. Medicine Consult

1. The consult service provides consultation to other medical and surgical services at Tampa General.
2. Consultation should be performed within 24 hours per hospital and residency guidelines.
3. Attending physicians will staff each patient directly within 24 hours. If the senior or junior resident has questions regarding consultative care, more immediately then they will be discussed with the attending by phone until the patient can be seen directly.
4. Rounds with the consult attending will take place at least six days weekly, the seventh day the senior resident will round on patients with any questions or issues covered through telephonic coverage or with the general medicine rounding a day.
5. Consultation will be provided by both the junior (PGY I resident) and by the senior (PGY II/III resident).
6. A team approach will be taken and completion of consults particularly when number of consults requires assistance, however, there will be a general attempt for the PGY I resident to complete the majority of consults primarily with any assistance provided by the senior resident or attending.

E. Emergency Room Rotation

1. Internal Medicine residents PGY I-III may be assigned to the emergency medicine service at Tampa General during their three years of training.
2. The resident will have first contact responsibility for a sufficient number of unselected patients to meet the educational needs of the resident.
3. The patient will not have prior triage other than by nursing personnel in the triage center.
4. Residents will rotate for at least four weeks for direct experience.
5. Total emergency medicine experience will not exceed three months over the three years of training.
6. They will not have any shift assignments exceeding twelve hours.
7. Each resident will have direct patient responsibility including participation in diagnosis management admission decisions across a broad spectrum of medical surgical and psychiatric illnesses.
8. Residents will learn how to determine which patients require hospitalization.
9. Emergency room faculty will supervise internal medicine residents and are on site 24/7

10. Residents may also seek timely on site consultations from other specialties for their patients in the emergency room and learn how to maximize communication in order to provide outstanding patient care.

F. ER Senior/Night Overflow Resident

1. ER senior is a night time senior resident (PGY II/III) who admits patients from 8 pm to 7 am.
2. The senior resident is responsible for the appropriate admission and care of those patients and in cross coverage as well as effective communication, the continuity of care to accepting teams in the morning.
3. The ER senior will also coordinate admissions to the medical service from the emergency room particularly when there are questions regarding the appropriate team that the patient is being admitted to, i.e., general ward, MICU or CCU.

G. Night Float Resident

1. The night float resident is a senior resident (PGY II/III) who cares for any admissions to the MICU after the primary team has checked out.
2. The senior resident is responsible for their admission and care appropriate communication with the pulmonary critical care fellow and attending when questions and issues arise.
3. The resident is also responsible for effective communication for the continuity of patient care when checking out to the primary team in the morning following their shift.

H. Medical Electives

1. Residents rotating through Tampa General in their elective month are responsible for consultations to their service. A full and thorough consultation will be performed and documented and staffed with the elective attending within 24 hours as established by hospital and residency guidelines.
2. Rounds are typically performed on each week day rounding on the weekends is acceptable as long as work hour limits and day off limits are followed per the ACGME guidelines.
3. When on elective rotations residents are on average scheduled for two cross coverage calls per month by the Chief Resident on the rotational schedule, otherwise no other call is anticipated during the elective month.
4. Residents participating on electives maybe in any of the post graduate years, PGY I-III.
5. Responsibilities will be determined based on levels of achievement with appropriate supervision by fellows and attendings in the elective discipline. Every attempt will be made to allow PGY I residents independent function and the completion of consultations with appropriate assistance of senior residents also present during that elective month.

JAMES A. HALEY VA HOSPITAL ROTATION GOALS/OBJECTIVES

A. Five general ward teams with one resident and two interns per team

1. The PGY I residents will be primarily responsible for the admission process for patients admitted to the general ward service with appropriate supervision by the senior PGY II/III resident and attending.
2. Attending rounds will be conducted each weekday and weekends when the team is post call or on overflow.
3. To insure the responsibility and general wards are limited to patient on the teaching service has diagnostic and therapeutic responsibility.
4. Patients cared for on the general service may be on the general medicine ward floor, step down unit or on telemetry.

B. Cardiac Care Unit

1. Residents will care for patients in the cardiac care unit who have suspected myocardial infarction or those with new onset congestive heart failure or atrial/ventricular arrhythmias or other cardiac disorders.
2. Admissions to the CCU are evaluated for acceptance by the senior cardiology resident, PGY II/III after discussion with the cardiology fellow or attending.
3. The PGY I resident rotating through the cardiac care unit will take primary responsibility for the day to day care of patients in the CCU, via supervision by the senior resident PGY II/III (and cardiology fellow/attending).
4. The CCU attending or appropriate coverage will round with the team or cross coverage on a daily basis in the CCU.

C. Medical Intensive Care Unit

1. Residents caring for patients in the MICU include those with hypotension, secondary to sepsis or hypovolemia, drug overdoses requiring ICU care, respiratory conditions requiring close observation, or intubation or any severe medical condition requiring close observation in the ICU setting.
2. The PGY I resident will be responsible for the day to day care of the ICU patients with the appropriate supervision by the senior (PGY II/III) resident and pulmonary critical care fellow/attending.
3. The MICU attending or appropriate coverage will round with the primary team six days weekly and the cross covering resident the seventh day.

D. Medicine Consult

1. The consult service provides consultation to other medical and surgical services at the VA Hospital.
2. Consultation should be performed within 24 hours per hospital and residency guidelines.
3. Attending physicians will staff each patient directly within 24 hours. If the senior or junior resident has questions regarding consultative care, more immediately then they will be discussed with the attending by phone until the patient can be seen directly.

4. Rounds with the consult attending will take place at least five days weekly, the other days the senior resident will round on patients with any questions or issues covered through telephonic coverage or with the general medicine rounding a day.
5. Consultation will be provided by both the junior (PGY I resident) and by the senior (PGY II/III resident).
6. A team approach will be taken and completion of consults particularly when number of consults requires assistance, however, there will be a general attempt for the PGY I resident to complete the majority of consults primarily with any assistance provided by the senior resident or attending.

E. Hospitalist Service

1. VA hospitalist service will have a single senior resident on an elective service with a core general medicine faculty member at the James A. Haley VA.
2. The resident will be responsible for the care of general medicine patients admitted to the floor based on the admission rotational schedule at the VA.
3. Responsibilities for patient care will be reviewed and assessed by the general medicine attending.
4. Round will take place with the attending on newly admitted patients and existing patients on weekdays and weekends within the limits of ACGME work hours and days off.

F. VA Receiving Ward

1. A senior resident (PGY II/III) will evaluate patients presenting to the VA emergency room supervised by the VA emergency attending.
2. Patients will be evaluated for admission or discharge based on standards of care and criteria for the VA Hospital with supervision by the ER faculty member.
3. Residents will be given coverage to attend didactic sessions including board review, morning report, noon conference, journal club, M&M conferences and Grand Rounds.
4. Through out the rotation the resident should gain an increasing level of independents in the management of patients in the emergency room based on the attendings assessment.

G. Night Float Resident

1. The night float resident is a senior resident (PGY II/III) who cares for any admissions to the MICU after the primary team has checked out.
2. The senior resident is responsible for their admission and care appropriate communication with the pulmonary critical care fellow and attending when questions and issues arise.
3. The resident is also responsible for effective communication for the continuity of patient care when checking out to the primary team in the morning following their shift.

H. ER Senior/Night Overflow Resident

1. ER senior is a night time senior resident (PGY II/III) who admits patients from 7 pm to 7 am.
2. The senior resident is responsible for the appropriate admission and care of those patients and in cross coverage as well as effective communication, the continuity of care to accepting teams in the morning.
3. The ER senior will also coordinate admissions to the medical service from the emergency room particularly when there are questions regarding the appropriate team that the patient is being admitted to, i.e., general ward, MICU or CCU.

I. Medical Electives

1. Residents rotating through James A. Haley VA in their elective month are responsible for consultations to their service. A full and thorough consultation will be performed and documented and staffed with the elective attending within 24 hours as established by hospital and residency guidelines.
2. Rounds are typically performed on each week day rounding on the weekends is acceptable as long as work hour limits and day off limits are followed per the ACGME guidelines.
3. When on elective rotations residents are on average scheduled for two cross coverage calls per month by the Chief Resident on the rotational schedule, otherwise no other call is anticipated during the elective month.
4. Residents participating on electives maybe in any of the post graduate years, PGY I-III.
5. Responsibilities will be determined based on levels of achievement with appropriate supervision by fellows and attendings in the elective discipline. Every attempt will be made to allow PGY I residents independent function and the completion of consultations with appropriate assistance of senior residents also present during that elective month.

MOFFITT ROTATION GOALS/OBJECTIVES

A. Hematology

1. The hematology service is made up of a senior resident (PGY II/III) with two PGY I residents.
2. There is also a hematology fellow and an attending assigned to supervise patient care.
3. Patients admitted to this service will have underlying hematologic disorders requiring inpatient care and ongoing management.
4. The PGY I resident will be primarily responsible for the admission and ongoing care of these patients with appropriate supervision by the PGY II/III resident and hematology fellow/attending.
5. Rounds will take place on each week day and on weekend when new patients are admitted to the primary team or cross covering resident within ACGME work hour limits.
6. Physician assistants or nurse practitioners may also be present and manage patients as directed by the supervising faculty member/fellow. Medicine residents PGY I/III will not be responsible for the teaching or supervision of physician assistants or nurse practitioners present on the service. Their teaching and supervision will be solely directed by the

supervising attending/fellow without interference with the learning or supervision of the internal medicine residents.

B. Oncology

1. The hematology service is made up of a senior resident (PGY II/III) with two PGY I residents.
2. There is also a oncology fellow and an attending assigned to supervise patient care.
3. Patients admitted to this service will have underlying solid tumors with complications from treatment and related otherwise.
4. The PGY I resident will be primarily responsible for the admission and ongoing care of these patients with appropriate supervision by the PGY II/III resident and hematology fellow/attending.
5. Rounds will take place on each week day and on weekend when new patients are admitted to the primary team or cross covering resident within ACGME work hour limits.
6. Physician assistants or nurse practitioners may also be present and manage patients as directed by the supervising faculty member/fellow. Medicine residents PGY I/III will not be responsible for the teaching or supervision of physician assistants or nurse practitioners present on the service. Their teaching and supervision will be solely directed by the supervising attending/fellow without interference with the learning or supervision of the internal medicine residents.

C. Hospitalist Service

1. Two senior residents PGY II/III will rotate through the elective hospital service at the Moffitt Cancer Center.
2. This service is directed by general medicine faculty who serve as hospitalist at the Moffitt Cancer Center.
3. The service will care for patients whose primary complications are medical.
4. Criteria for admission to this service are determined by the faculty member. Medical complications include those that are cancer related such as cancer related thrombosis or infections, etc.
5. The hospitalist resident will be responsible for the admission process and day to day care via the supervision of the hospitalist faculty member.

D. General Electives

1. Elective services at Moffitt include those in infectious disease, pulmonary critical care, cardiology, nephrology, gastroenterology and oncology or hematology ambulatory rotations.
2. Other elective services may have isolated consults at the Moffitt Cancer Center staffed with either a resident or fellow such as allergy/immunology, endocrinology, rheumatology, etc.
3. Residents rotating through Moffitt Cancer Center in their elective month are responsible for consultations to their service. A full and thorough consultation will be performed and

documented and staffed with the elective attending within 24 hours as established by hospital and residency guidelines.

4. Rounds are typically performed on each week day rounding on the weekends is acceptable as long as work hour limits and day off limits are followed per the ACGME guidelines.
5. When on elective rotations residents are on average scheduled for two cross coverage calls per month by the Chief Resident on the rotational schedule, otherwise no other call is anticipated during the elective month.
6. Residents participating on electives maybe in any of the post graduate years, PGY I-III.
7. Responsibilities will be determined based on levels of achievement with appropriate supervision by fellows and attendings in the elective discipline. Every attempt will be made to allow PGY I residents independent function and the completion of consultations with appropriate assistance of senior residents also present during that elective month.

OUTPATIENT CLINIC GOALS/OBJECTIVES

Continuity clinics in which residents participate include those general medicine clinics at the University of South Florida Morsani Center and the James A. Haley VA.

- A. Continuity clinics will take priority throughout the three years of resident training unless residents are excused based on rotational status or post call afternoon clinics.
- B. Rotations that residents are excused from include those in the intensive care units or night float.
- C. Residents will attend clinics during their emergency medicine rotations.
- D. Residents must attend a minimum of 130 weekly continuity clinics over the 36 months of training.
- E. Patient care experiences will not be interrupted by more than one month excluding vacations (What about maternity leave or sick leave)
- F. The number of patients seen by PGY I's versus PGY II/III residents will be those specified in the ACGME rules and regulations.
- G. Every attempt will be made for the residents to follow their own patients over a period of three years.
- H. If a resident's continuity patient is admitted to the hospital by another team then that team will contact the resident to advise them of the patient's admission and status.
- I. There should not be an interruption of residents during their continuity clinic unless an emergency circumstance warrants. Pagers should be turned off or handed off to team members during clinic.
- J. The resident PGY I/III will be primarily responsible for the evaluation, development of a diagnostic and therapeutic plan including preventative health care services for patients they see in their clinic as supervised by their general faculty outpatient supervisor during their training.
- K. The residents will staff their patient with the same faculty member over the three years of their training.

- L. Separate outpatient curriculum for residents PGY I/III are available on CD and on the Web site. There will be monthly quizzes on a specified portion of the curriculum on a monthly basis.
- M. Semi annual evaluations will be completed by their outpatient faculty member as well as completion of one to two outpatient prospective evaluation forms with patient feedback.
- N. Residents will have a variety of new and established patients as well as typical spectrum of disease states, visions of both genders and ages typical for an internist to care for.

COR

The COR rotation is an ambulatory block rotation which residents PGY I-III rotate through general medicine clinics and subspecialty clinics including orthopedics, ENT, podiatry, ophthalmology, urology and dermatology. The general medicine faculty coordinator will review their rotational outpatient schedule including both general and subspecialty clinics. The general medicine faculty coordinator will also be responsible for a summative evaluation process on New Innovations at the completion of each rotation. The residents PGY I-III will have a wide opportunity to see patients with a number of underlying medical conditions in the outpatient setting across a number of disciplines. On each of these encounters they will have the primary responsibility for the initial evaluation and diagnostic plan for each patient as supervised by the faculty member in that setting.

GYN CLINIC

A senior resident PGY II/III may electively rotate through the GYN clinic. The GYN clinic has a mixture of private and indigent patients seen in GYN faculty established clinics at the Hillsborough County Health Plan. The resident will have the opportunity to primarily evaluate patients seen with acute GYN problems as well as new or established preventative healthcare. Some will have the opportunity to gain increasing independence in appropriate pelvic examinations, pap smears and performance of colposcopy if desired under GYN faculty supervision. The GYN faculty member will have the responsibility for completion of a standard evaluation on the New Innovation system.

LINES OF RESPONSIBILITY FOR ATTENDINGS ON TEACHING SERVICES

Attending physicians who admit patients to the hospital as teaching patients and those assigned as ward attendings have duties and responsibilities that must be met. Resident involvement in patient care is for educational purposes and this needs to be the major focus particularly over service issues. There needs to be both teaching and management work rounds. Teaching rounds should be regularly scheduled and must be patient based settings where current case are presented in bases of discussion of such points as interpretation of clinical data, pathophysiology, differential diagnosis, specific management, use of technology and incorporation of evidence based medicine and clinical decision making in disease prevention. This includes both inpatient and consultative teaching. Teaching rounds will include direct resident and attending interaction with a patient. It must include bedside teaching and demonstration of interview and physical examination techniques. Teaching rounds occur on each week day for a minimum of one to two hours. Teaching rounds will not interfere with other resident didactic sessions including, morning report, noon conferences, Grand Rounds and board review. Management rounds involve the bedside review of patients their clinical data and the development of the daily plan, therapeutic and diagnostic. Such rounds are distinguished from teaching rounds on their focus of the care plan, such as order writing, documentation and communication with healthcare personnel or families. There is typically a single physician of record for the majority of patient on the teaching service. There will be combined teaching and management work rounds. Faculty may complete rounds for documentation purposes without residents so as not to interfere with the educational opportunities via didactic sessions. Attendings will be available 24 hours a day for supervision and communication

with residents. Attendings will review the admitting history and physical examination, progress notes and discharge summaries and give feedback to residents on their accuracy and appropriateness. Attendings must review all deaths on the service or review the official results of autopsies and communicate such autopsies to the residents who cared for the patient. The attending physician should be a mentor and role model showing for example, not only by excellence in patient care but also by the values of professionalism, commitment to scholarship and continued learning and an individuals response to the health care needs of society.

GENERAL COMPETENCIES/EVALUATORY PROCESS: INTERNAL MEDICINE RESIDENCY PROGRAM

- A. **Patient Care** – this will be evaluated via the month evaluations following inpatient and outpatient rotations, both required and elective via 360 degree inpatient/outpatient prospective reviews from multiple sources including, patients, nurses and faculty via outpatient clinic evaluations on a semi annual basis, via Program Director semi annual residency portfolio reviews, via self evaluation process performed by each resident semi annually during the portfolio review and mini CEX completion during the PGY I year.
- B. **Medical Knowledge** – this will be evaluated via the month evaluations following inpatient and outpatient rotations, both required and elective via 360 degree inpatient/outpatient prospective reviews from multiple sources including, patients, nurses and faculty via outpatient clinic evaluations on a semi annual basis, via Program Director semi annual residency portfolio reviews, via self evaluation process performed by each resident semi annually during the portfolio review and mini CEX completion during the PGY I year. This will also be evaluated through review of elective consult examinations and yearly In-training examination results as well as ultimately the certification for the ABIM.
- C. **Practice Based Learning** – this will be evaluated via the month evaluations following inpatient and outpatient rotations, both required and elective via 360 degree inpatient/outpatient prospective reviews from multiple sources including, patients, nurses and faculty via outpatient clinic evaluations on a semi annual basis, via Program Director semi annual residency portfolio reviews, via self evaluation process performed by each resident semi annually during the portfolio review and mini CEX completion during the PGY I year.
- D. **Interpersonal and Communication Skills** – this will be evaluated via the month evaluations following inpatient and outpatient rotations, both required and elective via 360 degree inpatient/outpatient prospective reviews from multiple sources including, patients, nurses and faculty via outpatient clinic evaluations on a semi annual basis, via Program Director semi annual residency portfolio reviews, via self evaluation process performed by each resident semi annually during the portfolio review and mini CEX completion during the PGY I year.
- E. **Professionalism** – this will be evaluated via the month evaluations following inpatient and outpatient rotations, both required and elective via 360 degree inpatient/outpatient prospective reviews from multiple sources including, patients, nurses and faculty via outpatient clinic evaluations on a semi annual basis, via Program Director semi annual residency portfolio reviews, via self evaluation process performed by each resident semi annually during the portfolio review and mini CEX completion during the PGY I year. A review of the professionalism modules as previously developed by the American Medical Association distributed to each resident in their PGY I year.

- F. **System Based Practice** – this will be evaluated via the month evaluations following inpatient and outpatient rotations, both required and elective via 360 degree inpatient/outpatient prospective reviews from multiple sources including, patients, nurses and faculty via outpatient clinic evaluations on a semi annual basis, via Program Director semi annual residency portfolio reviews, via self evaluation process performed by each resident semi annually during the portfolio review and mini CEX completion during the PGY I year.

All of these competency measures are reviewed on a quarterly basis by the Residency Evaluation Committee. The Program Director will also review periodically with appropriate minders procedure logs for documentation of resident competency and proficiency.

INTERNAL MEDICINE RESIDENCY PROGRAM CURRICULUM

The general goals and objectives of the Internal Medicine Residency Program's Curriculum have been listed separately. The curriculum is composed of primary care rotations in general internal medicine, intensive care units, subspecialty medicine, the Emergency Department, the Ambulatory Care Department, as well as in subspecialty electives.

The inpatient general internal medicine primary care rotations are conducted at Tampa General Hospital and the James A. Haley Veterans Hospital. The educational purpose of this experience is clearly outlined in the general statement on goals and objectives of the program as it relates to each level of training. Internists are physicians in adult care who have the expertise to take care of patients with single or multisystem diseases in the outpatient as well as inpatient settings. These rotations on general internal medicine inpatient services prepare the graduate to be able to provide outstanding care to the adult patient with complex medical problems. The principal teaching methods of the inpatient rotation include daily morning reports, didactic noon conferences, daily rounds including both management and teaching rounds, graded supervision, and regularly available full time subspecialty faculty who may be consulted as well as 24 hour availability of assigned ward Attendings. The patients are a heterogenous, socioeconomic mixture. By virtue of the fact that most admissions come through the Emergency Department, the types of diseases seen are generally in the same proportion as in "the real world". During these rotations, the teaching attending provides references to the resident for further education as well as encouraging the resident to use Medline searches, review appropriate literature, understand the impact of basic sciences on the clinical disease and read in a general textbook of internal medicine. At the conclusion of each rotation, the resident is evaluated by the attending. The electronic evaluation is discussed with each resident at the end of each rotation.

The inpatient intensive care unit rotations include the Medical Intensive Care Unit and Cardiac Intensive Care Unit at Tampa General Hospital and the James A. Haley Veterans Hospital. The educational purposes of these rotations are to prepare the house officer to evaluate, diagnose, and treat patients with acute cardiac pathology as well as those general medical patients who have illness sufficiently severe to require admission to an intensive care unit. The other objectives that are listed for general inpatient wards clearly also apply to these services. These rotations are of utmost importance since the internist, whose role is to care for adults with complex medical problems, may have a significant number of patients who have acute coronary pathology or single or multi-system disease serious enough to warrant intensive care. While many communities have a large number of subspecialists who could be called upon to provide this care, there are other areas in which the general internist serves as the intensivist. The principal teaching methods on these services include greater responsibility for each level of house officer. There are subspecialty fellows assigned to these rotations as well as subspecialty faculty who serve as Attendings. These faculty make attending rounds no less than five days per week and these rounds include both teaching and management rounds. The patient

characteristics and clinical encounters are similar demographically to those in the general internal medicine services. Once again, the training program's location in a large metropolitan area ensures that the types of diseases seen are consistent with those, which a trainee should encounter in his/her subsequent practice. Procedures performed during these rotations are consistent with care in these units and include invasive monitoring, EKG, spirometry and blood gas interpretation, central lines insertion, intubation, cardioversion, cardiac resuscitation, etc. Residents will be taught the indications, contraindications, complications and limitation of these procedures. Methods of evaluation are similar to those used on the general service.

The inpatient subspecialty wards include the Hematology and Oncology Services at the H. Lee Moffitt Cancer Center and Research Institute. The function, teaching methods, demographics, and methods of evaluation on these rotations are identical to those in general internal medicine. The rationale for these rotations are that the specialized wards in Hematology and Oncology provide experience and insight into the management of patients with hematologic and malignant diseases. Since the general internist will frequently care for patients who have malignant disorders, it is inherently important to present the trainee with adequate experience in these disciplines to meet the increased incidence and prevalence of malignant diseases in the United States. The resident may be supervised in bone marrow aspiration with an understanding of indications, contraindications, complications and limitation of these procedures.

Residents are given an appropriate experience in the Emergency Department as per the guidelines of the ACGME. The educational purpose of this rotation is to provide the resident with an opportunity to evaluate patients with a wide variety of acute medical problems that seek emergency care. The resident must be able to evaluate not only internal medicine diseases but also be able to triage patients to other appropriate disciplines. The value of this rotation is to provide the residents with expertise that would let them participate in the emergency room in their hospitals as well as to be able to identify, evaluate, and manage patients with whom they have first contact who have acute medical problems. There will be a written curriculum developed as an educational tool during this rotation. The Emergency Department is staffed with full time physicians who are thoroughly trained in internal medicine and have been approved by the Program Director in internal medicine. They evaluate the patient who is seen by the resident and provide feedback to the house officer. Residents are evaluated in the usual fashion at the conclusion of their Emergency Department rotation.

The COR rotation consist of an ambulatory block predominately at the University of South Florida Medical Clinics but would also including some clinics at other teaching sites. The purpose of this rotation is to provide the internist with expertise in the caring for outpatients in the non-internal medicine specialties. Residents see patients under the supervision of full time faculty members in the following non-internal medicine specialties:

- a) Dermatology
- b) ENT
- c) Gynecology
- d) Ophthalmology
- e) Non-Operative Orthopedics
- f) Rehabilitation Medicine
- g) Urology

The ambulatory block is a comprehensive approach to the non internal medicine specialties of primary care. Teaching methods are one to one. A resident sees patients under the supervision of a full time faculty member who is physically present in the clinic. There are multiple didactic sessions during this rotation in the area of primary care. The teaching methods include didactic sessions and reading material. The patients tend to be heterogeneous as far as socioeconomic status and types of diseases, and the evaluation of performance is consistent with that of the Department as previously stated.

There are multiple electives from which the residents may choose. These include consultation rotations in cardiology, infectious diseases, nephrology, gastroenterology, pulmonary medicine, hematology and oncology, geriatrics, neurology, psychiatry and general internal medicine as well as outpatient electives in endocrinology, allergy and immunology, rheumatology, dermatology and gynecology.

The educational purpose of these elective consultation rotations is to increase the fund of knowledge of the trainee so that their depth of knowledge is broadened sufficiently to perform the functions appropriate of an internist taking care of complex medical patients often with multi-system diseases. In general, these rotations provide the trainee an opportunity to evaluate a patient, develop a differential diagnosis and suggest a course of action that will lead to the proper diagnosis and treatment. By nature of the fact that a significant amount of patient encounters are in the outpatient facility, there is wide heterogeneity among the patients in regards to socioeconomic status, demographics, and types of pathology. Health promotion is emphasized in all of these electives. Important issues that deal with cultural, socioeconomic, ethical, occupational, environment and behavior are also stressed. The method of evaluation is similar to that described previously, i.e., a written evaluation is generated and reviewed with the trainee at the conclusion of the rotation. These evaluations will assess not only the residents fund of knowledge, history and physical examination as well as procedure skills but also their humanistic qualities, their ability to react appropriately to colleagues and ancillary healthcare providers as well as their enthusiasm and their desire to learn. Descriptions of the electives are listed below.

The Cardiology rotation allows the trainee to make consultative evaluation of patients with varied types of cardiology problems. The resident reviews the case, performs an appropriate history and physical, and then presents the case to an Attending cardiologist. During this rotation, the resident is expected to be able to evaluate the patient with ischemic heart disease, left ventricular dysfunction, valvular heart disease, cardiac arrhythmias, and congenital heart disease in the adult. The trainee will be expected to understand the implications, complications, and cost effectiveness of diagnostic studies such as echocardiography, exercise testing, ambulatory monitoring and cardiac catheterization as well as review current articles relating to Cardiology in the medical literature. Decision analysis based on results of objective testing will be discussed. Other less common cardiological problems will be discussed as seen. The resident is expected to read in a standard textbook of cardiology to improve his/her knowledge base.

The elective in Infectious Diseases will enable the resident to be able to evaluate patients with various types of infectious processes. These include, but are not limited to, common bacterial and viral infections as well as disorders seen in immunosuppressed, neutropenic, and/or transplant patients. The resident will have an understanding of how to evaluate laboratory studies as well as the indications and cost effectiveness of various testing, modalities. The resident will be given the opportunity to develop competency in interpretation of gram stains. The resident is expected to read about infectious diseases in a standard textbook of that discipline as well as current articles dealing with infectious diseases in the medical literature. At the conclusion of the elective, the resident is expected to evaluate, diagnose, and manage patients with fever, known infections, and occult infections.

The elective in Nephrology consists of both inpatient and outpatient experience in renal disease and hypertension. The resident is expected to be able to evaluate, diagnose, and manage patients with acute and chronic renal disease, fluid and electrolyte abnormalities, abnormal urinary sediments, and hypertension. The indications, complications, and cost effectiveness of invasive procedures including renal biopsy and arteriography will be discussed and an understanding of the pharmacology of antihypertensives will be presented. The resident is expected to read in a standard textbook of nephrology and hypertension about diseases and pathophysiology of this discipline. The resident will also be expected to read current articles in the medical literature dealing with Nephrology and Hypertension.

The Gastroenterology elective consists of both inpatient and outpatient exposure to the patients with diseases of the digestive system. The resident is expected to be able to evaluate, diagnose, and manage patients with GI bleeding, malabsorption, liver disease, abdominal pain, inflammatory bowel disease, and malignancies of the GI tract. There will be an understanding of the indications, complications, and cost effectiveness of upper and lower endoscopies, liver biopsies, and various invasive as well as non-invasive tests related to gastroenterology. There should be appropriate opportunities for the trainee to perform flexible sigmoidoscopies under supervision. The resident is expected to read about disease processes in a standard textbook of gastroenterology. The resident will also be expected to read current articles in the medical literature dealing with Gastroenterology.

The consult elective in Pulmonary Medicine will enable the resident to be able to evaluate, diagnose, and manage a multitude of pulmonary problems. This includes, but is not limited to, pneumonia, infectious diseases of the lung, neoplasms, chronic obstructive pulmonary disease, asthma, and other breathing disorders. The resident will be able to interpret pulmonary function testing and interpret chest x-rays. He/she should understand the indications, complications, and cost effectiveness of bronchoscopy, pulmonary function, and other procedures that are performed by the pulmonologist. At the conclusion of the elective, the resident will also be proficient in ventilatory management and the treatment of the patient with acute respiratory failure. The resident is expected to read about pulmonary disease in a standard textbook of medicine. The resident will also be expected to read current articles in the medical literature dealing with Pulmonary Medicine.

The Hematology and Oncology elective consists of evaluating, diagnosing, and managing patients with a wide variety of diseases. Because of the strong historical relationship between hematology and oncology, both groups of patients are included in this elective rotation. At the conclusion of the rotation, the resident will be able to evaluate, diagnose, and manage patients with hematological disorders such as anemia, thrombocytopenia, neutropenia, bleeding disorders, hyperthrombotic disorders and hematological malignancies and/or evaluate, diagnose, and manage patients with neoplastic diseases. The resident also will gain an understanding of the indications, complications, and cost effectiveness of bone marrow aspiration, chemotherapy, and treatment of patients with recombinant DNA products. The resident doing a hematology elective also will be proficient at evaluating blood smears and will have a better understanding of how to interpret bone marrow aspirations and biopsies. The resident is expected to read about Hematology and Oncology diseases in a standard textbook of medicine as well as review articles on this discipline in the current medical literature.

The rotation in Geriatric Medicine is a required elective which is a comprehensive learning experience in the total evaluation, management and care of the elderly patient. This includes both inpatient and outpatient experiences in the nursing home, HOSPICE, and the outpatient clinic. The resident will have an understanding of the specific problems related to the elderly as well as the pharmacology involved in treating this segment of the population. Experiences in rehabilitation will be included in the elective. At the conclusion of the elective, the trainee will be able to describe the appropriate care for patients with multiple geriatric problems including, but not limited to, confusion, dementia, gait instability, falls, urinary incontinence, rehabilitation, and nutritional deficiencies. Incorporating principles of medical ethics into complex discussions will be stressed. Reading in a standard textbook of medicine and/or geriatrics will be stressed.

The consultation in General Internal Medicine consists of an inpatient experience in providing evaluation, diagnosis, and management to patients on non-medical services as well as pre-operative risk evaluation and peri-operative care of the surgical patient. At the conclusion of the rotation the resident will be able to describe the various risk factors associated with increased morbidity and mortality of surgery and will be able to stratify patients based on these risk factors. The expected complications of surgery will be discussed as well as approaches to limit morbidity and mortality. The resident will provide primary care for the peri-operative subspecialty patient. There will also be an experience in the rehabilitation of the post-operative orthopedic patient. The resident is expected to

read in a general textbook of internal medicine as well as selective readings in the field of medical consultation.

The elective in Endocrinology is predominantly an outpatient elective with a minority of inpatient consultations. The resident will work with an attending physician from the Division of Endocrinology and Metabolism in the outpatient clinics seeing patients with a wide variety of endocrinological abnormalities including, but not limited to, diabetes, thyroid and adrenal disease, hypertension, dyslipidemia, and electrolyte abnormalities. At the conclusion of the rotation the resident will be able to discuss the appropriate therapies of both Type I and Type II diabetes as well as being able to evaluate, diagnose, and manage patients with thyroid and adrenal diseases. There will be an understanding of lipid metabolism and the pharmacology of the various lipid lowering agents. The resident is expected to read in a standard textbook of endocrinology and metabolism on appropriate diseases seen during this rotation. The resident will also be expected to read current articles in the medical literature dealing with Endocrinology and Metabolism.

The elective in Allergy and Immunology is predominantly an outpatient experience providing evaluation, diagnosis, and management for the patients with multiple allergies, asthma or immunodeficiency disorders. The resident will be able to discuss the various treatments of asthma as well as the indications, cost effectiveness, and management of people with allergic disorders. The resident will be able to describe the importance and function of cytokines and the complement system. Outpatient experience in treating immunodeficient patients will be acquired. The resident will present a conference to the Division of Allergy and Immunology. The resident is expected to read in a standard textbook of allergy and immunology on appropriate diseases seen during this rotation. The resident will also be expected to read current articles in the medical literature dealing with Allergy and Immunology.

The elective in Rheumatology will consist of mostly outpatient experience in evaluating patients who have various rheumatologic diseases. This will include, but not be limited to, patients with rheumatoid arthritis, degenerative joint disease, spondyloarthropathies, collagen vascular disease, and adjuvant disease. At the conclusion of the rotation the resident will be able to describe the differences between various arthritic diseases in regards to their evaluation, diagnosis, and management. The resident will have an opportunity to learn arthrocentesis and will be able to evaluate joint fluid. The resident will also have an understanding of the pharmacology of rheumatological medications. The resident is expected to read the primer in rheumatological diseases during this rotation.

The elective in Dermatology is an outpatient experience. Patients with a multitude of skin disorders will be seen in the outpatient clinics. The goal is for each resident to be able to recognize and diagnose skin diseases and understand fundamentals of patient management including cutaneous malignancies, actinic keratoses, psoriasis, acne, and skin infections. During this rotation the resident will become proficient in skin biopsies with an understanding as to their indications, complications, and cost effectiveness. The resident will participate in assigned dermatologic conferences and is expected to read in a standard textbook of dermatology about pathology during this rotation.

The GYN elective is co-administered by the Department of Obstetrics and Gynecology . During this rotation the resident will be at the Genesis Outpatient Clinic where ambulatory gynecology patients are seen. The resident will gain experience with adolescent medicine advising young women in health promotion, family planning, human sexuality and sexual transmitted disease. The resident is expected to be able to evaluate women with multiple gynecological problems including infections, bleeding and pain, as well as being able to perform pelvic examinations including pap smears, bimanual examinations and endometrial biopsies when appropriate. The residents will have the opportunity to learn how to insert and remove IUD's as well as fitting vaginal diaphragms. The resident will become efficient in interpretation of vaginal discharge for monilia, bacterial vaginosis and trichomonas. The resident will be able to evaluate, diagnose, and manage pelvic infections as well as have an

understanding of estrogen replacement therapy. The resident is expected to supplement his/her knowledge by reading in a textbook in gynecology.

The elective in Neurology is co-administered by the Department of Neurology. During this rotation the resident will work with advanced subspecialty residents and Attendings in the department of neurology. He/she will be responsible for doing in-hospital consultations, participate in the care of hospitalized patients and evaluate, diagnose and treat outpatient neurological problems under appropriate supervision. The resident is expected to be proficient in performing a complete and accurate neurological examination, developing a differential diagnosis and suggesting initial therapy. The rotation consists of approximately 2/3 inpatient care and consultation and 1/3 outpatient evaluation, diagnosis and care. The resident is expected to supplement his/her knowledge by reading in a general textbook of neurology. There will be periodic written tests on neurological information given by the Department of Neurology.

The elective in Psychiatry is co-administered by the Department of Psychiatry and occurs at Tampa General Hospital on Consultative Service. The Chief of the Consultative Service at Tampa General Hospital will be the individual from psychiatry in charge of the rotation. The resident will be expected to evaluate patients, perform an appropriate psychiatric examination and suggest initial therapy. The resident will follow these patients through their hospital course or as long as the psychiatry service feels appropriate. At the conclusion of the rotation the resident should be able to perform an adequate psychiatric evaluation and examination, understand common pharmacologic agents used in psychiatry and be able to initiate appropriate therapy for common psychiatric problems. The resident is expected to read in a general textbook of psychiatry during the rotation and will be evaluated by the Chief of the Consultative Service at Tampa General Hospital.

Consult exams are given monthly for residents on elective rotations based on questions from MKSAP. They are graded and residents receive a letter on areas that they need to improve their knowledge base. This is only utilized for self assessment purposes in preparation for the American Board of Internal Medicine Certification Exam.

YEARLY PRESENTATIONS

- A. **Practice Management** - Each year the department will present a series of monthly lectures that will discuss practice management. This will include descriptions of different types of medical practices, financial planning for physicians, contract negotiations, how to evaluate a prospective practice, risk management, etc. The goals and objectives of this series is to enable the residents to become familiar with the different choices of practice opportunities that are present in today's practice. The resident will also be able to understand the different types of contracts that he/she will be asked to sign. Furthermore, the resident will be able to determine what they need to do to have a solid financial foundation which will enable them to devote their time and skills to the practice of medicine.
- B. **Risk Management** - Lectures in risk management will be held both during the Practice Management Series and, at least monthly, this topic will be discussed at Morning Report. The goals and objectives of the Risk Management discussions will enable the resident to understand the concepts of standard of care in the community, adequate complete medical records, proper patient communication and how to interact with the hospital's risk manager.
- C. **HIV Education** - Lectures will be held monthly by the Infectious Disease Division and Sexually Transmitted Diseases. Residents will have the opportunity to round at the HIV Clinic, which is run

by the Division of Infectious Diseases and Tropical Medicine. Furthermore, the resident will have the opportunity to round on the Private Teaching Service, half of which is devoted to HIV. On this service there are both teaching and work rounds held daily. The goals and objectives of these rotations are to teach the resident the approach to the patient with HIV disease, understanding of pathophysiology of the initial viral infection and the consequences of altered immune system as it relates to health and disease. The resident will participate in the teaching rounds on these services. He/she will be expected to read in current textbooks of medicine as well as recent appropriate journal articles.

- D. **Cost-Effective Medical Approach and Socioeconomic Issues of Medicine** - Lectures will be held regularly in cost-effective and socioeconomic issues of medicine. There will be a minimum of one Morning Report that deals with socioeconomics and cost-effective medicine. This issue will furthermore be discussed in Journal Club as well as during lectures by the Division of Medical Ethics and Humanities. The goals and objectives of the lectures on Cost-Effective and Socioeconomic Issues of Medicine are to enable the resident to be able to discuss concepts of costs saved by treatments. The resident will also be able to discuss the concepts of numbers needed to treat as well as how evaluation treatment affects society. The resident will be expected to read about Cost Effective and Socioeconomic Medicine in current journals of general internal medicine. There will be a minimum of one Morning Report per month that deals with socioeconomics and cost-effective medicine.
- E. **Preventive Medicine** - The resident will be expected to become knowledgeable in the screening for disease, disease prevention and maintenance of general health and health promotion. Lectures will be given by the Division of General Internal Medicine in regards to health promotion and screening. There will be a minimum of three Journal Clubs during the course of the year that will deal with health promotion and screening for disease. The goals and objectives of this part of the curriculum will ensure that the resident understands the role of appropriate immunizations, screening for colorectal, breast and prostate cancers as well as the approach to dietary management as it relates to cardiovascular disease and malignancy. Resources that will be used are current textbooks of medicine as well as U.S. Public Health Service guidelines and those of the American College of Physicians and the American Cancer Society.
- F. **Journal Club** will be held on a monthly basis. During this time recent articles from the general literature will be reviewed. The goals and objectives of Journal Club are to prepare the resident for a career in life-long learning. The resident will be expected to understand common statistical determinations such as P values, intention to treat, and numbers needed to treat. The resident will also be expected to understand the differences between randomized clinical trials, case-controlled trials and epidemiological studies.
- G. **Basic Computer Skills** - The resident will have the opportunity to learn basic computer skills during both their inpatient rotation at the James A. Haley Veterans Administration Hospital as well as the Outpatient Care Clinic at the University of South Florida Medical Clinics. Each service at the James A. Haley Veterans Administration Hospital has a computer terminal specifically allocated to each resident. The house officer can not only enter appropriate orders for his/her patients but can do instant Medline searches as well as using Ovid. The integration of computers into the educational program at the James A. Haley Veterans Administration Hospital resulted in that institution receiving the award for the Outstanding Veterans Hospital in the Country. During the rotation at the University of South Florida Medical Clinics CARE Unit the resident is further instructed in Medline searches and using the computer for providing state-of-the-art care to patients.
- H. **Rehabilitation Medicine** - The residents are exposed to Rehabilitative Medicine in multiple areas, particularly inpatient medicine consults and during the CORE rotation. There are didactic lectures

that are held as part of the Noon Conferences and given by the Department of Physical Medicine. The goals and objectives of these experiences are to provide the resident with an understanding as to the potential of rehabilitation among patients with both medical and surgical diseases as well as to understand the limitations and extra means that a patient undergoing rehabilitation requires. They are expected to read in a general textbook of medicine about the importance of rehabilitation and its affect on the pathophysiology of patients. Furthermore, at the didactic session, a handout is given to the resident for their personal use describing the different aspects and potential goals of rehabilitation.

- I. **Laboratory Medicine** - Residents receive experience in laboratory medicine in virtually all of their rotations. As part of teaching rounds on General Medicine Services a concentrated effort is made to discuss the indications of tests that are ordered as well as decision analysis as to how to interpret the results. A minimum of three Morning Reports during the course of a month are devoted primarily to the area of laboratory medicine. The goals and objectives of these teaching lectures are to enable the resident to understand the indications for appropriate laboratory testing, to be able to interpret the results of testing performed and to be able to understand statistics involved with testing such as specificity, sensitivity, positive and negative predictor values. The resident is expected to read in a general textbook of medicine areas of laboratory testing. They are evaluated in the usual customary fashion during Attending rounds and at conferences.
- J. **Interdisciplinary Topics** - The following interdisciplinary topics are covered over the three years of residency through multiple opportunities including, Noon Conferences, Grand Rounds, Practice Management Seminars, Hospital Based CME opportunities, Journal Club and Morbidity/Mortality Conferences.
 - 1. Adolescent Medicine
 - 2. Clinical Ethics
 - 3. Medical Genics
 - 4. Quality Assessment/Improvement
 - 5. Risk Management
 - 6. Preventative Medicine
 - 7. Medical Informatics and Decision Making
 - 8. Public Policy
 - 9. Pain Management
 - 10. End of Life Care
 - 11. Domestic Violence
 - 12. Physician Impairment and Substance Abuse Disorders

DIDACTIC PART OF THE USF INTERNAL MEDICINE RESIDENCY CURRICULUM

Over the course of three years, Noon Conferences and Grand Rounds will cover the didactic part of the curriculum. This will be divided into appropriate areas of expertise. Some topics will be presented yearly while others will be part of the three year educational cycle. Still other conferences will be held much more frequently such as a monthly Journal Club, Morbidity and Mortality conference as well as a conference where the residents can give immediate feedback to the Chief of the Medical Service regarding their experiences during that month. Sections such as Practice Management, Risk Management, HIV Education, Cost Effective Medical Approach and related medical fields such as Adolescent Medicine, Psychiatry, Gynecology, ENT and Urology will be presented yearly. During the first four weeks of the academic year, topics at the Noon Conferences at both institutions will deal with the Basic Medical Management Education Series. These topics are listed below. Housestaff are

expected to be present at all of these lectures unless life-threatening problems arise. (SEE DESCRIPTION OF YEARLY PRESENTATIONS AT THE CONCLUSION THIS SECTION)

Emergency Medical Management Education Series

- a) Congestive Heart Failure and Pulmonary Edema
- b) Acute Myocardial Infarction: Management
- c) Valvular and Pericardial Disease
- d) Arrhythmia Recognition and Management
- e) GI Bleeding
- f) Hepatic Failure
- g) Hyperlimentation
- h) Blood Gas Determinations and Respiratory Diseases
- i) Respiratory Failure
- j) DKA and Hyperosmolar States
- k) Thyroid/Adrenal Crisis and Calcium States
- l) Hypertensive Emergencies
- m) Bleeding States
- n) Blood Products
- o) Septic Shock
- p) An Approach to the Rapid Diagnosis of Infectious Disease and Subsequent Therapy
- q) Coma and Seizures
- r) Cerebral Edema and CVA's
- s) The Impaired Physician

Noon Conference and Grand Rounds (minimum list of topics)

- A. Allergy - Immunology
 1. Adverse reactions to drugs
 2. Primary immunodeficiency diseases
 3. Asthma
 4. Rhinitis
 5. Sinusitis
 6. Anaphylaxis
 7. Atopic dermatitis
 8. Occupational and environmental asthma
- B. Cardiology
 1. Normal and abnormal myocardial function
 2. Heart failure
 3. The Bradyarrhythmias
 4. The Tachyarrhythmias
 5. Valvular heart disease
 6. Acute myocardial infarction
 7. Ischemic heart disease
 8. Cardiomyopathies
 9. Pericardial disease
 10. Cardiovascular pharmacology
 11. Electrocardiography
- C. Dermatology
 1. Psoriasis and cutaneous infections
 2. Cutaneous drug reactions
 3. Immunological mediated skin diseases
 4. Skin manifestations of internal disease

5. Photosensitivity and other reactions to light
6. Melanoma
7. Skin cancer
8. Disorders of the skin caused by aging

D. Endocrinology

1. Diabetes Mellitus
2. Disorders of the adrenal
3. Disorders of the thyroid
4. Disorders of the pituitary
5. Disorders of growth
6. Assessment of endocrine function
7. Calcium, phosphorus and bone metabolism
8. Disorders of the parathyroid gland
9. Paget's disease of bone
10. Endocrine manifestations of neoplasia

E. Gastroenterology

1. Diseases of the esophagus
2. Peptic ulcer and gastritis
3. Inflammatory bowel disease
4. Tumors of the large and small intestine
5. Acute hepatitis
6. Chronic hepatitis
7. Cirrhosis of the liver
8. Diseases of the gall bladder and biliary system
9. Acute and chronic pancreatitis
10. Diagnostic tests of liver disease
11. Malabsorption
12. Nutrition and its requirements
13. Parenteral and enteral nutritional therapy

F. General Internal Medicine

1. Hypertension
2. Hyperlipidemia
3. Medical consultation
4. Chronic sinusitis
5. Preventive medicine

G. Geriatrics

1. Dementia
2. Infections in the elderly
3. Falls
4. Pain management
5. Alzheimer's disease
6. The approach to the nursing home patient
7. The physiology of aging
8. Pharmacology in the elderly

H. Ethics

1. Living wills
2. Doctor - patient confidentiality
3. End of life decision making

4. Euthanasia
 5. Physician's responsibility to society
 6. Informed consent
- I. Hematology
1. Disorders of coagulation and thrombosis
 2. Coagulopathies
 3. Anti-platelet disorders
 4. Blood product therapy
 5. Bone marrow failure
 6. Myeloproliferative disorders
 7. Iron deficiency anemia
 8. Megaloblastic anemia
 9. Hemolytic anemias
 10. Disorders of hemoglobin
 11. Anemias associated with chronic disorders
 12. Bone marrow transplantation
- J. Infectious Diseases
1. Diagnosis of infectious diseases
 2. Infections in the compromised host
 3. Hospital acquired infections
 4. Immunizations
 5. Therapy and prophylaxis of bacterial infections
 6. Anti-fungal therapy
 7. Septicemia and septic shock
 8. Infective endocarditis
 9. Infectious diarrheal diseases
 10. Sexually transmitted diseases
 11. Urinary tract infections
 12. Acquired Immunodeficiency state
 13. Osteomyelitis
 14. Infections caused by animal bites and scratches
 15. Pneumococcal infections
 16. Staphylococcal infections
 17. Streptococcal infections
- K. Oncology
1. Cancer chemotherapy
 2. Malignant lymphomas
 3. Breast cancer
 4. Carcinoma of the prostate
 5. Lung cancer
 6. Paraneoplastic syndromes
 7. Principles of neoplasia
 8. Therapy for colorectal carcinoma
- L. Pulmonary
1. Diagnostic procedure and respiratory diseases
 2. Environmental lung disease
 3. Pneumonia and lung abscesses
 4. Bronchiectasis
 5. Chronic bronchitis

6. Emphysema and airway obstruction
7. Interstitial lung disease
8. Pulmonary thromboembolism
9. Neoplasm of the lung
10. ARDS
11. Mechanical ventilatory support
12. Interpretation of blood gases and PFT's
13. Outpatient management of chronic lung disease
14. Sarcoidosis
15. Tuberculosis
16. Cough and hemoptysis

M. Renal

1. Renal physiology
2. Disturbances of renal function
3. Acute renal failure
4. Chronic renal failure
5. The major glomerulopathies
6. Renal stones
7. Fluids and electrolytes
8. Glomerulopathies associated with multi-system diseases
9. Tubular interstitial diseases of the-kidney
10. Tumors of the urinary tract

N. Rheumatology

1. Immune complex diseases
2. Dermatomyositis and polymyositis
3. Systemic SLE
4. Rheumatoid arthritis
5. Scleroderma
6. Mixed connective tissue disease
7. Spondyloarthropathies
8. The vasculitis syndromes
9. Infectious arthritis
10. Osteoarthritis
11. Arthritis due to crystals

EXAMPLE Ambulatory Care Time

COR	1 Month	3%
ER – PGY I	2 Weeks	1.5%
Continuity Clinic	½ day per week	7.5%
Ambulatory Month	1 Month	3%
Dermatology	1 Month	3%
Allergy	1 Month	3%
Rheumatology	1 Month	3%
Women's Health	1 Month	3%
ER – PGY III	2 Weeks	1.5%
Psych	1 Month	3%
Neurology	2 Weeks	1.5%
Endocrinology	1 Month	3%
All residents have a minimum of 36%		36%

ACGME requirement $\geq 33\%$