TRIDENT MEDICAL CENTER

Graduate Medical Education Committee

Resident Handbook

2008-09

Revised: July 1st, 2008

RESIDENT HANDBOOK INTRODUCTION

The Resident Handbook is designed to guide residents [1] through important policies and procedures. This handbook will be reviewed and updated periodically. Any questions concerning policies, procedures or benefits should be addressed to the Medical Staff Office at (843) 797-4946. [2]

Some programs may have supplemental policy manuals providing additional guidance. These will be provided by your specific program. The Trident Medical Center Resident Handbook will be reviewed on an annual basis and will automatically be distributed to each Resident at the beginning of each academic year.

[1] Throughout this Handbook, the word "resident" refers to all specialty and subspecialty residents.

[2] Nothing in the policies contained in this Handbook shall be construed to constitute a contract and Trident Medical Center has the right to modify any policy at its discretion.

TRIDENT MEDICAL CENTER

Institutional Commitment to Graduate Medical Education

Medical education is a significant component of the mission of the Trident Medical Center. The Board of Trustees, the CEO and the administrators, medical and ancillary staff are committed to provide graduate medical education using the financial, educational and personnel resources necessary to ensure the highest quality programs. These graduate medical education programs will further our mission of educating future physicians while providing the highest quality care for our patients. We pledge to emphasize coordinated care with community physicians and to take advantage of cooperative opportunities to work with other institutions to fulfill mutual educational objectives.

We commit ourselves to provide graduate medical education programs that enable physicians in training to develop personal, clinical and professional competence under the guidance and supervision of the faculty and staff. The Program Directors will assure that patients receive safe, appropriate and humane care by resident physicians who will gradually assume responsibility for patient care based upon each trainee's demonstrated clinical competence. We further commit to conduct these programs in compliance with the institutional and specific requirements of the Accreditation Council for Graduate Medical Education (ACGME), the Joint Commission on Accreditation of Health Care (JCAHO) and in accordance with all applicable federal and state laws and regulations. In addition, Trident Medical Center will encourage residents to participate in a wide range of scholarly activities including quality improvement, research, presentations, and publications.

__________________________________ _______________
Terry Gunn, CEO Date

__________________________________ _______________
Eric Bolster, MD – Chair, Board of Directors Date

__________________________________ _______________
Helena Feather, DIO Date

__________________________________ _______________
Peter J. Carek, MD, MS Date
Chair, Graduate Education Committee

ELIGIBILITY AND SELECTION OF RESIDENTS

Statement of Policy

Residents are selected on a fair and equal basis without regard to race, color, religion, sex, national origin or sexual orientation. Selection is based upon the applicant's preparedness, ability, aptitude, academic credentials, interpersonal and written communication skills.
Applicants with one of the following qualifications are eligible for appointment:

- Graduates of medical schools in the United States and Canada accredited by the Liaison Committee on Medical Education (LCME).
- Graduates of colleges of osteopathic medicine in the United States accredited by the American Osteopathic Association (AOA).
- Graduates of medical schools outside the United States and Canada who meet the following qualifications:
  - Have received a currently valid certificate from the Educational Commission for Foreign Medical Graduates or
  - Have a full and unrestricted license to practice medicine in a U.S. licensing jurisdiction and
  - Speak and write fluent English.

Procedures

1. All programs are required to participate in the National Residency Matching Program (NRMP).
2. Only applicants with qualifications as required by the Accreditation Council for Graduate Medical Education are considered eligible for residency positions.
3. All applicants are required to complete an application form and submit this along with board scores, letters of reference, a dean's letter, and a medical school transcript. All applicants must have successfully passed USMLE Step 1 and Step 2 exams (or COMLEX Step 1 and Step 2).
4. Each program compiles the data and prepares a personal record on each applicant.
5. The program's Resident Selection Committee (consisting of appointed faculty and residents) screens applications according to established program criteria and selects applicants for interview.
6. A personal interview is granted to those applicants selected through the screening process. During this interview, applicants are informed of the terms and conditions of appointment, stipend, annual leave, professional leave, maternity/paternity leave, sick leave, professional liability insurance, hospital and insurance benefits, call rooms, meals, laundry, etc.
7. At the end of the interviewing period, the Resident Selection Committee objectively evaluates each candidate and prepares a list of applicants in rank order, which is then entered for the National Match process.
8. Any resident who has a disability (according to the Americans with Disabilities Act) and/or special restrictions on his/her medical license MUST report this information to the Program Director and the Medical Staff Office no later than the first day his/her residency program begins.

APPOINTMENT OF NEW RESIDENTS

Statement of Policy

Each resident is appointed to a specific ACGME-approved position in the Program in which he/she has been accepted.

Procedure

1. Each program is required to submit a list to the Medical Staff Office that identifies the residents appointed for the academic year.
2. Each new resident is required to sign a "Resident Agreement" with the Medical Staff Office. This signature signifies acceptance of the appointment.
3. Each new resident must comply with the Graduate Medical Education Committee (GMEC) policy for United States Medical Licensing Examination USMLE Step 3 (or COMLEX equivalent) exam.
4. Each new resident must pass a drug screen test and satisfactorily complete a criminal background check.

REAPPOINTMENT OF RESIDENTS

Statement of Policy

Each Resident Agreement has a one-year term. Residents can and should expect to complete their GME program providing they successfully complete the previous year's training requirements and they adhere to the program's and institution's established policies and procedures.

Procedure

1. Residents are promoted each year on the basis of their clinical performance, as measured by the faculty's evaluations and other evaluation methods; by the recommendation of the department's GME or promotions committee, the Program Director and by final approval of the GMEC.
2. Each resident must comply with the GMEC policy for USMLE Step 3 (or COMLEX equivalent).
3. If a Program Director decides not to reappoint a resident, the resident will be notified by March 1st of the academic year. If the cause for non-reappointment occurs after March 1st of the academic year, the Program Director will notify the resident about the non-renewal of the Resident Agreement as soon as circumstances will reasonably allow. The resident may appeal a decision of the non-reappointment (see section on Grievance Procedure.).

POLICY for the USMLE STEP 3 EXAMINATION

Statement of Policy

All Trident Medical Center residents must complete all three (3) steps of the USMLE sequence as part of their graduate medical education.

Procedure

1. All PGY-1 residents are required to register for and take the USMLE Step 3 Exam (or the equivalent COMLEX Step 3 Exam) prior to completion of the PGY-1 year on June 30th.
2. If a PGY-1 resident does not take the USMLE Step 3 examination (or COMLEX Step 3 Exam) during the PGY-1 year, the resident's Trident Medical Center Resident Agreement will NOT be renewed for the PGY-2 year.
3. All PGY-1 residents must PASS the USMLE Step 3 Exam (or COMLEX Step 3 Exam) by the end of the PGY-2 year on June 30th. If a resident does not pass the USMLE Step 3 Exam (or COMLEX Step 3 Exam) by the end of the PGY-2 year, the resident's Trident Medical Center Resident Agreement will NOT be renewed.
4. If a resident enters Trident Medical Center at the PGY-2 level and has not passed the USMLE Step 3 Exam (or COMLEX Step 3 Exam), the resident must PASS the USMLE Step 3 Exam (or COMLEX Step 3 Exam) by the end of the PGY-2 (June 30th). If a resident does not pass the USMLE Step 3 Exam (or COMLEX Step 3 Exam) by the end of the PGY-2 year, the resident's Trident Medical Center Resident Agreement will NOT be renewed.

    Note: A resident's PGY-2 year will NOT be extended to meet these requirements.

5. All specialty and subspecialty residents accepted into Trident Medical Center GME programs at the PGY-3 level or above MUST have passed USMLE Step 3 Exam (or the equivalent COMLEX Step 3 Exam) BEFORE entering the residency program on July 1.
6. Every resident is responsible for providing copies of the USMLE Step 3 Exam results (or COMLEX Step 3 Exam) to the Program Director and the GME Office.
7. The resident will be allowed two (2) days off from the program to take the USMLE (or COMLEX) exam. These two days will NOT be counted as annual or sick leave.
8. Exceptions to this policy will only be made by Trident Medical Center's Designated Institutional Official for GME, in consultation with the Program Director, and only then in rare and unusual circumstances.

RESIDENT AGREEMENT

Statement of Policy

Residents are provided a contractual agreement that outlines the terms and conditions of their educational appointment. (See Appendix 1)

Procedures

1. The agreement specifies the following:
   a. Resident responsibilities;
   b. Institutional responsibilities;
   c. Stipend support and benefits including: health and disability insurance, professional liability insurance, leave of absence, annual and sick leave, counseling services, etc.
   d. Duration of appointment and conditions of reappointment;
   e. Policies regarding professional activities outside the educational program;
   f. Procedures for discipline and redress of grievances;
   g. Procedures for handling complaints of sexual harassment and exploitation.
   h. Work conditions regarding on-call meal money, on-call rooms, resident lounge areas, etc.
   i. Promotion of patient safety and education through carefully constructed duty hours assignments and faculty supervision
   j. Policies on handling physician impairment
   k. Stipulation that residents are <u>not</u> required to moonlight and are <u>not</u> required to sign a non-competition agreement
   l. Policies regarding residency program closure or reduction
2. Annual renewal of the Resident Agreement is contingent upon reappointment by the Program Director, and the Designated Institutional Official (DIO) for GME (See policy on Promotion and Resignation, Transfer or Non-Reappointment of Residents).
3. A copy of the GMEC handbook, program Policies and Procedures Manual, and resident contract are provided to applicants for review during the interview process.

IDENTIFICATION BADGES

Statement of Policy

While in the Trident Medical Center, residents are required to wear identification (ID) cards in such a manner that name, picture and department are unobstructed (clearly visible) and worn at eye level. All specialty and subspecialty residents' ID cards state "Resident" to comply with the Lewis Blackman Hospital Patient Safety Act. The resident is the only individual authorized to wear his/her Trident Medical Center ID card.

Any resident reporting to duty without his/her official Trident Medical Center ID badge must obtain a temporary one. The ID cards are the property of Trident Medical Center and must be relinquished upon completion or termination from the residency program.

PROCEDURES

1. Trident Medical Center ID cards are issued by the Trident Medical Center.
2. Residents are required to promptly report the loss of their identification cards to their residency coordinator.

    NOTE: Resident ID cards will be replaced and the cost will be incurred by the resident who lost the card.

RESIDENT EDUCATIONAL ENVIRONMENT

Statement of Policy

The educational environment must be adequate for the physical, emotional and educational needs of all residents and be conducive to resident education and the care of patients.

Procedures

Trident Medical Center provides an educational environment in which residents may raise and resolve issues related to their residency programs without fear of intimidation or retaliation.

1. Trident Medical Center provides appropriate physical facilities, essential to both men and women, to meet each residency program's goals. This includes access to appropriate food services in all institutions participating in the residency programs as well as adequate on-call rooms.
2. All residents (specialty and sub-specialty) are expected to dress in appropriate professional attire when engaged in any residency activity. When residents are in a Trident Medical Center facility, they must abide by the Trident Medical Center Dress Code Policy.
3. Trident Medical Center will ensure that all patient care is supervised by qualified faculty. The Program Director must ensure, direct, and document adequate supervision of residents at all times. Residents must be provided with rapid, reliable systems for communicating with supervising faculty. Faculty schedules will be structured to provide residents with appropriate supervision and consultation.
4. Trident Medical Center provides a medical records system that: documents the course of each patient's illness; adequately supports quality patient care; provides information for residents' quality assurance and quality improvement activities and serves as a resource for scholarly activities.
5. Trident Medical Center provides adequate and appropriate patient support services such as phlebotomy, laboratory, transport, messengers, diagnostic testing along with nursing and other allied health professionals.
6. Trident Medical Center provides counseling and other support services to meet each resident's unique needs. Any resident in need of such services should contact his/her Program Director, the Medical Staff Office, or the Employee Assistance Program.
7. Parking is available to all residents in one of the campus garages or lots.
8. Each residency program recognizes that the resident's personal and family needs must be addressed for them to function optimally. The Office of Graduate Medical Education at the Medical University of South Carolina supports the operation of a Resident Auxiliary organization for spouses and partners. For more information, contact Alisa Barnes (571-7644 or 425-7003 / alisa2317@yahoo.com).
9. Each residency program must foster humanistic values and cross-cultural sensitivity and respect for all individuals. If any resident feels s/he is the subject of harassment or discrimination based on race or cultural or sexual orientation, s/he is encouraged to contact the DIO for GME.
10. Trident Medical Center, the Program Director, the faculty and the Medical Staff Office will provide an environment by which a) residents can develop a personal program of learning to foster continued professional growth with guidance from the teaching

staff; b) participate fully in the educational and scholarly activities of their programs and, as required, assume responsibility for teaching and supervising other residents and students; c) have the opportunity to participate on appropriate institutional and program committees and councils whose actions affect their education and/or patient care; d) participate in an educational program regarding physician impairment, including substance abuse.

11. Trident Medical Center insures that each program defines, in accordance with its Program Requirements, the specific knowledge, skills, attitudes and educational experiences required for residents to demonstrate attainment of the ACGME Six General Competencies:
    a. Patient care that is compassionate, appropriate and effective for the treatment of health problems and the promotion of health;
    b. Medical knowledge about established and evolving biomedical, clinical and cognate (e.g. epidemiological, social and behavioral) sciences and the application of this knowledge to patient care;
    c. Practice-based learning and improvement that involves investigations and evaluations of their own patient care, appraised and assimilation of scientific evidence and improvements in patient care;
    d. Interpersonal and written communication skills that result in effective information exchange and "teaming" with patients, their families and other health professionals;
    e. Professionalism as manifested through a commitment to carrying out professional responsibilities, adherence to ethical principles and sensitivity to a diverse patient population;
    f. Systems-based practice as manifested by actions that demonstrate an awareness of and responsiveness to the larger context and system for health care and the ability to effectively call on system resources to provide care that is of optimal value.

RESIDENT DUTY HOURS

Statement of Policy

Residents' duty hours must reflect and reinforce the physician's obligation for adequate, continuous patient care while at the same time recognizing that prolonged and difficult hospital duties detract from this obligation. It is further recognized that adequate leisure time is important for the resident's personal development and health.

1. Duty hours are defined as all clinical and academic activities related to the residency program, i.e., patient care (both inpatient and outpatient), administrative duties related to patient care, the provision for transfer of patient care, time spent in-house during on-call activities, and scheduled academic activities such as conferences. Duty hours do not include reading and preparation time spent away from the duty site.
2. Duty hours must be limited to 80 hours per week, averaged over a four-week period, inclusive of all in-house call activities. "In-house" moonlighting must be counted toward the 80-hour limit. Moonlighting in any Trident Medical Center/MUSC facility, the Ralph H. Johnson VA Medical Center, St. Francis Hospital, Roper Hospital, East Cooper Hospital or any facility affiliated with a specific residency program, is considered "in-house" moonlighting.
3. Residents must be provided with one day in seven, averaged over a four-week period, free from all educational and clinical responsibilities inclusive of call. One day is defined as one continuous 24-hour period free from all clinical, educational, and administrative activities.
4. In-house call must occur no more frequently than every third night, averaged over a four week period. Certain specialties have more restrictive requirements regarding the scheduling of in-house call. (See specific RRC Program Requirements for more details.)
5. Continuous on-site duty, including in-house call, must not exceed 24 consecutive hours. Residents may remain on duty for up to six additional hours to participate in didactic activities, transfer care of patients, conduct outpatient clinics and maintain continuity of medical and surgical care (unless further limited by the relevant Program Requirements.)
6. No new patients may be accepted after 24 continuous hours on duty. A new patient is defined as any patient for whom the resident has not previously provided care (unless otherwise defined in the relevant RRC Program Requirements.)
7. Adequate time for rest and personal activities must be provided. This should consist of a ten (10) hour time period provided between all daily duty periods and after in-house call. If a resident is called into a facility from home call, the ten-hour interval does not reset. It is based on the initial time the resident left the facility or ended his/her duty period.
8. The frequency of at-home call (pager call) is not subject to the every third night limitation. However, at-home call must not be so frequent as to preclude rest and reasonable personal time for each resident. Residents taking at-home call must be provided with one day in seven completely free from all educational and clinical responsibilities, averaged over a four-week period. At-home call is defined as call taken from outside the assigned institution.
9. When residents are called into the hospital or clinic from home, the hours they spend in the facility are counted toward the weekly 80-hour limit.

10. The Program Director and the faculty must monitor the demands of at-home call in their programs and make scheduling adjustments as necessary to mitigate excessive service demands and/or fatigue.
11. An RRC may grant exceptions for up to 10% of the 80-hour limit, to individual programs based on a sound educational rationale. However, prior permission of Trident Medical Center's GMEC is required.
12. Faculty and residents must be educated to recognize the signs of fatigue and adopt and apply policies to prevent and counteract the potential negative effects.

Procedures

1. All residents are required to report their duty hours using the E*Value system. Residents must log their duty hours a minimum of once every thirty days. If thirty days pass without a resident logging his/her duty hours, a verbal warning will be issued by the Program Director. Repeated failure to report duty hours or falsification of duty hours will result in suspension and/or termination from the residency program.
2. Residents who encounter problems or difficulty complying with the ACGME duty hours requirements should resolve this matter with his/her Program Director. If the matter cannot be resolved with the Program Director or if the resident encounters violations, s/he should contact the DIO for GME.

RESIDENT SUPERVISION

Supervision refers to the dual responsibility that an attending physician has to enhance the knowledge of the resident and to ensure the quality of care delivered to each patient by any resident. Such control is exercised by observation, consultation and direction. It includes the imparting of the attending physician's knowledge, skills, and attitudes by the attending physician to the resident and ensuring that patient care is delivered in an appropriate, timely, and effective manner.

Statement of Policy

The intent of this policy is to ensure that patients will be cared for by clinicians who are qualified to deliver care and that this care will be documented appropriately and accurately in the patient record. This is fundamental, both for the provision of excellent patient care and for the provision of excellent education and training. Faculty supervision of residents assures resident education.

The quality of patient care, patient safety, and the success of the educational experience are inexorably linked and mutually enhancing. Incumbent on the clinical educator is the appropriate supervision of the residents as they acquire the skills to practice independently and simultaneously provide the highest standard of patient care.

Additionally, it should be understood that documentation of patient care that is acceptable for purposes of third-party billings is governed by guidelines that are defined by payers, such as the Centers for Medicaid and Medicare Services (CMS) or third-party insurers. Trident Medical Center provides one level of care and the level of supervision never varies on the basis of patients' financial or insurance status.

Scope:

Attending physicians are responsible for the care provided to each patient and they must be familiar with each patient for whom they are responsible. Fulfillment of that responsibility requires personal involvement with each patient and with each resident who is participating in the care of that patient. Each patient must have an attending physician of record whose name is recorded in the patient chart. When patients are transferred between services, the attending physician of record or his/her designee must designate in the order section of the medical record the name of the new accepting attending physician of record. It is recognized that other attending physicians may at times be delegated responsibility by the attending physician of record; in such instances, the attending physician of record is responsible to ensure that the residents involved in the care of the patient are informed of such delegation and can readily access an attending physician at all times and the attending of record if necessary. Attending physicians must always be available and willing to speak with patients when hospitalized patients wish to contact their attending physicians about their medical care in accordance to the SC Blackman Patient Safety Act.

Within the scope of the training program, all residents must function under the supervision of an attending physician. On-call schedules and rotation schedules for each residency program are to be developed on a periodic basis to provide residents with a variety of patient care educational experiences consistent with the program requirements of that particular program. At a minimum, backup must be available at all times for on-

call residents in the form of more senior residents in addition to appropriately credentialed attending physicians.

It is the responsibility of each Program Director to establish categories of all resident activities according to graduated levels of responsibility and appropriate levels of supervision outlined below. The requirements for on-site supervision will be established by the Program Director for each residency program in accordance with ACGME, American Medical Association (AMA), JCAHO, and CMS guidelines and should be monitored through periodic departmental reviews, with institutional oversight through the GMEC internal review process. It is the responsibility of the Program Director to ensure that resident specific scopes of practice "privileges" are current and posted to the E-Value software system so that both medical staff and hospital staff can determine which specific patient care activities can be carried out by residents. The level of supervision (physical presence of attending physicians, home call backup, etc.) needed by the resident will be the responsibility of the Attending Physician. This level of supervision must be consistent with the requirement for progressively increasing resident responsibility during a residency program and the requirements of the individual department, as well as common standards of patient care. The levels of supervision are:

Level 1. The attending physician or other appropriately privileged physician is physically present and directly involved in the care/procedure.

Level 2. The attending physician or other appropriately privileged physician is present in the operative/procedural suite or on the unit and immediately available for consultation.

Level 3. The attending physician or other appropriately privileged physician is immediately available in the facility or on the Trident campus.

Level 4. The attending physician or other appropriately privileged physician is off the Trident campus immediately available by telephone and able to physically return to campus within a reasonable amount of time.

In order to ensure patient safety and quality patient care while providing the opportunity for maximizing the educational experience of the resident in the ambulatory setting, it is expected that an appropriately privileged attending physician will be available for supervision during clinic hours. Patients followed in more than one clinic will have an identifiable attending physician for each clinic. Attending physicians are responsible for ensuring the coordination of care that is provided to patients.

Policy Standards:

Quality graduate medical education can occur only in settings that are characterized by the provision of high quality patient care. As a practical matter, preparing future practitioners to meet patients' expectations for excellence requires that they learn in environments epitomizing the highest standards of medical practice. Even more important, as an ethical matter, justifying the participation of residents in the care of patients requires adherence to uncompromised standards of quality medical care.

1. The attending physician of record is responsible for the quality of all of the clinical care services provided to his or her patients.

2. All clinical services provided by resident physicians must be supervised appropriately to maintain high standards of care, safeguard patient safety, and ensure high quality education, based on patient acuity and resident's graduated level of responsibility.
3. Each residency program will have written guidelines governing supervision of residents; these guidelines will vary according to specialty, intensity of patient care responsibilities on a given rotation, level of experience, and educational requirements.
4. Attending physicians directly responsible for the supervision of patient care services provided by resident physicians must be available to participate in that care. The presence of residents to "cover" patients on inpatient services or to provide care in ambulatory settings does not diminish the standards of availability required of the physician of record.
5. Attending physicians are responsible for determining when a resident physician is unable to function at the level required to provide safe, high quality care to assigned patients, and must have the authority to adjust assigned duty hours as necessary to ensure that patients are not placed at risk by resident physicians who are overly fatigued or otherwise impaired.

Procedure:

1. All patient care performed by residents during training will be under the supervision of an attending physician credentialed to provide the appropriate level of care. The specifics of this supervision must be documented in the medical record by the attending physician or resident.
2. A supervising/attending physician must be immediately available to the resident in person or by telephone 24 hours a day during clinical duty. Residency Program Directors must assure this occurs. Residents must know which supervising/attending physician is on call and how to reach this individual.
3. Inpatient supervision: The supervising/attending physician must obtain a comprehensive presentation from the resident including a history and physical with co-signed attending attestation for each admission. This must be done within a reasonable time, but always within 24 hours of admission. The supervising/attending physician must also require the resident to present the progress of each inpatient daily, including discharge planning. All required supervision must be documented in the medical record by the resident and/or the supervising/attending physician according to Medical Staff rules and regulations.
4. Outpatient supervision: The supervising/attending physician must be available to assist residents regarding outpatient activities. All required supervision must be documented in the medical record by the resident and/or the supervising/attending physician.
5. Consultative Service supervision: The supervising/attending physician must communicate with the resident and obtain a presentation of the history, physical exam and proposed decisions for each referral. This must be done within an appropriate time but no longer than 24 hours after completion by the resident of the consultation request. All required supervision must be documented by the resident and/or the supervising/attending physician.
6. Operating Room and Non-Operating Room Procedural supervision: The supervising/attending physician must ensure that procedures performed by the resident are warranted, that adequate informed consent has been obtained and that the resident has an appropriate level of supervision during the procedure. Attending responsibilities for procedures may include the administration of sedation. The level

of supervision (according to the four levels outlined previously in this policy) must match both the resident's ability to determine the appropriateness of the procedure and the resident's ability to perform the procedure. The supervising/attending physician will be present for the key portions of all procedures performed in the Main Operating Room and Ambulatory Operating Room, and for all other high risk procedures, as defined below, regardless of the setting. For all other procedures, the level of supervision must be commensurate with demonstrated competence by the resident for that procedure. Further, the key portions of a procedure should be considered to include all periods of more than minimal risk, determination of which will depend on the particular patient and the skills/experience of the resident being supervised.

When a teaching physician is not present during non-critical or non-key portions of the procedure and is participating in another procedure, he or she must arrange for another qualified physician to be immediately available to assist the resident in the other case should the need arise. A supervising/attending physician may not be involved in more than 2 overlapping procedures, except in the case of an emergency, anesthesia services, or when all of the procedures are office based.

All required supervision must be documented by the resident and/or the supervising/attending physician according to Medical Staff rules and regulations. (Note: This policy is only intended to specify the level of resident supervision necessary to assure high quality medical care and does not reflect billing guidelines. Medical Staff are also expected to provide adequate documentation of levels of care and supervision that conform to compliance and billing guidelines.

7. Emergency care: Nothing in this policy should limit the immediate provision by residents of life-saving care or care deemed essential for emergency circumstances. As soon as possible after residents deliver emergency care that would normally require the presence of an attending physician, resident physicians must notify the supervising/attending physician of the care delivered and discuss the patient's history and physical findings and the justification for emergency interventions. In exceptional circumstances, adequately trained residents may initiate surgery in the operating room if any delay would be considered life-threatening. Every reasonable effort must be expended by the resident to confer with the attending physician before beginning a surgical case. An attending physician must join the surgical case as soon as possible. The Medical Director of the Operating Room will review and report to the Trident Medical Center Medical Director all instances wherein a resident initiated emergency surgery and performed key elements of surgery without an attending physician present.

Non-Operating Room High Risk Procedures

The following non-operating room procedures require supervising/attending presence for all key portions of the procedure

- Diagnostic or interventional cardiac catheterization (right or left)
- Interventional vascular procedures
- Interventional radiological procedures
- Implantable pacemakers and ICD implantation
- Gastrointestinal endoscopic procedures
- Pulmonary endoscopic procedures

- Transesophageal echocardiography

PROFESSIONALISM

Statement of Policy

An increased focus on professionalism in medicine over the past decade has occurred. Many within and outside medicine have called for training medical students and residents in order to develop the attributes of medical professionalism. Physicians must recognize their responsibility to meet their obligations to their patients, their communities and their profession.

ACGME Definition of Professionalism - As manifested through a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population.

Procedure

1. Each program will develop a curriculum program to teach medical professionalism.
2. Each program will develop methods to evaluate professionalism as part of the residents' overall evaluation.
3. Each program will develop policies and procedures to handle incidents of unprofessional behavior, including documentation of the incident(s) and counseling o f the resident.
4. The assessment of professionalism must begin with a shared definition of the knowledge, skills and attitudes to be assessed. Some of the following sets of behaviors, but not all, comprise medical professionalism.*
   a. Physicians subordinate their own interests to the interests of others;
   b. Physicians adhere to high ethical and moral standards;
   c. Physicians respond to societal needs, and their behaviors reflect a social contract with the communities served;
   d. Physicians evince core humanistic values, including honesty and integrity, caring and compassion, altruism and empathy, respect for self, patients, peers, attendings, nurses, and other health care professionals;
   e. Physicians exercise accountability for themselves and for their colleagues;
   f. Physicians recognize when there is a conflict of interest to themselves, their patients, their practice;
   g. Physicians demonstrate a continuing commitment to excellence;
   h. Physicians exhibit a commitment to scholarship and to advancing their field;
   i. Physicians must (are able to) deal effectively with high levels of complexity and uncertainty;
   j. Physicians reflect critically upon their actions and decisions and strive for improvement in all aspects of their work;
   k. Professionalism incorporates the concept of one's moral development;
   l. The profession of medicine is a "self-regulating" profession, dependent on the professional actions and moral development of its members; this concept includes one's responsibility to the profession as a healer;
   m. Professionalism includes receiving and responding to critiques from peers, students, colleagues, superiors;
   n. Physicians must demonstrate sensitivity to multiple cultures;
   o. Physicians must maintain competence in the body of knowledge for which they are responsible - they must have a commitment to life long learning;
   p. The attributes of altruism and duty.

Swick, HM "Toward a Normative Definition of Medical Professionalism" *Academic Medicine* 75(6):612-6, 2000

It is not possible to list all accounts and behaviors which constitute unprofessional conduct. The following are some common types of unprofessional (and unacceptable) behaviors; cheating on scholarly activities, plagiarism, falsification of data on personnel records, medical records or other official documents, fraud, forgery, altering medical records without approval, sexual harassment, and inappropriate relationships between administrators, faculty and other supervisory personnel and a resident, alcohol or substance abuse, etc. A resident who exhibits a pattern of unprofessional behavior (e.g. repeated incidents) will be suspended and/or terminated from the residency program.

MEDICAL RECORDS

Statement of Policy

The resident is responsible for the preparation of a complete, legible and current medical record for each patient in compliance with all hospital, state and federal (e.g., CMS - Center for Medicare and Medicaid Services) and HIPAA - Health Insurance Portability and Accountability Act) regulations. The medical records system documents the course of each patient's illness and care; is available at all times and is adequate to support quality patient care, education of residents, quality assurance activities and scholarly work.

Procedures

- Records will be monitored weekly by Health Information Management (HIM) personnel for compliance. HIM personnel shall review the Medical Records of all discharged patients to ensure that the record is complete within the applicable timeframes as noted below.
  - Through this review process, physicians with incomplete/delinquent medical records are identified for appropriate notification as defined in the Medical Staff Bylaws, Rules and Regulations.
  - A "first letter" of notification will be mailed and faxed to all physicians who have incomplete records seven (7) days after date of discharge.
  - If, at fourteen (14) days after date of discharge, physician fails to complete all records provided, a letter of impending suspension will be mailed and faxed.
  - If, at twenty-one (21) days, the physician still has not completed all records provided, a certified letter will be sent to the physician's primary office by certified mail informing him/her that privileges will be suspended if all relevant medical records are not completed within nine (9) days. HIM, with the assistance of Medical Staff Leadership and Hospital Administration will attempt to contact the physician to make arrangements for record completion.
  - If, at thirty-one (31) days, the physician has failed to complete all relevant delinquent records provided, the physician will receive a notification of automatic suspension (per Medical Staff Bylaws, Article VIII, Section 8.3-3) and be restricted from practicing at Trident Health System, except for ER Unassigned Call Coverage at the discretion of the Medical Executive Committee and Board of Trustees. The physician shall remain suspended until all of the relevant delinquent records are complete. Reinstatement of these privileges shall be automatic upon documented completion of the relevant records.
  - HIM Director will send Notification of suspension to:
    - Administration
    - All Hospital Departments
    - Chief of Staff
    - Chief of Medicine
    - Chief of Surgery
  - If, at sixty (60) days after initial notification, any relevant medical records should remain incomplete, the responsible physician's Medical Staff Privileges will be terminated. Once all relevant delinquent medical records are completed, the physician will be eligible to reapply for privileges at Trident

Health System. This request for privileges will be handled in the same manner as a new application for medical staff membership.

If physician receives automatic suspension for delinquent medical records three times in one 12-month period, privileges will be terminated*. Once all delinquent medical records are completed, the physician will be eligible to reapply for privileges at Trident Health System. This request for privileges will be handled in the same manner as a new application for medical staff membership.

Note: Any suspensions $\geq$31days or terminations* related to failure to complete medical records may be reportable to the National Practitioner Data Bank, "if the failure to complete medical records is related to the physician's professional competence or conduct and adversely affects or could adversely affect a patient's health or welfare."

*Action regarding a physician's privileges is at the discretion of the Medical Executive Committee and the Board of Trustees.

QUALITY ASSURANCE/IMPROVEMENT ACTIVITIES

Statement of Policy

Although residency training in itself is a quality assurance/improvement activity of sorts, residents and faculty must participate in the same quality assessment and improvement process as other members of the Trident Medical Center's Medical Staff.

Procedures

1. Through the appropriate faculty, each resident is accountable to the hospital and its medical staff for quality assurance activities.
2. All quality assurance/improvement activities are performed in accordance with Trident Medical Center's hospital-wide quality assurance/improvement plan.
3. Quality assurance/improvement activities in the Hospital's clinics are monitored and coordinated separately through a designated faculty member in each training clinic.
4. All of the above activities are assisted and monitored by the Hospital's Quality Improvement Coordinator.
5. Identified patient care concerns are brought to the attention of the resident's faculty member and, through the faculty, to the resident. Remediation and improvement processes are carried out in accordance with the hospital's and clinical department's quality assurance plans.
6. Data from autopsies are used whenever possible to aid in both the continuous quality assurance processes and the residents' education.
7. Each residency program's quality assurance/improvement activities are reviewed annually by the GMEC or as part of the Internal Residency Review Process.

MALPRACTICE COVERAGE

Professional Liability Insurance

Trident Medical Center provides residents with medical professional liability insurance. This coverage includes all patient care activities required by the residency programs including any approved “internal” moonlighting. The policy is an “occurrence” policy; therefore, protection extends beyond the last day worked.

The policy will pay all sums the insured is legally obligated to pay, up to the limits stated in the policy, due to an occurrence which results in injury arising out of rendering or failure to render one or more of the professional services listed in the policy.

Residents are not covered under this policy for any act arising out of dishonest, fraudulent, criminal, malicious, or deliberately wrongful acts or omissions. The following are also not covered:

1. Any resident whose acts or omissions are responsible for false and fraudulent claims;
2. Any resident who violates or shows disregard for Federal and State statutes and regulations;
3. Any resident who engages in external moonlighting.

As a Trident Medical Center resident, you may have the opportunity to practice medicine in various facilities through out the state. Residents are to report occurrences according to the guidelines within various clinical departments, hospital, or facility where care is provided.

Residents must cooperate with the Medical Staff Office and Risk Manager upon any and all requests made to them.

NOTE: In the event a claim or suit is filed after a resident leaves Trident Medical Center, it is still the resident's responsibility to cooperate with the departments listed above. Again, the policy is “occurrence" based, therefore, residents will not have to purchase “tail coverage.”

Occurrences or Reportable Incidents “Occurrence” means any accident, incident, or other event (including non-action) which does occur or may reasonably be expected or intended by the insured.

Examples of occurrences

- unexpected death
- serious medication reaction
- loss of limb(s)
- hospital acquired fractures or lacerations
- loss of eye
- loss of reproductive function
- total or partial paralysis
- unplanned returns to the operating room
- unplanned transfers to a critical care unit

- delays in D/C greater than 2 days unplanned readmission or ER visit “against medical advice” situations

NOTE: The patient and/or family may believe an injury has occurred and bring legal action against a care giver.

Injury as Defined
“Injury” means bodily physical injury, sickness, disease, mental or emotional distress accompanied by physical manifestation thereof, or death resulting from any one or more thereof.

For physicians, the limits are in the amount of $1 million for each claim and $3 million in aggregate.

A representative from Risk Management is available to discuss any concerns residents may have about risk issues, reporting occurrences, insurance coverage, and responsibility for maintaining coverage. For further information, call 847-4006.

MOONLIGHTING POLICY

Statement of Policy

Residency training is a full time educational experience. Extramural paid activities (moonlighting) must not interfere with the resident's educational performance; nor must those activities interfere with the resident's opportunities for rest, relaxation, and independent study. As a result, residents are not required to engage in moonlighting activities as a condition for appointment to a Trident Medical Center residency program.

PROCEDURES

Moonlighting is defined as any activity, outside the requirements of the residency program, in which an individual performs duties as a fully-licensed physician and receives direct financial remuneration. This includes, but is not limited to:

1. Providing direct patient care
2. Conducting "well" physical examinations
3. Reviewing medical charts, EKGs, or other information for a company or an agency
4. Clinical teaching in a medical school or other educational programs involving clinical skills
5. Providing medical opinions or testimony in court or to other agencies
6. Serving as a "team" physician or medical official for an event

Any moonlighting by a resident who is employed by any of the following organizations is considered "internal moonlighting:"

1. Trident Hospital and its clinics
2. MUSC hospitals and its clinics
3. Ralph H. Johnson VA Medical Center and its clinics
4. Roper Hospital and its clinics
5. St. Francis Hospital and its clinics
6. East Cooper and its clinics
7. Any physician's office, clinic or medical facility which has an "affiliation agreement" with the resident's program

If a resident is employed by any other organization other than those listed above, it is considered "external moonlighting" and is to be reported as such.

Moonlighting privileges may be curtailed or prohibited by the Residency Program Director on any of the following grounds:

1. If it is determined that such activities interfere with the resident's patient care responsibilities and educational performance or if such activity adversely impacts the professional reputation of the resident and/or Trident Medical Center; or
2. If such limitation is required by the appropriate organization(s) responsible for the accreditation/certification of graduate medical education programs; or
3. If the resident fails to abide by the procedures outlined herein.
    a. It is the responsibility of the resident to obtain and provide professional liability insurance (malpractice) coverage for all “external” moonlighting. The Trident Medical Center bears no legal or professional responsibility for a resident while s/he is moonlighting at an outside facility (i.e. non- Trident Medical Center).

b. Moonlighting on a "limited license" is prohibited by the State Medical Board of Examiners. The resident is responsible to obtain a permanent South Carolina medical license.
c. If a resident "moonlights," the following conditions must be met:
    1) It must be clear that such activity does not violate the rules and regulations of any federal (e.g. CMS) or state agency, or patient care regulations (e.g. HIPAA) or accrediting (e.g. Joint Commission for the Accreditation of Healthcare Organizations) organizations and/or the facility's credentialing policies and procedures
    2) The resident must possess the written approval of his/her Residency Director. This written statement of permission must be kept in the resident's file in the department. The Resident's performance in the program will be monitored for any adverse effects from moonlighting. In such instances, the Program Director may withdraw his/her permission to moonlight.
    3) Moonlighting that occurs within the residency program, the sponsoring institution, the non-hospital sponsor's primary clinical site(s) and/or any sites affiliated with the residency program (i.e., internal moonlighting) must be counted toward the 80-hour weekly limit for duty hours.
    4) The Resident is responsible for reporting all moonlighting hours (i.e. internal and external moonlighting) using the E*Value system. Failure to report moonlighting hours will result in suspension and/or dismissal from the residency program.
    5) All moonlighting activities must be monitored by the residency Program Director and the documentation of this activity (i.e. hours per week) must be kept in the resident's file.

NOTE: THE RESIDENT MUST HAVE APPROVAL, IN WRITING, FROM HIS/HER PROGRAM DIRECTOR TO ENGAGE IN ANY MOONLIGHTING ACTIVITIES.

Residents working under J-1 sponsorship or an H-1B are prohibited from engaging in outside remunerative work of any kind or nature whatsoever in accordance with ECFMG and INS regulations.
1. Both J-I sponsorships and H-1B petitions are employer-specific.
2. Residents in violation are immediately considered in violation of status and are subject to disciplinary action up to and including termination from their program and deportation.

Any resident who fails to follow the moonlighting policy of Trident Medical Center and his/her program will be sanctioned for such actions including suspension and/or dismissal from the residency program.

A resident who is on "formal academic remediation" is prohibited from engaging in any moonlighting activities during the period of remediation.

Any questions regarding professional liability coverage must be directed to specific residency Program Directors.

EVALUATION OF RESIDENTS

Statement of Policy

Residents are evaluated in writing at the end of each clinical rotation by their faculty. Residents' "professionalism" is evaluated by other members of the health care team and included as part of the evaluation process. Residents are expected to evaluate each other in accordance with program policy. Once every six months, each resident receives a formal "summative evaluation" conducted by his/her Program Director (or designee). A written summary of this "six-month performance review" meeting is part of each resident's permanent file. All evaluation forms and reports will be maintained within the E*Value system.

Procedure

1. Each department has the right to use an evaluation method in compliance with its RRC requirements. All evaluation forms are approved by the GMEC.
2. These evaluation forms are completed by attending faculty upon completion of clinical rotations and other criteria.
3. Completed evaluation forms are signed by the faculty member(s) and the resident and are placed in the resident's file.
4. Evaluations of the resident by nursing, staff and other health professional who work with the residents will be considered in the overall evaluation of a resident's performance in accordance with departmental policy.
5. At the end of each six month period of training, the Program Director or a designated faculty member must meet with each resident to discuss the faculty's evaluations of the resident, the non-physician evaluations of professionalism and the peer (i.e. resident) evaluations. At this time, the resident is required to sign each of the faculty's evaluation forms to verify s/he has seen its content. A resident may write a letter of dispute for any evaluation s/he feels is inaccurate or incomplete.
6. During the six month performance review, the Program Director (or his/her designee) discusses the resident's performance as indicated by the evaluations. The resident's strengths as well as areas for improvement are noted; any corrective measures are also discussed. A written summary of this meeting, signed by the Program Director (or his/her designee) and the resident, is placed in the resident's permanent file.
7. Continued unacceptable or marginal performance, as noted on the evaluation forms, will be addressed through the development of a formal academic remediation program which details specific corrective actions. The resident will be considered on formal academic remediation during this period. The remediation program will include a timetable for completion and the actions to be taken as a result of the resident's performance during this period. Both the Program Director and the resident must sign the remediation program before it is implemented.
8. A copy of the remediation program for any resident on formal academic remediation must be submitted to the DIO for GME before the remediation period commences.

EVALUATION OF ROTATIONS AND FACULTY MEMBERS BY RESIDENTS

Statement of Policy

Residents are required to provide an evaluation of each rotation, including an evaluation of the faculty involved in that rotation. In addition, they are required to complete an annual summary evaluation of their own residency program and its faculty. All evaluation forms and reports will be maintained within the E*Valve system.

Procedures

1. At the end of each rotation, the resident is provided with a confidential evaluation form. This evaluation form includes questions on the rotation's content as well as the quality of supervision.
2. The resident completes the form and returns it to the residency program coordinator.
3. Residents will provide the Program Director with evaluations of the faculty member's teaching skills. These evaluations will be provided by using the GMEC-approved forms. Each program is responsible for determining the procedure by which the resident will evaluate the faculty's teaching skills.
4. At least annually, the residents will meet as a group or complete a survey to review the entire residency program and submit a report of this evaluation to the Program Director. This annual evaluation may include but not be limited to:
    a. each faculty member's supervision and teaching
    b. each rotation's benefits or deficiencies for achieving the learning objectives
    c. the quality of the didactic sessions
    d. the quality of research and scholarly activity
    e. the general working conditions
    f. the leadership of the Program Director
    g. the overall program goals and objectives
    h. the ACGME six competency areas in relation to the curriculum
    i. the resources available to the residents
5. To ensure proper anonymity of residents in completing these evaluations, Program Directors will provide each faculty member a "summary report" of the evaluations.
6. Program Directors and faculty are expected to use the information collected to continually improve the quality of the program. To this end, the summary of the annual program evaluation should specifically highlight these program changes.

PROMOTION, RESIGNATION, TRANSFER OR NON-REAPPOINTMENT OF RESIDENTS

Statement of Policy

Residents are promoted on the basis of acceptable periodic clinical evaluations, which may be augmented by other evaluation methods, by recommendation of their program's Promotion Committee, the Program Director, and by final approval of the GMEC.

Procedure

1. Each department's Residency Program Director and faculty members review the resident's performance during the academic year.
2. If it is determined by the department's Residency Program Director and faculty that the resident is eligible for promotion, this recommendation is forwarded to the GMEC and the GME Office.
3. In some cases, the Program Director and faculty may determine that a Resident be promoted to the next year but his/her Resident Agreement will not be renewed at Trident Medical Center.
4. If significant deficiencies in the resident's performance are identified, a plan for remedial work, including monitoring performance, may be arranged by the Resident's Residency Program Director. The Resident will remain at his/her current stipend level during the remediation period. If a Resident fails to make satisfactory progress in performance: 1) the Resident may be dismissed from the program or 2) the Resident Agreement may not be renewed and s/he will not receive credit for the work completed.
5. If significant deficiencies in the Resident's performance are identified and the Program Director and faculty determine that remedial program is not possible, the Resident will be dismissed from the program.
6. Any specialty resident or subspecialty resident (i.e., fellow) in an ACGME-approved program may request permission to resign from his/her current program or to transfer to another program at Trident Medical Center / MUSC or another institution during the academic year.
    a. This request must be made in writing to his/her Program Director.
    b. Upon receipt of this request, the Program Director will forward his/her recommendation to either approve or deny the request to the ACGME Designated Institutional Official (DIO) for GME.
    c. A request to transfer to another program within Trident Medical Center / MUSC must also include a letter of approval from the Program Director of the accepting program.
    d. If a resident requests permission to transfer to another program either outside or inside Trident Medical Center / MUSC at the completion of the current academic year, the resident must make the request, in writing, to his/her Program Director on or before March 1st of the current academic year.
    e. The Program Director's recommendation must be received by the DIO for GME by March 15th.
    f. The only exception to these two deadlines is for reasons of medical emergency or extenuating circumstances that may occur after March 1st. In those instances, the resident must notify the Program Director as quickly as the circumstances will allow. If the resident does not make the request before March 1st and transfers to another program at the completion of the

current academic year, the transfer will be considered unprofessional behavior and will result in academic sanctions against the resident.

   g. The final decision regarding the resignation, transfer and/or academic sanction(s) will be made by the DIO for GME.

7. In a situation where a resident is not going to be reappointed, the Program Director will provide the resident with written notice of intent not to renew the Resident Agreement with the resident. This notification must be made by March 1st of the current academic year. If the reason(s) for non-reappointment occur after March 1st, the resident will be notified as quickly as the circumstances will allow.
8. If a decision is made not to reappoint a resident, the resident can request a grievance hearing to review the decision. (See Grievance Procedure)

ACADEMIC DEFICIENCIES AND CORRECTIVE ACTIONS

Statement of Policy

Each Residency Program Director is responsible for assessing and monitoring each resident's academic and professional progress including knowledge, skills and professional behavior as well as adherence to departmental policies and procedures concerning resident education and the hospital's graduate medical education policies. If a Program Director determines that a resident should undergo a mental health assessment as part of an educational consultation, the cost for this evaluation will be provided by the Medical Staff Office and GMEC. Failure to meet the established academic standards will result in corrective action(s) up to and including dismissal from the program.

Procedure

1. Each Residency Program Director will devise written guidelines concerning resident accountability, monitoring and disciplinary actions, all of which are subject to the initial approval and annual review of the GMEC.
2. Policies regarding academic deficiencies will be generally uniform throughout all residency programs and will include the following categories of corrective actions:

    2.1 Oral Reprimands (OR) or Written Warnings may occur for deficiencies for which some corrective action is necessary. The resident will have the opportunity to correct the deficiency. If the deficiency is corrected, no further action will be taken. If the deficiency is not corrected, the resident may be placed on "formal academic remediation", suspended or dismissed from the program.

    2.2 Formal Academic Remediation (FAR) will be imposed for more serious and/or prolonged deficiencies. The resident will have the opportunity to remediate the deficiency within a defined period of time, as set forth in the "learning contract" established by the Program Director. The resident will receive a written document describing remediation measures to be corrected, the specific time period in which improvement must be demonstrated, and the possible consequences if no improvement is made. The resident will be required to sign this document.

    2.3 Suspension (S) may be imposed. During suspension, the resident will be removed from his/her clinical rotations and will not receive credit for training during this time period. Suspension will be for a specified period of time and specific corrective measures will be required. Following successful completion of the terms of the suspension, the resident will be placed on "formal academic remediation" upon reinstatement into the residency program as outlined in 2.2.

    2.4 Dismissal (D) of a resident may occur for academic reasons, disciplinary reasons, or if s/he is deemed to be an immediate threat to patient safety. (See Resident Dismissal Policy)

3. Prior to the imposition of any action that may result in formal academic remediation, suspension or dismissal, the Residency Program Director must submit the recommendation to the DIO.
4. A resident who does not report to work for three (3) consecutively scheduled work days, without speaking directly to his/her Program Director, will be dismissed from the residency program and his/her Resident Agreement will be terminated. The resident will have five (5) business days from the date of dismissal to contact the DIO for GME and explain the reason(s) for the failure to contact the Program Director. If the DIO for GME accepts the explanation, the resident will be reinstated. If the DIO for GME does not accept the explanation, the dismissal will be upheld.

RESIDENT DISMISSAL

Statement of Policy

A resident may be dismissed from his/her residency program. The resident has the right to appeal the decision through the Resident Grievance Procedure.

Procedures

1. Each Program will have regular evaluations of residents and will define specific criteria to recommend dismissal based upon these evaluations and/or other material(s) which document the reason for dismissal.
2. The Program Director will recommend dismissal by notifying the DIO for GME. The DIO for GME will conduct a thorough review of the resident's situation and share the results with the Program Director. In the event the DIO concurs with the program's recommendation, the DIO will notify the resident via certified mail and outline a specific time-frame for dismissal. The resident will be informed of the right to appeal the decision.
3. Reasons for dismissal include, but are not limited to, the following:
   a. Incapacitating illness, which, in the judgment of the Program Director and faculty, precludes the resident from participation in the graduate medical education program and patient care activities.
   b. Failure of the resident to abide by Trident Medical Center policies, GMEC policies, resident-related provisions of the hospital's Medical Staff Bylaws/Rules and Regulations, and/or any applicable federal and state laws.
   c. Failure of the resident to maintain satisfactory levels of academic and clinical performance as determined through periodic evaluations and a formal academic remediation plan.
   d. Actions which directly violate any of the terms of the Resident Agreement.
4. In the event of dismissal, the resident has the right to appeal the decision through the appropriate Resident Grievance Procedure, academic or disciplinary.
5. In the event the resident's dismissal is upheld after a formal grievance hearing, the DIO for GME will notify the South Carolina Board of Medical Examiners, the ECFMG when necessary, and when appropriate, the ACGME.

GRIEVANCE PROCEDURE FOR ACTION RESULTING FROM ACADEMIC DEFICIENCIES

Statement of Policy

The procedures as stated herein are for the purpose of residency matters related to the competency of the resident of a Trident Medical Center sponsored residency program. The affected Resident shall be entitled to a grievance hearing following: 1) a decision of dismissal from a program, 2) failure to obtain credit for academic work completed as a result of academic deficiencies, or 3) non-reappointment (i.e. non-renewal of the Resident Agreement).

Procedure

1. Upon receipt of written notice from the DIO for GME of a decision leading to an adverse action, a resident may request a review of that decision by the Graduate Medical Education Committee. The resident must make this request to the DIO for GME within ten (10) business days of receiving that notice.
2. The Resident must submit this request, in writing to the DIO for GME. Requests for a grievance hearing will not be accepted from anyone other than the affected resident. The DIO for GME, upon receipt of the request will appoint an ad hoc grievance committee of the GMEC and this committee will be convened to review the adverse decision. The ad hoc committee will consist of a Program Director, one Chief Resident, one faculty member, one medical staff member (not a member of the program faculty) and one hospital official. The Resident may choose the Program Director to be on the committee and either a faculty member or a hospital official. If the Resident making the appeal does not choose a Program Director or hospital official within ten (10) business days, the DIO for GME will appoint these individual(s).
3. The ad hoc grievance committee will meet within ten (10) business days of being named by the DIO for GME. The Resident will be notified, by certified mail, of the date, time and location of the meeting. The ad hoc grievance committee will review the Resident's record of performance and any relevant documents. The ad hoc committee may request and consider any additional information as the members deem necessary. The Resident may present any relevant information or testimony from any colleague or faculty member. The Resident is NOT entitled to legal representation during the ad hoc grievance committee hearing.
4. During the grievance hearing, the committee will consider the following questions:
    a. Was the Resident's performance judged using the same criteria and instruments as those used for other Residents in the program?
    b. Was the Resident notified of the specific deficiencies to be corrected?
    c. Was the Resident instructed to correct the deficiencies?
    d. Was the Resident placed on "formal academic remediation?" (If the Resident was <u>not</u> placed on "formal academic remediation," the Program Director must provide the reasons for that action.)
    e. Was the Resident's performance re-evaluated according to the terms of the remedial program.
5. The ad hoc committee shall then forward its recommendation to the DIO for GME, who, in turn, will notify the Resident of the final disposition. (i.e. There is no further appeal of a dismissal.)

6. If desired, the Resident may seek additional grievance through the Trident Medical Center Department of Human Resources noted below.

Statement of Policy:

To provide a step process of dispute resolution for employment-related disputes. This policy is designed to provide employees an opportunity to resolve certain employment-related claims in a fair and reasonable manner. The stop process is intended to assist the Affiliated Employers and their employees in creating and maintaining open, forthright and honest communication.

Procedure:

1. The Step Process. Employees are encouraged to first discuss any problems with their immediate supervisor. If resolution does not occur within a reasonable time, the problem is to be submitted in writing to the next applicable step. At each written step, the employee is responsible for identifying the problem, why it is felt that the action taken was inappropriate and what action is recommended to be taken. The Human Resources Department is available to assist employees in expressing their concerns in writing. The process to executive review consists of the following four steps that employees generally must follow to obtain a resolution of a problem:

   1. Discuss problem with Supervisor
   2. Appeal Supervisor's decision to Department Head
   3. Appeal Department Head's decision to Peer Review Panel
   4. Appeal Peer Review Panel's or Department Head's decision to CEO or designee.

- Step 1: Supervisor

  The employee is to meet with and discuss the dispute with his/her immediate supervisor. In situations where the dispute relates to the supervisor, the employee may consult with the Human Resources Department for guidance and go directly to Step 2. The Supervisor will provide a written response within seven calendar days of the meeting and send a copy to the Human Resources Department.

- Step 2: Department Head

  If the dispute is not resolved at Step 1 or if the Human Resources Department determines that Step 1 is not appropriate for use, the employee must submit the dispute in writing to the employee's Department Head within seven calendar days of the Supervisor's written decision in Step 1 or within seven calendar days of the determination of the Human Resources Department that the dispute should be initially submitted at the Step. The employee is responsible for identifying the dispute, why it is felt that the action taken was inappropriate and what action is recommended to be taken. If the employee takes no action within seven calendar days to advance the dispute, the employee is deemed to be in support of the decision at the prior level.

  The Human Resources Department is available to assist employees in expressing their concerns in writing. A written response from the employee's

Department Head will be provided within seven calendar days of the date the Department Head receives the employee's written request to consider the dispute. If the employee fails to raise the dispute to this Step, it is considered to have been resolved at the previous Step and the employee can take no further action concerning that dispute.

• Step 3: Peer Review Panel
If the dispute is related to a disciplinary action involving termination of employment, loss of status or loss of pay, the Department Head's response in Step 2 does not resolve the matter, and the employee wishes to pursue it further, the employee must submit it to the Peer Review Panel in writing within seven calendar days of the date of the Department Head's written response in Step 2. If the employee's complaint is not related to a disciplinary action involving termination of employment, loss of status or pay, the employee will proceed directly to Step 4 below. If the employee fails to raise the dispute to this Step, it is considered to have been resolved at the previous Step and the employee can take no further action concerning that dispute.

The Panel will be convened and administered by the Human Resources Department. The Panel will meet within 30 days of the receipt of the employee's written request to convene in order to review the dispute. This peer review process is unrelated to any state's licensure process.

The Panel will review the facts and make a decision based on the application of policy and procedure, and may award back pay and/or reinstatement, when appropriate. Although the Panel has the authority to decide whether or not a policy or procedure has been followed, the Panel does not have the authority to modify benefit plans, establish or change policies or procedures, or award monetary (compensatory or punitive) damages, nor does the decision of the Panel have the effect of setting a precedent. The decision of the Panel is subject to review by the Affiliated Employer's Chief Executive Officer or designee as appropriate, who must ensure that the Panel's decision is consistent with applicable laws, regulations, and policies.

• Step 4: CEO or designee
If the employee's complaint is not related to a disciplinary action involving the termination of employment or if the Peer Review Panel's response in Step 3 does not resolve the dispute, the employee may submit it to the Affiliated Employer's CEO or Corporate Senior Vice President as appropriate. If the employee wishes to proceed to Step 4, the written request for review at this step must be submitted within seven calendar days of the decision form either Step 2 or Step 3, whichever is applicable. The Human Resources Department will submit the documented problem for review and response. A written response will be provided by the CEO/designee within seven calendar days of the date the documented problem is received for review. If the employee fails to raise the dispute to this Step, It is considered to have been resolved at the previous Step and the employee can take no further action concerning that dispute.

2. <u>The Peer Review Panel Process.</u>

Panel Composition: The Panel will consist of five Affiliated Employer employees, and will be chaired by a Human Resources Representative. The Chairperson will convene the Panel and will serve as the facilitator for the meeting. The Chairperson is not a voting member of the Panel. Non-exempt employees shall be paid for time worked as a Panelist.

Panel Selection: Five Affiliated Employer employees will be randomly selected from a list of qualified employees who volunteer for participation in the dispute resolution program. Employees must have a minimum of one year of employment with the Affiliated Employer and have no current, written disciplinary action. The names of Panelists for each individual hearing are taken in rotation order from the lists maintained by the Human Resources Department.

A list of managers will be used to select the Panel for an employee who is a manager, lists of non-management employees will include a list of nurses to select the Panel for an employee who is a nurse, a list of clinical employees to select the Panel for an employee who is a clinician, and staff list to select the Panel for an employee who is neither a nurse nor a clinician.

For a non-management proceeding, three of the Panelists must be non-management employees, and two must be management employees. For a management proceeding, all five of the Panelists must be management employees. To ensure objectivity, the Panelists should not be in the same department as the affected employee, should not be familiar with the problem or have a close relationship with any of the parties involved. The affected employee may challenge the selection of one of the five Panelists.

Panel Proceedings: The proceedings of the Panel will be informal and conducted in accordance with the following guidelines:

a) The Chairperson will convene the meeting, introduce the parties, state the issues to be decided and present any pertinent information, including an explanation of policies and procedures involved, if necessary.
b) The parties (the employee and the department head or designee) will be permitted to present his or her case in accordance with such guidelines as to duration and manner of presentation as the Chairperson has established and communicated to the parties before the hearing.
c) Any party may present evidence in support of its position, including relevant documents and the testimony of witnesses; but a party may not present the testimony of more than three witnesses unless the Panel decides that there is good cause to allow additional witnesses. The Panel will determine what evidence it will consider and the weight such evidence will be given. The panel may permit a party to submit a written statement at the Panel meeting setting forth his or her position and the evidence supporting it.
d) At any time during the Panel meeting, after the initial opening statement by both parties, the Panelists may ask questions or request information form the parties or from the witnesses.
e) Immediately following the Panel meeting, the Panelists will convene in private to discuss the case and vote by secret ballot or by open vote on

the issues presented. The Panel decision shall be determined by a majority vote (3 of 5). The Panel's responsibility shall be to evaluate the facts presented and reach a decision based on those facts.
f) If the Panel decides that it needs additional information during its deliberation in order to reach a decision, it may hear additional testimony and/or consider additional documents.
g) Once a decision has been reached by the Panel, the Panel meeting will be reconvened and, with the parties present, the Chairperson will announce the decision. Alternatively, the decision of the Panel may be communicated to the affected employee by telephone or mail without reconvening the Panel. The Human Resources Department will ensure that all action required to implement the decision of the Panel are carried out promptly following review by the affiliated Employer's Chief Executive Officer or designee as appropriate, who must ensure that the Panel's decision is consistent with applicable laws, regulations, and policies.

Panelists: The Peer Review Panel process is an opportunity to participate in a process intended to ensure that disputes concerning the termination of employment are resolved in a prompt, fair and equitable manner. The issues presented may have serious and long lasting consequences. Employees selected as a Panelist are expected to:

- Render an objective and unbiased decision that is based only on the facts presented and the application of policies and procedures,
- Maintain strict confidentiality and not disclose any of the information learned during the process, and
- Participate fully in the Peer Review Panel process.

DISCIPLINARY PROBLEMS AND CORRECTIVE ACTION
(With Respect to State and Federal Laws)

Statement of Policy

Trident Medical Center has a disciplinary system which, depending upon the circumstances, gives the resident the opportunity to improve his/her performance or conduct after violating state or federal law.

Procedures

1. Residents are expected to abide by all applicable state and federal laws.
2. A resident, who is suspected of violating state or federal laws, will have corrective action initiated by his or her supervising faculty, Program Director, and/or the DIO for GME. Length of service and previous disciplinary and work performance records may also be considered. It is not possible to list all acts and omissions which may result in disciplinary action. Violation of these rules will result in disciplinary action ranging from written reprimands to dismissal depending upon the severity of the situation.
3. Any resident assisting other residents or employees to breach any standards before, during or after the fact, can expect to receive the same corrective action as the offender.
4. Each written corrective action report should contain the specifics of the misconduct discussed with the resident and signed by both the resident and the Program Director. The report should also outline what corrective action is required of the Resident. The signature of the resident is mandatory and acknowledges that s/he has received a copy of the report. If a resident refuses to sign the corrective action report, s/he will be suspended from the residency program. The completed corrective action report is forwarded to the DIO.
5. A resident who is dismissed will receive a final paycheck from the hospital for hours worked to the day of dismissal.
6. **Residents who engage in scientific research at Trident Medical Center are responsible for maintaining the integrity of all research projects in accordance with accepted policies, rules and guidelines.**
7. Residents who are dismissed have a right to submit a request for a formal grievance hearing within ten (10) working days. (See Grievance Procedure for Termination Due to Misconduct).
8. If a Resident is arrested or formally charged with any infarction of the law, other than a minor traffic violation and/or misdemeanor, the offending Resident shall report such violation or charges to his/her Program Director or the DIO for GME within 48 hours of the offense. The Resident will immediately be placed on an "administrative leave of absence" by the DIO for GME. If the Resident fails to notify his/her Program Director, Chair or the DIO for GME within 48 hours of the offense, the Resident will be suspended from the residency program. The DIO for GME, in consultation with the Residency Program Director and the Legal Office, will determine the conditions for reinstatement. The DIO for GME will notify the resident, in writing, of the terms of the leave of absence, or suspension, and the reinstatement.

GRIEVANCE PROCEDURE FOR TERMINATION DUE TO MISCONDUCT (“DISCIPLINARY CAUSE”)

Statement of Policy

The procedures as stated in this document are for the purpose of resolving matters related to the misconduct (i.e. violation of State or Federal laws) of a resident of Trident Medical Center. The affected resident shall be entitled to representation including legal counsel during these procedures. All directed and associated costs of legal or other representation, shall be the sole responsibility of the resident. Trident Medical Center shall reserve the right to be represented by an appointed member of the Trident Medical Center staff and/or legal counsel during these procedures.

RIGHTS OF PARTIES

Should a disciplinary matter be presented at a hearing, the parties thereto shall have a right to: call and examine witnesses, introduce exhibits, cross examine witnesses on any matter relevant to the issues, and/or rebut any evidence presented. The affected resident upon whose request that hearing is held may be called as a witness and fully examined by the committee.

HEARING

Should a hearing be requested, said hearing shall be conducted by an ad hoc committee of the GMEC appointed by the DIO for GME. The hearing will be conducted in an informal manner by the DIO as long as proper decorum is preserved.

RECORD

All findings and actions of the committee shall be recorded with sufficient accuracy to permit an informed, valid judgment to be made by any group who, at a later date, may be called upon to review the record and render a recommendation or decision on the issues. The hearing committees shall elect at its discretion the most appropriate method to be used for creating the record but not limited to: electronic recording, detailed transcription, or minutes of the proceedings.

QUORUM

The majority of the hearing committee shall be a quorum and must be present throughout the hearing and deliberations. If a hearing committee member is absent from any substantial part of the proceedings, that member shall not be permitted to participate in the deliberations and/or decisions of the committee.

POSTPONEMENTS

A request for postponement or delay of a hearing may be granted by the hearing committee upon the showing of good cause and only if in the committees’ judgment the request is timely.

RECESS OR CONTINUATION

The hearing committee may recess the hearing and reconvene the same without additional notice in order to accommodate the participants or for the purpose of obtaining new or additional evidence or consultation. Upon conclusion of the presentation of oral and written evidence by the parties to the hearing, the hearing shall be deemed closed. The hearing committee shall there upon give their timely deliberation to the issues outside the presence of the parties. Upon conclusion of its deliberations and a decision on the issues, the hearing shall be declared concluded.

SUMMARY SUSPENSION AND DISMISSAL

The Chairman of the Board of Directors, the President of the Medical Staff, the Chairman of the appropriate clinical department, or the Chief Executive Officer, each and individually, shall have the authority to request that a Program Director or his designee consider summary suspension of all or any portion of the clinical privileges of a Resident when in their sole discretion patient safety and well being may be in jeopardy. Summary suspension shall be effective immediately upon imposition and dismissal procedures may be commenced within five (5) days of suspension.

DISMISSAL PROCEDURE

A resident may be relieved of clinical duties at any time on the recommendation of any faculty member to the Program Director, when in the opinion of the Program Director such action is deemed as in the best interest of patient care. The resident will be fully advised of the reasons for such action and the action will be immediately communicated to the Designated Institutional Official for GME. Upon request of the resident, the reason for such action shall immediately be stated in writing. All efforts shall be made to reassign the resident to non-patient care activities consistent with his or her educational objectives for the period involved. If such action is indicated for reasons that can normally be considered to be transient or correctable by remedial assistance, a continuing review of the situation will be the responsibility of the Program Director who will return the resident to full activities as soon as possible. If such action is indicated for reasons not considered to be transient or remedial, the Resident will be dismissed.

AUTOMATIC SUSPENSION OF LICENSE

Statement of Policy

Action by the State Board of Medical Examiners revoking or suspending a resident's license or placing him/her upon probation shall automatically suspend all of his/her hospital privileges and may result in dismissal from the residency program.

Procedure

1. When a question arises concerning the dismissal of a resident, the Program Director shall first discuss the matter with the resident in a personal and informal conference. The resolution of the matter may invoke appropriate remedial action or the dismissal of the resident. The Program Director will write a letter to the DIO for GME recommending a course of action (i.e. remediation or dismissal).
2. If the DIO for GME concludes that there is sufficient evidence to justify dismissal from the residency program, the DIO for GME will notify, in writing, the Program Director, and the resident. This notification shall state:
   a. grounds for dismissal based on evidence of failure to meet the conditions of the resident's appointment to the training program. The resident's total professional behavior shall be considered.
   b. grounds for dismissal with sufficient information, particularly of the underlying facts, to fully inform the Resident of the reason for the dismissal.
3. If the Program Director recommends remediation, the DIO for GME will establish a hearing committee consisting of three individuals: a Program Director, a Chief Resident and a faculty member. The DIO for GME will preside over the committee.
4. The purpose of the committee will be to review the information regarding the Resident's actions leading to the suspension of his/her license as well as determine the appropriate remedial plan.
5. The remedial plan will be reviewed by the Program Director and signed by him/her and the resident.
6. The resident's salary and fringe benefits shall be continued during these proceedings until a final decision is made by the DIO for GME.
7. The above provision for termination for cause shall not apply to the decision to not reappoint a resident resulting from his/her failure to attain educational objectives of his/her training program. (See Grievance Procedure for Academic Deficiencies.)

SEXUAL HARASSMENT POLICY FOR RESIDENTS

Statement of Policy

Equal employment opportunities are provided to all employees and applicants for employment without regard to race, color, religion, sex, national origin, age, disability, or status as a Vietnam-era or special disabled veteran in accordance with applicable federal laws. This policy applies to all terms and conditions of employment, including, but not limited to, hiring, placement, promotion, termination, layoff, transfer, leaves of absence, compensation, and training.

This policy expressly prohibits any form of unlawful employee harassment based on race, color, religion, sex, national origin, age, disability, status as a Vietnam-era or special disabled veteran, or status in any group protected by state or local law. Improper interference with the ability of employees to perform their expected job duties is not tolerated.

With respect to sexual harassment, the following is prohibited:

1. Unwelcome sexual advances, requests for sexual favors, and all other verbal or physical conduct of a sexual or otherwise offensive nature, especially where:
   - Submission to such conduct is made either explicitly or implicitly a term or condition of employment;
   - Submission to or rejection of such conduct is used as the basis for decisions affecting an individual's employment; or
   - Such conduct has the purpose or effect of creating an intimidating, hostile, or offensive working environment.
2. Behaviors that engender a hostile or offensive work environment will not be tolerated. These behaviors may include but are not limited to offensive comments, jokes, innuendoes, and other sexually oriented statements, printed material, material distributed through electronic media, or items posted on walls or bulletin boards.

The interpretation of this or any Human Resource policy rests with the Human Resource Department who reserves the right to modify, change or discontinue the policy at any time.

Procedure

Each member of management is responsible for creating an atmosphere free of discrimination and harassment, sexual or otherwise. Further, employees are responsible for respecting the rights of their coworkers.

- If employees experience any job-related harassment based on sex, race, national origin, disability, or other factor prohibited by federal, state or local statute, or believe that they have been treated in an unlawful, discriminatory manner, they should promptly report the incident to their supervisor, who will investigate the matter and take appropriate action, including reporting it to Human Resources.
- If employees believe it would be inappropriate to discuss the matter with their supervisor, they may bypass their supervisor and report it directly to the Human Resources Department, which will undertake an investigation or they may call the

Ethics Line at 1/800-455-1996. The complaint will be kept confidential to the maximum extent possible.

• If it is determined that an employee is guilty of job-related harassment of another individual, appropriate disciplinary action will be taken against the offending employee, up to and including termination of employment. Any form of retaliation against any employee for filing a bona fide complaint under this policy or for assisting in a complaint investigation is prohibited.

PHYSICIAN IMPAIRMENT

Statement of Policy

The Trident Medical Center recognizes it has a fundamental duty and responsibility to assume the health and well-being of its residents. Physician impairment, due to alcohol, substance abuse and emotional illness, is often first manifested during medical school or residency training and may escape detection or intervention. Residents are entitled to the support of an educational environment that is protective, sensitive and able to intervene competency in potentially destructive and dysfunctional situations, without jeopardizing the residents' rights to confidentiality and the continuation of his/her residency training. Residents will be strongly encouraged to seek help or assistance for any problems with alcohol, drugs or mental illness that affect their ability to function as a resident.

Definition: For purposes of this policy, "impaired" shall mean under the adverse influence of alcohol or any narcotic or drug; or, mentally unable to reason, communicate or perform medical services in a safe and professionally acceptable manner or carry out any duties or assignments or requirements of the residency program.

South Carolina Recovering Professionals Program
Toll-Free, 24-hour Helpline 1-(877)-349-2094 or 1-(803)-737-9280
www.scrpp.org

Trident Medical Center Employee Assistance Program
Toll-Free, 24-hour Helpline 1-(800)-434-5100
www.hcabenefits.com

MUSC Center for Drug and Alcohol Programs (CDAP)
(843) 792-2727
www.musc.edu/cdap/

PROCEDURE

1. Impairment in a resident may be subtle or overt, but is most often first noticed as a significant and persistent change in behavior. Such changes may be manifested in any or all of the physical, emotional, family, social, educational or clinical domains of functioning. These behavioral changes are often referred to as "red flags." In the event that a faculty member, non-physician hospital staff member, resident, student or Program Coordinator notice these "red flags," s/he will notify the Program Director and/or the DIO for GME immediately.
2. The Program Director will contact the resident and demand to meet with the resident immediately. The Program Director will then contact the DIO for GME and arrange for the meeting to take place in a neutral location.
3. If the resident acknowledges a problem with alcohol, substance abuse or emotional problems, s/he will be removed from the clinical area and be tested for impairment. **The cost of this testing will be paid by the Resident.** The resident will be placed on an administrative leave of absence pending a further evaluation of their condition. The resident may be reinstated by the DIO for GME in consultation with the Program Director based on the results of the evaluation.

4. If a resident requires intervention in the form of inpatient treatment, s/he will be placed on a leave of absence. The resident may be reinstated by the DIO for GME in consultation with the Program Director, based on results of the treatment.
5. If a resident refuses to acknowledge a problem with alcohol, substance abuse or emotional problems, s/he will be removed from the clinical area. The resident will be asked to submit to a drug/alcohol urine test in order to rule out these factors. If the resident refuses to submit to this test, s/he will be immediately suspended from the residency program. The terms for reinstatement from the suspension will be determined by the DIO for GME and the Program Director.

6. If the resident fails to accept the terms of reinstatement from a leave of absence or from a suspension, or if the resident fails to satisfy the terms of his/her reinstatement or treatment, s/he will be dismissed from the residency program.

Warning Signs of Impairment

- Performance Deteriorates
  - Inconsistent work quality and lowered productivity. Spasmodic work pace deteriorated concentration, signs of fatigue
  - Increased mistakes, carelessness, errors in judgment
- Poor Attendance and Absenteeism
  - Absenteeism and lateness accelerate, particularly before and after weekends
  - Often the complaint of flu, stomach distress, sore throat, headache, or other vaguely defined illness
- Attitude and Physical Appearance Changes
  - Details are often neglected, assignments handled sloppily
  - Others are blamed for the individual's own shortcomings
  - Colleagues and the supervisor himself are often deliberately avoided
  - Personal appearance and ability to get along with others deteriorates
  - Colleagues may show signs of poor morale and reduced productivity, often because of the time spent "covering up" for the substance abuser
- Health and Safety Hazards Increase
  - A higher than average accident rate emerges
  - Careless handling and maintenance of machinery and equipment
  - Taking of needless risks in order to raise productivity following periods of low achievement
  - Disregard for safety of colleagues
- Domestic Problems Emerge
  - Complaints about problems in the home and with the family increase. There is talk of separation, divorce, delinquent behavior in children
  - Financial problems recur with frequency

It is impossible to note all the behavioral symptoms that may occur in this process of deterioration, or to define precisely their sequence and severity. They may appear single or in combination, and they may very well signify problems other than substance abuse.

REDUCTION/CLOSURE POLICY FOR RESIDENCY PROGRAMS

If the ACGME withdraws accreditation of a program, or if a decision is made voluntarily to close a residency program, the Medical Staff Office will work with the program to establish a phase-out plan that allows currently enrolled residents to complete their training. If that is not possible, the Medical Staff Office, in conjunction with the program, will assist the displaced residents in obtaining positions in another accredited training program.

In the event, Trident Medical Center decides to reduce the number of positions in any residency training program, the residents in that program will be notified by the DIO for GME. Every effort will be made to accomplish the reduction without adverse effect on residents currently in training. If that is not possible, the Medical Staff Office, in conjunction with the program, will assist the displaced residents in obtaining a position in another accredited training program.

1. Resident Salaries
2. Benefits
    I. Annual Leave
    II. Sick Leave
    III. Maternity
    IV. Bereavement Leave
    V. Professional Leave of Absence
    VI. Insurance Coverage
    VII. Parking Permits
    VIII. On-Call Meals
3. Family and Medical Leave Act
4. Uniform/Lab Coats
5. Harper Student Wellness Center
6. Employee Health

    Workers Compensation Form
7. Vaccines
8. Student Loan Deferments
9. Resident Separation Policy
10. Resident/Fellow Clearance Sheet

RESIDENT STIPENDS

Statement of Policy

The following Resident stipends (approximate) are set for July 1 – June 30. Stipends will be reevaluated in the spring of each year and any changes will be made effective July 1 each year. All Residents will be notified if there are changes to the established stipend levels.

PROCEDURE

1. Resident stipends (approximate)

Year	Amount
PG-1	$45,000
PG-2	$47,250
PG-3	$48,500

2. This policy is reviewed and revised annually.

BENEFITS

I. Annual Leave with pay may be given per twelve month period as specified by the Trident Medical Center Department of Human Resources, unless specifically limited as required for specialty board certification. Time away from Trident Medicine Center for job interviews, board exams, meetings and conferences must be taken as annual leave unless other arrangements are approved by the Program Director according to departmental policy. Annual leave is granted at the discretion of the Program Director and must be approved, in writing, by the Program Director (or his/her Designee) in advance.

> Note: Annual leave, like all other benefits to residents, does not carry over from year to year. It does not accrue over time. The Resident Agreement is for one year only, thus, at the end of each year, the terms of the agreement are void, which means all benefits end on the final day of the Agreement.

II. Sick Leave with pay may be given per twelve month period as specified by the Trident Medical Center Department of Human Resources. Under certain circumstances, additional sick leave (e.g., Family Medical Leave Act) without pay may be granted with the written approval of the Program Director, who will send a copy of this approval to the Graduate Medical Education Office. The Resident may be required to "make-up" any time missed in accordance with the Residency Program and Board Eligibility requirements.

III. Maternity Leave will be granted per twelve month period as specified by the Trident Medical Center Department of Human Resources. The Resident may request additional "unpaid" time off. This request must be approved by the Program Director in writing, in advance. If an ACGME RRC and/or the Specialty Board restricts annual time off to less than six (6) weeks in an academic year, the Program Director will defer to the allowable RRC and/or Specialty Board Eligibility requirement(s).

Paternity Leave will be granted to the spouse/partner after the birth or adoption per twelve month period as specified by the Trident Medical Center Department of Human Resources. This Sick Leave time is to be counted as part of the three weeks described previously.

Any Resident who is on Maternity/Paternity Leave may be required to "make up" time missed while on leave in accordance with the RRC or Specialty Board Eligibility requirements.

Official Approval for Maternity/Paternity Leave - The Resident must make a written request for Maternity/Paternity leave to the Program Director the beginning of the Second Trimester so that appropriate accommodations (e.g. rotation schedules, call schedules, etc.) can be made. If the Resident is pursuing adoption, the Resident must notify the Program Director, in writing, at the time of adoption request filing. The total duration of Maternity/Paternity leave must be approved, in writing, by the Program Director or his/her Designee using the GME Maternity/Paternity Approval form. A copy of this approval form must be received by the individual program coordinator one month before the Resident begins the Maternity/Paternity leave in order for the leave to be official.

A Resident who is approved for maternity or paternity leave must comply with the

requirements of the federal Family Medical Leave Act (FMLA). (See "Salaries and Benefits")

IV. Bereavement Leave with pay shall be given per death of an immediate family member (i.e., parents, siblings, grandparents, children or spouse) as specified by the Trident Medical Center Department of Human Resources. The Resident may be required to "make-up" the time missed in accordance with the Residency Program and Board Eligibility requirements.

V. Professional Leave of Absence may be granted under special circumstances and will be handled on an individual case-by-case basis by the DIO for GME in consultation with the Residency Program Director. The terms and conditions of the leave of absence will be given to the resident in writing. The Resident may be required to "make-up" the time missed in accordance with the Residency Program and Board Eligibility requirements. Terms of reinstatement after a Leave of Absence will be developed, written and approved by the Program Director and the DIO for GME before the resident will be permitted to return to the residency program.

In the event of military leave, the resident is required to provide his/her Program Director with a copy of the military "orders." The orders should contain the time of deployment and locations. The Program Director must prepare a plan for the resident to "make up" time away from the residency program. The plan, along with a letter approving the LOA, should be submitted to the DIO for GME along with a copy of the military orders. Any resident that is required to fulfill military obligations, MUST still complete all the training program requirements for Board eligibility. This may require a change in the original date for the completion of the program.

VI. INSURANCE COVERAGE: Insurance coverage shall be available to the resident through:
A. Health Insurance - The resident will receive health (including hospitalization) and dental at nominal cost. Dependents are covered at the Resident's expense.
B. Life Insurance
C. Travel Insurance - All Trident Medical Center residents are covered by Workers' Compensation which is designed to provide benefits for individuals who have incurred medical expenses or are unable to work due to bona fide occupational injuries or illnesses.
D. Disability Insurance
E. Professional Liability Coverage - The resident will be covered for malpractice liability while performing duties and responsibilities in the program. The policy provides $??? per medical occurrence and the coverage will extend beyond the time in residency from incidents that occurred during their training (i.e., "tail coverage) AMOUNTS AND OTHER INFORMATION PER TRIDENT

VII. Meals: Trident provides meals from the cafeteria and physician lounge.
Procedure:
1. Each resident is eligible to receive meals in one of the above venues. During evening hours and on weekends, meals are available in the cafeteria only.
2. Any misuse or abuse of meals provided to residents will result in the loss of allotments from this source for the remainder of the year.

Family and Medical Leave Act

Graduate Medical Education/ Resident Program

Statement of Policy

The Extended Sick Leave (ESL) Policy is ancillary to the PTO program. The goal of ESL is to provide income protection to eligible full-time employees. ESL hours are provided hours and are not accrued hours. Full-time employees receive ESL hours based on their full-time status. ESL hours will be provided to all qualified employees who have met the employment period requirements as indicated in the policy detail.

Procedure

I. Accrual Rates

A. Extended Sick Leave hours will be provided to full-time regular employees each pay-period. Full-time 2.77 hours/pay period or 9 days annually.

B. The maximum accumulation for a full-time employee is 840 hours. This is based on a minimum of 7 years of service. The number of hours provided would begin on the pay period in which the 91st day of employment starts. All rehire rules will apply to the provided ESL time.

II. Use of ESL

A. Extended Sick Leave time off will start after 24 hours of consecutively scheduled work time off due to personal disability or illness. Paid-Time-Off (PTO) will be used for the first 24 hours of illness or disability. The 24-hour period may be split into (3) eight-hour shifts or (2) 12-hours shifts. If PTO time is unavailable, the time will be unpaid. It is the supervisor's responsibility to monitor this process. Employees who are on formal approved Family Medical Leave or approved General Medical Leave may sue ESL immediately.

B. Employees who are absent due to illness or injury three consecutively scheduled workdays or more must provide Human Resources and his/her respective department director with a physician's release to return to work, The work release must indicate that the employee can return to work without restrictions if the illness or injury is not work related. If any regular part-time or full-time employee is absent for more than 5 consecutive scheduled work days, the employee should be instructed to complete all qualifying Medical Leave or Family Medical Leave Act forms. Department managers should send the employee or an immediate family member to Human Resources in the event of a prolonged absence. Immediate family members should also contact Human

Resources as soon as possible.

C. Employees may not transfer ESL hours to another employee for any reason.

D. ESL is used primarily for the employee's personal illnesses. An employee will be permitted to use ESL, when of formal approved FMLA, for an immediate family member; current spouse, child, father or mother for 72 hours only. Time spent away form work under the FMLA act past the 72 hours will require unpaid leave or the use of PTO hours.

E. ESL can be used for full days only. No less than eight-hour increments can be used at a time. Employees are responsible for checking the qualifications under the Family Medical Leave (Policy A.HRD.05.03.B). Qualified FMLA employees must have worked 1 year and completed 1250 hours of worked/productive time. Employees who qualify for Family Medical Leave Act time may use ESL time immediately upon being placed on formal FMLA leave. Formal leave is identified at the time in which the paperwork has been completed and returned to Human Resources. In the event of an emergency, ESL time may be retroactively placed to the date of the emergency. When all ESL time has been used for personal FMLA time, the employee will then be required to use PTO time.

F. Full-time employees who change status to part-time and have accumulated ESL time, will be permitted to use the provided ESL hours for personal illness only. Part-time employees will not be provided ESL while in a part-time status.

III. Reinstatement Following Illness

Reinstatement following any period of absence due to illness, whether or not covered by sick leave, will be handled as provided for in the Leave of Absence Policy and in accordance with Federal and State laws.

IV. Department Directors and Above

Department Directors and above will be provided ESL hours equal to his/her years of service with the company. The maximum number of hours provided will not exceed 840 hours. Human Resources will be responsible for making any changes in the directors provided ESL hours. All provided time will be changed on January 1st of each year following the original hire date. As of the initial effective signature date of this policy, active directors and above will be grand-fathered into the system with his or her existing hours.

0-3 years 320 hours

3+ to 7 years 640 hours
7+ years 840 hours

V. Transfer

Regular Full-time transferring employees may transfer ESL hours upon transfer. The number of hours transferred from another HCA facility cannot exceed the maximum level of accrual based on the number of years of experience indicated above.

VI. Terminated Employees

Employees who are separated from the Health System for any reason will not receive any pay out of ESL hours.

UNIFORMS/LAB COATS

Statement of Policy

New residents at the Trident Medical Center are provided with two new white clinic lab coats. After the first year, each resident will be provided with one new white clinic lab coat at the beginning of each new year of training. The Medical Staff Office will NOT provide new lab coats for name changes. If a resident changes programs, s/he is provided with two new lab coats during his/her first year and one new lab coat each subsequent year of training. If a resident sub-specializes in the same department, s/he receives only one new lab coat each year of training.

Procedure

1. All PGY-1 residents and any other resident who is new to the Trident Medical Center will pick up their lab coats from the departments prior to July 1st of each year.
2. All PGY-2 and up residents will be notified by the respective residency program regarding the date to register for a replacement lab coat. Each department/division will be responsible for reordering the replacement lab coats.

EMPLOYEE HEALTH

Statement of Policy

1. Health assessment screenings, including a pre-employment drug test, are required of all new residents and shall be scheduled and completed prior to starting their program. Appointments for health screenings will be scheduled by the designated representative within each program. Confirmation that the employee has completed the health screening shall become a part of each resident's personnel record.
2. Tuberculin (TB) testing and evaluation or TB symptom updates will be done on all paid and non-paid employees who have the potential for exposure to M. tuberculosis. Each employee will be assigned a level of TB risk and corresponding testing intervals. Frequency of TB testing is dependent upon each employee's work environment (Level 1 = Annual testing, Level 2 = Every 6 months testing for high risk areas, Level 3 = Every three months post exposure follow-up, Level 4 = Every two years for employees not working or frequenting hospital facilities, i.e. business offices off campus).
3. All residents entering Trident Medical Center programs will not be authorized to begin their programs unless they satisfactorily complete a drug screen test. If they refuse or test positive to drug use, they will be reported to their Program Director and the DIO for GME for further action.
4. Residents with job related injuries will be treated by the Trident Medical Center Employee Health Services. Worker's Compensation Reports for job related injuries must be completed by the Program Director.

PROCEDURE

1. On the Job Injuries
    a. For any on the job injuries, residents should report immediately to their Program Director and a Workers' Compensation Employer's First Report of Injury or Illness Form (ACORD) should be filled out and signed by the Program Director. The resident should then report to Trident Medical Center Employee Health Services if the incident occurs Monday-Friday 7:00 a.m. - 5:00 p.m. If assistance is needed after hours or on weekends or holidays, the resident should report directly to the Emergency Department. Note: If the injury is an ocupational exposure to blood borne pathogens, the resident should contact the Employee Health Nurse at 847-4938. **It is extremely important all blood borne pathogen exposures be reported within two hours so that the appropriate medical attention can be administered.**

2. Non-Job Related Injuries
    a. Injuries or illnesses which are non-job-related and non-emergent should be cared for by the resident's private physician. (Residents with acute injuries/illnesses can be seen in the Emergency Services department at anytime.)
    b. Trident Medical Center Employee Health Services will not provide residents with permission to be excused from work due to non-job related injuries or illnesses. It will be the responsibility of the Program Director to make the decision when a resident requests to leave work because of illness or to receive medical treatment. Program Directors will not be asked to make

medical decisions, but to make sound decisions, based on their observations of the resident.

VACCINES

Statement of Policy

Residents are required to have a physical exam with Trident Medical Center Employee Health Services. All immunization records are required the day of the exam. If residents do not bring previous immunization records, he/she will receive all necessary vaccines on arrival. Physical exams will be limited to examination of those organ systems whose impairment will substantially impact the ability of the resident to perform the essential duties of the job.

Measles

A. Born before 1957:
1. Documented measles or MMR given after 1967

B. Born in or after 1967,
1. Two documented live measles given after 1967, OR
2. Two documented MMR vaccines, OR
3. Documented positive titer
4. If none of the above, vaccination WILL be required.

Rubella

1. One Documented Rubella, OR
2. One documented MMR vaccine, OR
3. Documented positive titer.

Varicella

1. Reports past history of Chicken Pox or positive titer.
2. If negative history or unknown, perform titer.
3. If non-immune, vaccinate with two doses.

Tetanus

1. Reports Tetanus booster within the past ten years
2. If not, vaccinate Document refusals

Hepatitis B Recommended for employees with expected blood/body fluid contact.

1. Documentation of dates vaccine given
2. Sign declination if refusing vaccine or have had the vaccine in the past and do not have documentation.
3. If unknown, titer. If titer negative, vaccinate.

TB

1. Documented PPD skintesting within the last three months
2. New employees over 40 years may have 2 STEP PPD testing initiated.
3. Persons with a positive or newly positive PPD must:
    a. Show documentation of a past positive
    b. Provide Carolina Center for Occupational Health with a clear CXR report at or following the time of the PPD conversion.
    c. Document a TB sign and symptom sheet

Vision

1. Color Discrimination testing for all clinical personnel performing reading for urine dip, glucose, hemocult, etc.

STUDENT LOAN DEFERMENTS

Certain undergraduate and medical school loans can be deferred for part or all of a resident's training period. The individual residency programs are authorized to complete deferment and forbearance forms. Residents should contact the appropriate lender requesting these forms. The residency program will process the forms and keep copies of them within the resident's personal file.

RESIDENT SEPARATION POLICY

Statement of Policy

Residents are required to exit through their specific residency program office before their last working day at the Trident Medical Center. This exit process is to ensure that all appropriate paperwork is completed before the resident leaves. The resident's certificate will be held in the residency program office until this information is provided.

Procedures

1. The resident must turn in the following to the residency program office upon termination, resignation, or completion of program:
   a. Picture ID badge
   b. Controlled Substance Card
   c. VA ID badge (if applicable)
2. Parking Cards are to be turned in to the Program Coordinator.
3. Beepers are to be turned in to the Program Coordinator.
4. The resident must be cleared by the Department of Health Information Services.
   NOTE: All Medical Records must be completed and returned.
5. The resident must provide the residency program office with a forwarding address.

Institutional Disaster Policy

Statement of Policy

The Family Medicine and Transitional Year Residency Programs operate as members of the organized medical staff and follow the Trident Medical Center's Emergency Preparedness Plans. In the event of a major disaster requiring resident reassignment, the Institution will assist residents in continuing their training in one of the HCA-affiliated hospitals (Colleton Medical Center, Summerville Medical Center, Grand Strand Regional Medical Center) or in transitioning to another one of the South Carolina Area Health Education Consortium residency programs.

Procedures

See Appendix 4.

Internal Residency Review Process

Statement of Policy

The purpose of the Internal Residency Review process is to assess both ACGME accredited programs compliance with the Institutional, Common and Program Requirements. In addition, the Review should assess whether each program has defined, in accordance with the relevant Program Requirements, the specific knowledge, skills and attitudes required, and provide educational experiences for the residents to demonstrate competency in the following areas: patient care skills, medical knowledge, interpersonal and communication skills, professionalism, practice-based learning and systems-based practice. The internal review is to provide evidence of the program's use of evaluation tools to ensure that the residents demonstrate competence in each of the six areas. The internal review is to appraise the development and use of dependable outcome measures by the program for each of the general competencies and to appraise the effectiveness of each program in implementing a process that links educational outcomes with program improvement. The internal review is to appraise the educational objectives of the program, the effectiveness and the adequacy of available educational and financial resources to meet these objectives, and the effectiveness in addressing any citations from previous ACGME letters of accreditation and previous internal reviews.

Procedures

1. The GME Committee has appointed an internal review committee consisting of a Chair (who is a Program Director from a program other than the one being reviewed), one faculty member, a resident (from a program other than the one being reviewed), and a hospital administrator. The committee is staffed by one member of the GME Office. An external reviewer may also be included on the committee as determined by the GMEC.

2. Internal reviews are conducted on both ACGME-accredited residency programs. A scheduled review takes place at midpoint between ACGME site visits. All programs are given notification of the internal review by the GMEC at least one year out and reminders are sent regularly starting two months prior to the actual internal review.

3. Program Directors are required to go to the ACGME website and print out the PIF for their program for completion.

4. Faculty members are given a questionnaire to complete and are returned with all PIF documents for review.

5. Residents are given a questionnaire to completer and are returned with all PIF documents for review.

6. Residents complete an interview survey.

7. The Committee reviews the completed Internal Residency Review Document (i.e. PIF, Faculty questionnaire results, resident questionnaire results, and summary of

resident interview), letters of accreditation from previous ACGME reviews, reports, if any, sent to the ACGME from the program, the last Internal Review Report, if applicable and Program, Common and Institutional Requirements.

8. A meeting is held where the Internal Review Committee interviews the Program Director, the residency coordinator, peer selected residents from each level of training, and any faculty or persons related to the program being reviewed, as needed.

9. During the internal review the panel will assess:

a) the educational objectives of the program;
b) the effectiveness of the program in meeting is objectives;
c) the adequacy of available educational and financial resources to support the program;
d) the effectiveness of the program in addressing areas of noncompliance and concerns in previous ACGME accreditation letters and previous internal reviews;
e) the effectiveness of the program in defining, in accordance with the Program and Institutional Requirements the specific knowledge, skills, attitudes, and educational experiences required for the residents to achieve competence in the following: patient care, medical knowledge, practice-based learning, and improvement, interpersonal and communication skills, professionalism and systems-based practice;
f) the effectiveness of the program in using evaluation tools developed to assess a resident's level of competence in each of the six general areas listed above;
g) the effectiveness of the of the program in using dependable outcome measures developed for each of the six general competencies listed above; and,
h) the effectiveness of each program in implementing a process that links educational outcomes with program improvement.

10. Following the interviews, the Internal Residency Review Committee meets to consider their findings and prepares a written report. The original report is reviewed by the Internal Review Committee and the Program Director for accuracy. The report must address strengths, weaknesses, concerns, opportunities as well as future goals, and mechanisms for follow-up.

11. The GMEC reviews the report at its next regular meeting and makes recommendations for follow-up as appropriate. The GMEC votes on the report and either approves or disapproves.

12. Approximately six months after the internal review, a member of the Internal Review Committee will meet with the program director and follow-up on the recommendations of the review panel. If any concerns were cited, the Program Director and the member of the Internal Residency Review Committee will work together to address and correct the concerns and will submit a report to the GME Committee. Approximately one month prior to the ACGME conducting their program survey, there will be a meeting to reassess the program and assure that concerns and issues have been addressed and corrected and the program is prepared for their site visit. The completed PIF will be reviewed at that time.

TRIDENT MEDICAL CENTER

RESIDENT CLEARANCE SHEET

I, _________________________ , signify by the signatures below that I have no unfulfilled commitments or outstanding obligations as a specialty/subspecialty resident at the Trident Medical Center.

Trident Medical Center / MUSC Identification Badge:
Your ID badge must be returned to your Department:
Received by:____

Medical Records:
Any outstanding medical records (including primary care records) must be completed prior to sign off by Medical Records.
Received by:____

SIMON Pager:
Your pager must be returned to the Program Coordinator.
Received by:____

NEW POSITION
Residency or
Fellowship____________________________________Institution:_________________
Academic
Faculty:______________________________________Institution:__________________
Private Practice
Address:____

____

Other____

W2 FORWARDING
ADDRESS:____

Signed:____

Dated:____

Please return this form to your program coordinator.

NOTE: You will receive your program certificate upon completion of this clearance sheet.

APPENDIX 1: RESIDENT AGREEMENT

The 2007 - 2008 Resident Agreement is available as a PDF:

APPENDIX 2: EVALUATION FORMS

Assessment of Resident Professionalism
Clinical Performance of Residents
Resident to Resident Assessment
Clinical Rotations
Resident Evaluation of Faculty Teaching Skills
Student Evaluation of Resident and Clinical Faculty
Conferences and Seminars

APPENDIX 3: MOONLIGHTING AND LEAVE OF ABSENCE FORMS

Moonlighting Approval Form
Leave of Absence Form

Appendix 4: Institutional Disaster Policy