



**School of Medicine**

**LOUISIANA STATE UNIVERSITY  
HEALTH SCIENCES CENTER  
SCHOOL OF MEDICINE – NEW ORLEANS  
GRADUATE MEDICAL EDUCATION  
POLICY AND PROCEDURE MANUAL**

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## ACCEPTANCE OF NEW 2011 COMMON PROGRAM REQUIREMENTS STATEMENT

The institution through the GMEC supports the spirit and letter of the ACGME Duty Hour Requirements as set forth in the Common Program Requirements and related documents July 1, 2003, 2011 and subsequent modifications. Though learning occurs in part through clinical service, the training programs are primarily educational. As such, work requirements including patient care, educational activities, administrative duties, and moonlighting should not prevent adequate rest. The institution supports the physical and emotional well being of the resident as a necessity for professional and personal development and to guarantee patient safety. The institution has developed and implemented policies and procedures through the GMEC to assure the specific ACGME policies relating to duty hours and supervision are successfully implemented and monitored.

On February 17, 2011 the GMEC passed a resolution that each training program must have a policy and process for each of the following areas and a method to monitor and assure effectiveness of each:

- Assuring effective transitions (hand offs)
- To encourage residents to use alertness management strategies
- Monitor residents use of strategic napping
- Monitor frequency and intensity of house call events
- Ensure each case in which a resident stays longer than 24+4 is documented and reviewed
- Ensure continuity of care is ensured incase a resident may be unable to perform their duties
- Set specific guidelines for when residents must communicate with their attending.
- Assure residents and faculty inform patients of their respective role in patient care.
- Demonstrate appropriate levels of supervision are in place for all residents
- Develop rotational schedules associated with attending call schedules in New Innovations
- Develop guidelines for supervision

All of the noted above methods will be monitored by the institutional during the Program End of Year Reports, Program Performance Reviews, and Internal Reviews.

The institution has developed Core Curriculum Modules on Sleep Fatigue and Mitigation. These modules must be completed by both faculty and residents to remain compliant and up to date with institutional policies and regulations.

## **ACGME COMMUNICATIONS WITH PROGRAMS**

According to the ACGME Institutional Requirements beginning July 1, 2003 the Graduate Medical Education Committee must review and approve the following types of communication between programs and the ACGME (RRC) prior to submission to the ACGME:

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

Should a program have a submission of the above to the ACGME, it must notify the GME Office by the 5th of the month in order for the item to be placed on the monthly GMEC agenda (meetings are held the third Thursday of each month.). Programs are responsible for entering there submissions into WebADS (if applicable) prior to the GMEC meetings.

## **ACGME ABSENCE OF THE DIO/SIGNATURE AUTHORITY PROCEDURE**

In the absence of the DIO the Director of Accreditation reviews and cosigns all program information forms and any documents or correspondence submitted to the ACGME by program directors including all items listed in IR III B 10 a-k. (Approved GMEC Oct. 2007)

## **ACGME CHANGE IN PROGRAM DIRECTOR REQUEST POLICY**

All requests for new program director’s must be initiated by the DIO through ADS (staff of all RRCs will no longer accept requests submitted via paper or email). To initiate a change in program director, the DIO must log into ADS and under *Program and Resident Information*, select *Initiate PD Change* from the menu on the left. The DIO must then click on the *Request PD Change* icon for the appropriate program and is then prompted to respond to several questions. The DIO must also verify that the new PD meets the required qualifications and is approved by the GME Committee.

An email which provided the login information will be automatically sent to the new PD when the request is initially submitted by the DIO. The program director must log into ADS to complete professional and certification information, as well as other required documentation. After the request is complete and submitted, the new program director’s name will be posted in ADS and the submitted materials will be forwarded to the review committee staff.

## **ACGME LETTERS OF AGREEMENT**

The ACGME is requiring all programs to have Letters of Agreement with the Major or Participating Institutions (Affiliating Entities) where their residents rotate. These letters are not part of, nor, take away from the required Contracts, Affiliation Agreements and Supplements which are administered through the LSUHSC Contracts Office. Each Letter of Agreement (3 originals of each) requires the program directors signature and the person/faculty who oversees the residents at the affiliating entity (etc) signature in addition to a signature from the affiliating entity (CEO, or Medical Director) if applicable. The Letter of Agreement is good for five years unless a program director or oversight person changes at the institution. In that case a new letter must be executed. It is the responsibility of the individual programs to execute the ACGME Letters of Agreement. A template for the ACGME Letters of Agreement can be obtained in the Office of Graduate Medical Education

**One original stays in the training program files, the second original must be submitted to the Director of Accreditation in GME, and the third original must remain at the participating institution for their files.**

## **ACGME POLICY ON SPONSORSHIP OF PROGRAMS**

The ACGME does not recognize co-sponsorship of residency training programs. The ACGME mandates that there be one sponsor that assumes the ultimate “educational” responsibility for the AGME-accredited programs. The ACGME seeks assurance that the sponsoring institution ensures that there is adequate financial support for the residents to fulfill the responsibilities of their educational program. The sponsoring institution is held accountable for making sure funding is adequate, and that funding sources do not have an adverse impact on the residents’ educational program, and that the sponsoring institution maintains strong oversight of financial or other resident support issues.

## **ACCEPTING RESIDENT FROM ANOTHER PROGRAM**

All programs are required to verify the adequate performance of a resident in writing before accepting the trainee from another program. The program director must obtain written or electronic verification of previous educational experiences and a summative competency-based performance evaluation of the transferring resident directly from his/her training program. This documentation must be submitted to the GME Office with all new hire transfer paperwork.

For applicants applying to LSU School of Medicine-New Orleans Training programs all transfer documents as noted on the LSU GME Website must be completed and submitted to and approved by the Graduate Medical Education Office before an applicant can be accepted into the program

## ADEQUATE REST FOR RESIDENTS POLICY (EFFECTIVE 7/1/2011)

In order to ensure residents have adequate rest between duty periods and after on –call sessions we adopt the following policies:

1. Our Duty Hours Policy contains the following relevant language:

a. PGY-1 resident should have 10 hours, and must have eight hours, free of duty between scheduled duty periods.

b. Intermediate-level residents [as defined by the Review Committee] should have 10 hours free of duty, and must have eight hours between scheduled duty periods. They must have at least 14 hours free of duty after 24 hours of in-house duty.

c. Residents in the final years of education [as defined by the Review Committee] must be prepared to enter the unsupervised practice of medicine and care for patients over irregular or extended periods. This preparation must occur within the context of the 80-hour, maximum duty period length, and one-day-off-in seven standards. While it is desirable that residents in their final years of education have eight hours free of duty between scheduled duty periods, there may be circumstances [as defined by the Review Committee] when these residents must stay on duty to care for their patients or return to the hospital with fewer than eight hours free of duty.

Circumstances or return-to-hospital activities with fewer than eight hours away from the hospital by residents in their final years of education must be monitored by the program director.

All of this is in the context of the other duty hours requirements.

2. All employees of LSUHSC are under **Chancellors Memorandum 37** which is the LSHSC Fitness for Duty Policy. This describes the expectations for employees to report to work fit and safe to work. It further defines what are considered unsafe/impaired behaviors, the requirement for self or supervisor referral to the Campus Assistance Program, and what steps are taken thereafter.

3. The institutional Policy of Professionalism and Learning Environment further amplifies the expectations for residents to be fit for duty and to take it upon themselves to be well rested with the following language:

Residents must take personal responsibility for and faculty must model behaviors that promote:

1. Assurance for fitness of duty.
2. Assurance of the safety and welfare of patients entrusted in their care.
3. Management of their time before, during and after clinical assignments.
4. Recognition of impairment (e.g. illness or fatigue ) in self and peers.
5. Honest and accurate reporting of duty hours, patient outcomes, and clinical experience data.

4. The moonlighting policy anticipates potential trouble areas and describes a method for monitoring the effects of moonlighting on residents.



5. Adequate sleep facilities are in place at each institution and our alertness management / fatigue mitigation policy and process encourages good sleep hygiene as well as recommending such strategies and pre-call strategies, strategic napping and post-call naps.
6. Foremost our Professionalism and Learning Environment Policy requires faculty to model behaviors that encourage fitness for duty as noted above and our Supervision Policy requires faculty to observe for signs of fatigue especially during transitions.

#### **ADVANCED STANDING FOR RESIDENTS WITH PREVIOUS TRAINING POLICY**

This policy is regarding the house officer training Level and pay level for house officers who have had previous postgraduate training. LSU does not grant any credit to pay house officers at a higher level of salary if the house officer has completed an internship or residency prior to entering LSU residency programs as House Officer 1's. For pay purposes, residents will be paid at the lowest PGY year rate at which they could enter a program. If they can enter as a PGY1 they will be paid as a PGY1. If they must have one year of training (e.g. preliminary year) before they can begin training, they will be classified as a PGY2. This is in effect regardless of past training. In cases where residents could enter after two periods (e.g. Plastic Surgery) the resident will be paid at either level as determined by the GME Office. Other cases will be considered individually.

House officers that transfer into a training program from another training program will be appointed and paid at the level of training the house officer is in as long as all previous training months are approved by the specialty board of the program the house officer transferred into. If the board does not accept any of the house officer's previous training, the house officer will begin at the HO 1 level.

#### **AGREEMENT OF APPOINTMENT - NON-RENEWAL**

The institution must ensure that programs provide the residents with a written notice of intent not to renew a resident's agreement of appointment (contract) no later than four months prior to the end of the resident's current agreement of appointment. However if the primary reason(s) for the non-renewal occur(s) within the four months prior to the end of the agreement of appointment, the institution must ensure that the program provide their residents with as much written notice of the intent not to renew as the circumstances will reasonable allow, prior to the end of the agreement of appointment. Residents must be allowed to implement the institution's grievance procedures as addressed in House Officer Manual when they have received a written notice of intent not to renew their agreements of appointment. Conditions for reappointment and non renewal of the contract are discussed in the House Officer Manual.

## **ALERTNESS MANAGEMENT / FATIGUE MITIGATION STRATEGIES POLICY (EFFECTIVE 7/1/2011)**

Residents and faculty are educated about alertness management and fatigue mitigation strategies via on line modules and in departmental conferences. Alertness management and fatigue mitigation strategies are outlined on the pocket cards distributed to all residents and contain the following suggestions:

1. Warning Signs
  - a. Falling asleep at Conference/Rounds
  - b. Restless, Irritable w/ Staff, Colleagues, Family
  - c. Rechecking your work constantly
  - d. Difficulty Focusing on Care of the Patient
  - e. Feeling Like you Just Don't Care
  - f. Never drive while drowsy
2. SLEEP STRATEGIES FOR HOUSESTAFF
  - a. Pre-call Residents
    1. Don't start Call w/a SLEEP DEFICIT – GET 7-9 hours of sleep
    2. Avoid Heavy Meals / exercise w/in 3 hours of sleep
    3. Avoid Stimulants to keep you up
    4. Avoid ETOH to help you sleep
  - b. On Call Residents
    1. Tell Chief/PD/Faculty, if too sleepy to work!
    2. Nap whenever you can (> 30 min or < 2 hours)
    3. BEST Circadian Window 2PM-5PM & 2AM- 5AM
    4. AVOID Heavy Meal
    5. Strategic Consumption of Coffee (lasts 3-7 hours)
    6. Know your own alertness/Sleep Pattern!
  - c. Post Call Residents
    1. Lowest Alertness 6AM –11AM after being up all night
    2. Full Recovery from Sleep Deficit takes 2 nights
    3. Take 20 min. nap or Cup Coffee 30 min before Driving

In addition programs will employ back up call schedules as needed in the event a resident can't complete an assigned duty period.

### **How Monitored:**

The institution and program monitor successful completion of the on line modules. Residents are encouraged to discuss any issues related to fatigue and alertness with supervisory residents, chief residents, and the program administration. Supervisory residents will monitor lower level residents during any in house call periods for signs of fatigue. Adequate facilities for sleep during day and night periods are available at all rotation sites and residents are required to notify Chief Residents and program administration if those facilities are not available as needed or properly maintained. At all transition periods supervisory residents and faculty will monitor lower level residents for signs of fatigue during the hand off. The institution will monitor implementation of this indirectly via monitoring of duty hours violations in New Innovations, the Annual Resident Survey (administered by the institution to all residents and as part of the annual review of programs) and the special review process.

## **ANNUAL PERFORMANCE REVIEWS RATINGS FOR PROGRAM EDUCATIONAL EFFECTIVENESS**

All programs are to submit an End of Year report to the Director of Accreditation by July 1 of each year regarding the results of the meeting. The information should include the following:

1. Program is reviewed more than just once a year (bi annual)
2. Minutes are kept  
Containing, Time, Location, Those in Attendance (faculty and residents)
3. Review of Documents  
Board Passage Rates; Inservice Scores, Core Curriculum Completion, Letters of Accreditations (Citations, Cycle Length), Internal Review Results, Progress Reports, WebADS Data, Rotation Schedules, Curriculum (Lectures – Topics and Speakers; Goals and Objectives for each rotation; Required Readings or assignments; Staff at site – supervision), Policies and Procedures, Residency Manual, ACGME Resident Survey Results, LSU End of Year House Office Questionnaire Results, Procedure Logs, Evaluation Instruments and Feedback Results, Supervision and Duty Hours Compliance
4. Action Plans developed, Follow-up date for action plans

## **APPOINTMENT OF HOUSE OFFICERS**

Programs must secure, in writing, funding for all house officers that will be training in the program. If funding is not adequate, match quotas or number of house officers the program accepts for that year must be adjusted

## **CLOSURE/REDUCTION POLICY**

If the University itself intends to close or to reduce the size of a House Officer program or to close a residency program, the University shall inform the Designated Institutional Official, the GMEC, and House Officers as soon as possible of the reduction or closure. In the event of such reduction or closure, the University will make reasonable efforts to allow the House Officers already in the Program to complete their education or to assist the House Officers in enrolling in an ACGME accredited program in which they can continue their education. (Approved GMEC: Oct. 20, 2007)

## **RELOCATION OF RESIDENCY PROGRAMS OR ALLOCATION OF POSITIONS POLICY**

All program directors are mandated to notify the Assoc. Dean, Dean, Chancellor, and Director of Governmental Affairs of any proposed changes in resident allocations or program changes in any facility involved in the University's educational mission. That information, in turn, will be communicated by the Director of Governmental Affairs to the Systems Office as well as to any legislators whose constituents might be affected by such a move.

## DEA NUMBERS

All temporary DEA Numbers issued at MCLNO are valid from the date issued thru the house officer's period of training. Use of this temporary DEA number is restricted to prescriptions written only for MCLNO patients on the MCLNO Prescription Form # MCL 12/95 (blue). Violators will be reported to the Medical Director and DEA for appropriate disciplinary action.

Once the house officer receives the LSBME license, he/she is eligible to apply for his/her permanent DEA License. The application process takes 3-6 months to complete, therefore, it is recommended that physicians begin this process before their temporary DEA Number expires.

## DISASTER POLICY FOR GME

A disaster is an event or set of events that causes significant alteration or interruption to one or more programs. Instructions for how to proceed are described in item 2 below.

1. The Disaster Plan is designed to cover unanticipated and anticipated disasters that result in partial or complete loss of training facilities. In the case of anticipated disasters (e.g. hurricanes) the resident is expected to follow the rules in effect for the training site to which they are assigned at that time (e.g. Code Gray at MCLNO). In the immediate aftermath the resident is expected to attend to personal and family safety and then render humanitarian assistance where possible (e.g. temporary medical facilities). In the case of anticipated disasters, residents who are not 'essential employees' and are not included in one of the clinical sites emergency staffing plans should secure their property and evacuate should the order come. If there is any question about a house officer's status, he/she should contact their Program Director before the disaster. Residents who are displaced out of town will contact their Program Directors as soon as communications are available. In most cases temporary residency offices will be established at the local Charity Hospital (EKL – Baton Rouge, UMC – Lafayette and Chabert – Houma) soon after the disaster and residents who have not been able to contact their program can report there for instructions. In addition to the resources listed below the residents are directed to the Accreditation Council for Graduate Medical Education (ACGME) web site for important announcements ([www.acgme.org](http://www.acgme.org)) and guidance. The ACGME, Program Directors and DIO will work closely together to assure as smooth a response as practical and to assist residents in their needs.

2. All LSUHSC employees are governed by the **“Policy on Weather Related Emergency Procedures for LSUHSC-New Orleans (CM-51).”** The resident is expected to be familiar with this policy. Of particular note are the following:

- a. **Communication** – all communication will be maintained via the Emergency Web Site ([www.lsuhs.edu](http://www.lsuhs.edu)), the Emergency Information Hot Line (866-957-8472) and via statewide radio and television. In the event of complete loss of usual communication methods PIN numbers for key administration and others will be listed on the Emergency Web Site.

- a. **Phone Trees** – all academic units must submit phone trees and disaster plans to the Chancellor’s Office by May 1 of each year.
- b. **Personnel Availability** – all employees are required to update their personal contact information on the LSUHSC-NO registry website.
- c. **The LSUHSC-NO campus** will not serve as an evacuation site.

3. **Administration** will relocate and reestablish function at the earliest possible time in a central location most likely on the main campus of LSU in Baton Rouge. The location and further information will be listed on the web site. Communication will begin immediately between the DIO and Program Directors. Weekly or more frequent meetings will be held at a central site to begin working with program directors on relocation of training program rotations and reassignment or transfer of residents where necessary.

4. **Payroll** – residents are paid by electronic deposit and is done off site therefore there will be no interruption anticipated. Residents are encouraged to bank with an institution that has at least regional offices.

### 5. **Transfers**

There are two types of transfers: temporary and permanent. Residents are advised that these two terms are often confused by accepting programs as are the rules regarding temporary transfer of Medicare funding. To protect the resident the following steps should be followed:

**A.) Temporary Transfers** – refer to those transfers where the program remains open and needs to assign the resident for a particular educational reason to an in- or out of state facility. These transfers are sanctioned by the program and may or may not involve transfer of funding caps. The significant distinction here is these rotations are not for the duration of the residents training except in some residents in their final year of training and occur because your training program establishes them for specific training experiences. They remain LSUHSC-NO employees and receive paychecks from LSUHSC-NO.

**B.) Permanent Transfers** – The institution understands that in severe catastrophes that residents previously in good standing and committed to the program may develop a personal or professional need to transfer out of the program to another program. The institution does not encourage this but understands this need may arise and believes the program and institution should take reasonable steps to help this occur in a timely and smooth fashion. In the case of permanent transfers the resident is leaving their LSU program permanently to complete either all or their current period of training at another institution. These residents are no longer LSUHSC-NO employees and receive no paycheck from LSUHSC-NO. They become employees of the accepting institution. It is important for all parties to recognize that LSUHSC-NO does not “own” residency caps (Medicare) therefore cannot affect transfer of these caps. Residents who permanently transfer do not have funding or caps that transfer with them. In addition, during a complete disaster with parties spread out in different geographic locales and travel difficult there may not be time to physically route a letter. Since time is often of the essence in obtaining a position the institution has adopted the following procedures:

- a. The resident sends an email to the LSUHSC-NO Program Director requesting permanent transfer to a certain program (named in the email) effective a certain date and include the

accepting Program Director and DIO name and contact information and specifically their email addresses. The residents email should indicate the resident has initiated this request and it is not due to any actions on LSUHSC-NO part, that the resident expressly permits the Health Science Center to release information regarding his/her standing in the program and relevant information regarding educational status and the performance of the resident, and the LSU DIO must be copied.

- b. The LSUHSC-NO Program Director then writes an email to the accepting Program Director copying the DIO of both institutions and the requesting resident, stating that the LSUHSC-NO program releases the resident and that the resident is at a specified level of training and in good standing in the program and any other relevant information. This email must state that this is a permanent transfer and that no funding or GME caps will transfer with the resident. It should reflect the termination date.
- c. The accepting Program Director must reply to all of the acceptance and understanding and agreement of the terms outlined in the transfer email.
- d. Once this is completed the transfer is official and the resident contacts the LSUHSC-NO Residency Program Business Manager or the GME Office for instructions on termination.

6. Within 10 days the DIO will contact the ACGME to devise a plan for steps to be taken and information to be provided to the ACGME. Within 30 days the DIO will submit plans for program reconfiguration to the ACGME.

Approved by GMEC: June 21, 2007

## **DRUG SCREENING**

House officers are not allowed to start work prior to receiving the results of the pre-employment drug screening. This is in accordance with LSUHSC Human Resources policy.

All drug screening for new hire house officers should be done as soon as possible after the MATCH. House officers are to contact their program coordinator to schedule their drug screening. House officers should bring with them a valid driver's license or valid state id with photo or a passport; prescription medication they are currently taking; and a completed agreement to submit to Drug Testing/Release of Test Results Form, Drug Notification Form, and where applicable Chain of Custody document and kit.

## **DUTY HOURS POLICY** (Effective 7/1/2011)

The institution adopted the ACGME Duty Hours that may be summarized as:

## **Maximum House of Work Per Week**

Duty hours must be limited to 80 hours per week, averaged over a four week period, inclusive of all in-house call activities and all moonlighting.

## **Mandatory Time Free of Duty**

Residents must be scheduled for a minimum of one day free of duty every week (when averaged over four weeks). At-home call cannot be assigned on these free days.

## **Maximum Duty Period Length**

Duty periods of PGY-1 residents must not exceed 16 hours in duration.

Duty periods of PGY-2 residents and above may be scheduled to a maximum of 24 hours of continuous duty in the hospital. Programs must encourage residents to use alertness management strategies in the context of patient care responsibilities. Strategic napping, especially after 16 hours of continuous duty and between the hours of 10:00 p.m. and 8:00 a.m., is strongly suggested.

It is essential for patient safety and resident education that effective transitions in care occur. Residents may be allowed to remain on-site in order to accomplish these tasks; however, this period of time must be no longer than an additional four hours.

Residents must not be assigned additional clinical responsibilities after 24 hours of continuous in-house duty.

In unusual circumstances, residents, on their own initiative, may remain beyond their scheduled period of duty to continue to provide care to a single patient. Justifications for such extensions of duty are limited to reasons of required continuity for a severely ill or unstable patient, academic importance of the events transpiring, or humanistic attention to the needs of a patient or family.

Under those circumstances, the resident must:

appropriately hand over the care of all other patients to the team responsible for their continuing care; and,

document the reasons for remaining to care for the patient in question and submit that documentation in every circumstance to the program director.

The program director must review each submission of additional service, and track both individual resident and program-wide episodes of additional duty.

## **Minimum Time Off between Scheduled Duty Periods**

PGY-1 resident should have 10 hours, and must have eight hours, free of duty between scheduled duty periods.

Intermediate-level residents [as defined by the Review Committee] should have 10 hours free of duty, and must have eight hours between scheduled duty periods. They must have at least 14 hours free of duty after 24 hours of in-house duty.

Residents in the final years of education [as defined by the Review Committee] must be prepared to enter the unsupervised practice of medicine and care for patients over irregular or extended periods.

This preparation must occur within the context of the 80-hour, maximum duty period length, and one-day-off-in seven standards. While it is desirable that residents in their final years of education have eight hours free of duty between scheduled duty periods, there may be circumstances [as defined by the Review Committee] when these residents must stay on duty to care for their patients or return to the hospital with fewer than eight hours free of duty.

Circumstances or return-to-hospital activities with fewer than eight hours away from the hospital by residents in their final years of education must be monitored by the program director.

### **Maximum Frequency of In-House Night Float**

Residents must not be scheduled for more than six consecutive nights of night float. [The maximum number of consecutive weeks of night float, and maximum number of months of night float per year may be further specified by the Review Committee.]

### **Maximum In-House On-Call Frequency**

PGY-2 residents and above must be scheduled for in-house call no more frequently than every-third-night (when averaged over a four-week period).

### **At-Home Call**

Time spent in the hospital by residents on at-home call must count towards the 80-hours maximum weekly hour limit. The frequency of at-home call is not subject to the every-third-night limitation, but must satisfy the requirement for one-day-in-seven free of duty, when averaged over four weeks.

At-home call must not be as frequent or taxing as to preclude rest or reasonable personal time for each resident.

Residents are permitted to return to the hospital while on at-home call to care for new or established patients. Each episode of this type of care, while it must be included in the 80-hour weekly maximum, will not initiate a new “off-duty period”.

Residents are required to log all duty hours in New Innovations Software Program or its replacement program. Those who fail to log duty hours or log erroneous duty hours are subject to disciplinary action. (GMEC Feb 2011)



The institution as well as each program is required to monitor and document compliance with these requirements for all trainees. To accomplish this, the institution will implement the following policies and procedures:

1. Each program will need to sign a statement attesting to compliance with these requirements at all sites.
2. Each program will develop their own written duty hours policy that is in keeping with the ACGME and Institutional policy. This policy will be distributed to all trainees and faculty with a copy provided to the GME Office. The policy must delineate specifically how compliance will be monitored and what actions will be taken to remedy problems. Yearly changes or revisions to policies must be forwarded to the GME Office.
3. Programs must monitor residents for fatigue. The institution will develop resources to educate faculty and residents about sleep deprivation and fatigue.
4. The institution will ask each participating institution to advise it where legally permissible of incidents or trends suggesting fatigue as a component of the problem.
5. If the program has developed and instituted a method to monitor for individual resident duty hour compliance (eg work hour logs) it will regularly share this data with the institution.
6. The institution encourages programs to add questions on the duty hour requirements to their monthly rotation evaluations in addition to other monitoring.
7. The institution will make it clear to residents that our Ombudsman is available to field questions or complaints about duty hours and those such complaints will remain anonymous.
8. The resident agreement of appointment/contract includes a reference to duty hours policy and an agreement to participate in institutional monitoring of duty hours.
9. Internal Reviews include detailed sections on duty hours.
10. An annual web-based questionnaire will be administered to residents regarding duty hours by the GME Office. Responses will be anonymous.
11. The GME Office will randomly audit programs.
12. Program specific data will be presented annually in the End of Year Program Review Minutes submitted to the GME Office for review.
13. Violations of duty hours requirements by participating institutions may result in removal of residents from that institution.
14. Programs with violations will be subject to close, regular monitoring by GMEC.
15. Programs cited by the ACGME for duty hour violations will have special monitoring programs implemented.
16. Moonlighting must be strictly approved in writing and monitored to assure resident fatigue does not become a problem.
17. Duty Hours Hotline is established to monitor residents complaints.

This policy applies to every site where trainees rotate.

## **GRANTING DUTY HOUR EXCEPTIONS**

The Graduate Medical Education Committee (GMEC) will accept, review and act on requests to increase resident duty hours up to a maximum of 88 hours per week when averaged over a four week period.

Applications for such increases shall be based on a sound educational rationale. Only programs in good standing with their RRC may apply for increases.

### **Process:**

1. Programs will submit a written request as described below.
2. After screening by the Graduate Medical Education Office to be sure the application is complete, it will be presented for consideration at the next regularly scheduled GMEC.
3. GMEC will vote to endorse or not endorse the request based on the merits of the application. The decision is not appealable.
4. If approved the Designated Institutional Official/Chair of GMEC will prepare a letter of endorsement to be included in the programs application to their RRC along with a copy of the Institutions Policies and Procedures for Granting Duty Hour Exceptions.
5. The institution will reevaluate the continued necessity and appropriations of the increase and patient safety aspects of the increased hours at each internal review.

### **Application Format:**

The program must supply information on each of the areas below sufficiently detailed for GMEC to make an informed decision.

1. Patient Safety: Describe how the program will monitor, evaluate, and ensure patient safety with extended resident work hours.
2. Educational Rationale: Provide a sound educational rationale which should be described in relation to the program's stated goals and objectives for the particular assignments, rotations, and levels of training for which the increase is requested. Blanket exceptions for the entire educational program should be considered the exception, not the rule.
3. Moonlighting Policy: Include specific information regarding the program's moonlighting policies for the periods in questions.
4. Call Schedules: Provided specific information regarding the resident call schedules during the times specified for the exception. Explain how this will be monitored.
5. Faculty Monitoring: Provide evidence of faculty development activities regarding the effects of resident fatigue and sleep deprivation.

## **DUTY HOURS ATTESTATION STATEMENT**

The following statement must be signed by every incoming program director of a LSU training program.

As the program director of \_\_\_\_\_(program name) at LSU School of Medicine-New Orleans I have read the Institutional Policy regarding Duty Hours and by signing this document I attest to compliance of the policy in the

\_\_\_\_\_ training program. I verify that a copy of the policy has been issued to each of the faculty members and house officers within my program.

I also attest that my program has developed a program specific duty hours policy that is in compliance with the ACGME and institutional guidelines and it has been issued to the faculty and house officers within my program.

I agree to monitor the house officers for fatigue and educate the faculty and house officers about the seriousness of sleep deprivation and fatigue on work performance. As program director I agree to report to the Graduate Medical Education Committee (GMEC) semi annually regarding data, house officer performance and compliance within my program to the duty hours policy.

Should changes be made to the program policy or monitoring issues the LSU School of Medicine- New Orleans Office of Graduate Medical Education and the GMEC Committee will be notified.

#### **EXPERIMENTATION AND INNOVATION**

The GMEC must maintain oversight of all phases of educational experiments and innovations that may deviate from Institutional, Common, and specialty/subspecialty-specific Program Requirement, including:

Approval prior to submission to the ACGME and/or respective RRC

Adherence to Procedures for “Approving Proposals for Experimentation or Innovative Projects” in ACGME Policy and Procedures and

Monitoring quality of education provided to residents for the duration of such a project.

#### **EXTREME EMERGENT SITUATIONS**

Extreme emergent situation is defined as a local event (such as a hospital-declared disaster for an epidemic) that affects resident education or the work environment but does not rise to the level of an ACGME-declared disaster as defined in the ACGME Policies and Procedures.

#### **Declaration of an Extreme Emergent Situation:**

Declaration of an extreme emergent situation may be initiated by a Program Director or by the DIO. Declaration of a qualifying local disaster is made by the DIO, in collaboration with the hospital CEO, the COO, the CMO, affected Program Directors, and Department Chairs. When possible, an emergency meeting of the GMEC – conducted in person, through conference call, or through web-conferencing – shall be convened for discussion and decision-making as appropriate.

**Procedure:**

After declaration of an extreme emergent situation:

The Program Director of each affected residency/fellowship program shall meet with the DIO and other university/hospital officials, as appropriate, to determine the clinical duties, schedules, and alternate coverage arrangements for each residency program sponsored by the Institution. ACGME's guidelines for development of those plans should be implemented, including:

Residents and fellows must be expected to perform according to the professional expectations of them as physicians, taking into account their degree of competence, level of training, and context of the specific situation. Residents who are fully licensed in this state may be able to provide patient care independent of supervision in the event of an extreme emergent situation, as further defined by the applicable medical staff by-laws.

Residents are also trainees/students. Residents/fellows should not be first-line responders without consideration of their level of training and competence; the scope of their individual license, if any; and/or beyond the limits of their self-confidence in their own abilities.

Program Directors will remain in contact with the DIO about implementation of the plans to address the situation, and additional resources as needed.

The DIO will call the ACGME IRC Executive Director if (and, only if) the extreme emergent situation causes serious, extended disruption that might affect the Institution/Program's ability to remain in substantial compliance with ACGME requirements. The ACGME IRC will alert the respective RRC. If notice is provided to the ACGME, the DIO will notify the ACGME IRC ED when the extreme emergent situation has been resolved.

The DIO and GMEC will meet with affected Program Directors to establish monitoring to ensure the continued safety of residents and patients through the duration of the situation; to determine that the situation has been resolved; and to assess additional actions to be taken (if any) to restore full compliance with each affected resident's completion of the educational program requirements.

*Approved GMEC: August 16, 2012*

**FELLOW RANKING**

To distinguish a fellow from a resident, the LSU Systems Office approved the following titles for fellows:

House Officer 8 – first year of fellowship program

House Officer 9 – second year of fellowship program

House Officer 10 – third year of fellowship program

**THESE TITLES DO NOT RELATE TO THE POSTGRADUATE YEAR OF THE INDIVIDUAL.**

## **GRADUATE EDUCATION TEMPORARY PERMIT (GETP)**

The LSBME may issue a GETP to an International Foreign Medical Graduate (FMG), for the purpose of enrolling & participating in an accredited program of postgraduate medical education (residency or fellowship). The FMG must pass USMLE Step 3 within the 24 months during which GETP is maintained; otherwise, the IMG is ineligible for further training. The FMG must also comply with other provisions of the LSBME.

## **INP-55 POSITIONS**

LSU does not allow appointment of international medical graduates into INP-55 positions for training purposes.

## **J-1 VISA RESIDENTS AND FELLOWS**

The institution policy states that there are to be no gratis appointment clinical training positions for International Medical Graduates on J-1 ECFMG sponsored visas. In addition fellows on J-1 visas must not be appointed in part as instructors nor may they moonlight to generate any income. Trainees on J-1 visas may not be appointed to gratis or self funded positions, nor may they moonlight to generate any income.

## **LEAVE OF ABSENCE (LOA) ACCOUNT**

The House Officer LOA account was set up to be used in the PS-Resident Scheduler System to schedule house officers on LOA/LWOP from the program. It is a non-paying account. House officers are placed on this account in the PS-Resident Scheduler system if they have used all vacation, sick leave and other allowed paid leave. House officers are also assigned to this account in the PS-Resident Scheduler System if they have not passed Step 3 of the Licensing exam and are entering their 3rd year of post graduate training; if they are away doing a "research" year to fulfill a future fellowship requirement; and if they have to return to their country but will be returning to the US to complete training during the same academic year.

## **LICENSURE**

House Officer Contracts state all house officers must have a valid LA Medical Permit/License/GETP for training. It is the house officer's responsibility to contact the LSBME regarding licensure and to maintain a valid LA Medical License or permit during all training years. All questions regarding permits or licensure should be directed to LSBME staff.

Licensure is available to graduates of medical school who complete the PGY 1 or PGY 2 year, pass USMLE Step 3 and meet all other requirements of the LSBME.

Graduates of Osteopathic Schools follow the same procedure as the MD graduate for interns and PGY2s, and must pass USMLE Step 3 or Complex 3 before proceeding to the PGY 3 year of training. They need to contact LSBME to apply for the permit.

Individuals that do not want to apply for a LA Medical License are eligible for a LA Medical Permit after completing the PGY 2 year if they have taken and passed USMLE Step 3. They should contact LSBME to apply for the permit.

All questions regarding permits or licensure should be directed to LSBME staff.

## **Permits**

### **PGY1**

- For up to 12 months
- Issued to graduates of medical /osteopathic schools
- For first year internship

To enter the PGY2 year, interns (PGY1) must either apply for full licensure or renew their training permit. House Officers are encouraged to take and pass USMLE Step 3 in their PGY1 year so that they can apply for full licensure after the PGY1 year. Applicants who do not pass USMLE Step 3 in their PGY1 year may apply for a PGY2 permit for up to 12 months except for international medical graduates (IMG's). There is no extension of the training permit beyond 24 months of total training (i.e. PGY1 and 2) without passing USMLE Step 3. Please see the LSBME.org site for rules governing obtaining full licensure for those who do pass Step 3.

### **PGY2**

- For up to 12 months
- Issued to graduates of medical /osteopathic schools
- Can be issued to graduates of a medical / osteopathic school who have not taken and/or passed USMLE 3/ Complex 3
- If applicant has not previously received LSBME-issued PGY 1 permit (i.e. applicant from out-of-state moving to LA and applying for PGY 2 permit) applicant must complete a licensure application and provide letter from PGY 2 Program Director. There is generally no permit or license issued and immediately available to the applicant who has not taken and passed the USMLE Step 3 when the PGY 2 permit expires.

The following documents are needed for a one-year valid PGY 2 permit:

- 1) Permit fee-which is determined by the State Board
- 2) A promotion letter signed by the Program Director stating PGY 2 name and starting and ending dates in program as PGY 2. These letters must be dated May 1st or later.

All programs with PGY 2s must send LSBME a letter, signed by the program director, for each PGY 2 informing LSMBE that the individual is a PGY 2 in their program and include the fiscal year.

## **LOSS OF ACCREDITATION - MAJOR PARTICIPATING INSTITUTION**

When a Major Participating Institution loses its accreditation or recognition, the Sponsoring Institution must notify and provide a plan of response to the IRC within 30 days of such loss.

## **MATCH POLICY**

All programs that are able to participate in the Match must do so in accordance with all rules and regulations of the NRMP. Programs are advised to be aware of the rules regarding hiring of residents/fellows outside of the Match.

Programs that receive the list of students that they matched before Match Day are not to share this information with the students either directly or indirectly prior to Match Day. The Match ceremony is a very special event in the student's life and placement should be a surprise until the student receives notification from the Associate Dean of Student Affairs.

## **MEAL TICKETS – MCLANO**

The value of the MCLANO meal tickets will be \$4.50. This ticket will cover the cost of daily meal specials to include a small drink.

## **MEDIA POLICY**

The Office of Information Services is charged with the responsibility for releasing information about programs, emergencies, crimes, controversies, the official position on issues involving the LSU Health Science Center, and other events to which the press has a reasonable claim.

The following procedures are established:

1. LSUHSC personnel shall not release information about programs, events and other activities to the media independent of the Office of Information Services.
2. No one is authorized to speak to the media concerning LSUHSC policy or significant matters affecting the HSC unless directed to do so by the Office of Information Services and the Chancellor's Office.
3. All media contact to the campus must be directed to the Office of Information Services.
4. The Office of Information Services is responsible for coordinating efforts of the HSC to obtain coverage in the news media.
5. Faculty and staff should make every effort to apprise the Office of Information Services of events which may be newsworthy.
6. Faculty and staff shall work with the Office of Information Services to "be available" to representatives of the news media when requested.
7. HSC personnel contacted for an interview by media representatives shall immediately inform the Office of Information Services.
8. The Office of Information Services will conduct Media Training as necessary or requested, to prepare faculty and staff to deal effectively with media.

## **MEDICAL MALPRACTICE VERIFICATION REQUESTS FOR HOUSE OFFICERS**

The verification form requires, that the person requesting the verification must indicate briefly the nature of his/her association with the listed hospital(s)/company(ies), facility and/or organization(s). This information must be included when submitting the form for the Director of Medical Education's signature. After signing, the form will be forwarded to Vice Chancellor for Administrative, Community and Security Affairs office for the verification letter. Forms that are submitted for the Director of Medical Educations' signature that do not include the required information will be returned to the department to complete. Please provide complete addresses on all agencies not listed in the multiple choice section.

**LSUHSC DOES NOT PROVIDE COVERAGE FOR WORK NOT DONE FOR OR ON BEHALF OF LSUHSC (MOONLIGHTING). CONTRACTS BETWEEN LSUHSC AND OTHER INSTITUTIONS HAVE THE MALPRACTICE COVERAGE LANGUAGE ALREADY IN THEM FOR WORK DONE FOR AND ON BEHALF OF LSUHSC.**

### **MOONLIGHTING POLICY** (Adopted 6/28/2016)

Moonlighting is any medical-type professional activity that is not part of the course and scope of the resident or clinical fellow's educational program. Moonlighting must not interfere with the ability of the resident or clinical fellow to achieve the goals and objectives of the educational program. All medical and non-medical type outside employment should be reviewed and approved by the program in accordance with LSU System Permanent Memorandum – 11.

- All moonlighting activities must be reported by each resident and each clinical fellow as duty hours within the New Innovations Software Program.
- All moonlighting must be counted toward the 80-hour weekly work hour limit.
- Residents and clinical fellows cannot be required to engage in moonlighting activities.
- PGY - 1 residents are not permitted to engage in any moonlighting activity.
- Resident and clinical fellows employed under a J-1 visa are prohibited by law from participating in moonlighting activities.
- Residents and clinical fellows are not permitted to participate in any moonlighting activities at pain or weight loss clinics.
- Individual ACGME-accredited Programs may prohibit moonlighting by the Program's residents and clinical fellows.
- Each resident and clinical fellow must submit to his/her Program Director, a prospective, written request for approval of all moonlighting activity, which must be signed and approved by the Program Director and/or Department Head and maintained as part of the resident or fellow's permanent training record. Each request for moonlighting must include the nature, duration and location of the moonlighting activities and must be accompanied by a completed Disclosure of Outside Employment Form in accordance with LSU System Permanent Memorandum - 11.



- Residents and clinical fellows participating in moonlighting activities must be fully licensed to practice medicine in each state where he/she moonlights and must have their own Federal DEA # to support any moonlighting activities. Neither a training license nor a training DEA # may be used to support any moonlighting activities.
- Residents and clinical fellows moonlighting will not be covered for medical malpractice under the University's Professional Liability Insurance Policy. Residents and fellows must maintain adequate professional liability coverage or ensure that his/her outside employer provides adequate professional liability coverages. It is the responsibility of the resident or fellow and his/her outside employer to determine what level of coverage is "adequate". It is further the responsibility of the resident or fellow and his/her outside employer to determine whether the resident or fellow has the appropriate licensure, and the appropriate training and skills to carry out his/her assigned duties.
- Each Program Director shall be responsible for ensuring that moonlighting activities do not interfere with the ability of the resident or clinical fellow to meet the goals, objectives, assigned duties, and responsibilities of the educational program. Each Program Director shall monitor all moonlighting activities in his/her Program. If, at any time, moonlighting activities are seen as producing adverse effects on the resident or clinical fellow's performance in the Program, the Program Director may withdraw permission to moonlight.
- Permission for moonlighting may be withdrawn at any time by the Program Director, Department Head, and/or the Associate Dean of Graduate Medical Education.
- Residents and clinical fellows moonlighting without prior written approval will be subject to disciplinary action.

Any resident or clinical fellow violating any LSUHSC-NO moonlighting rule, policy or procedure will be subject to disciplinary action.

**SPECIAL CONSIDERATIONS DESERVING EMPHASIS:**

The following behaviors are highly discouraged and in some cases, may be illegal. The LA State Board and the DEA will independently investigate and prosecute individual residents if they so desire.

Moonlighting if not fully licensed and if the House Officer does not have his/her own malpractice and DEA number.

Pre-signing of prescriptions.

Using prescriptions outside the assigned facility is prohibited –number is site specific.

Signing documentation saying you saw a patient and you didn't see the patient

Failure to put all narcotics prescriptions in the patient's name and address plus the date

Having a nurse do assigned tasks that are the physicians responsibility.

Failure to read the fine print. (House officers are held accountable for all things signed.)

Failure to follow accepted practice guidelines for everything especially weight loss and pain patients.

Failure to be cognizant of Medicare fraud and abuse guidelines

Treatment of family members

Note: If a House Officer treats anyone he/she must create a medical record which includes a history, physical and appropriate laboratory and diagnostic tests in keeping with the standard of care. This activity is considered moonlighting and requires licensure, DEA and malpractice insurance independent of those provided as part of the training program. It is far better to refer family members and friends to another practitioner.

Once a House Officer has treated someone a doctor-patient relationship has been created and all the legal and professional issues that entails. This includes HIPAA laws precluding discussing it with the program or anyone else.

### **MOONLIGHTING - FOREIGN MEDICAL GRADUATES**

Moonlighting by J-1 visa holders is not allowed. This was instituted to prevent abuse of J-1 visa holders and to prevent their having to moonlight to generate their own salary. If an activity is considered an integral part of a program it should be covered by the base salary. If it is not covered by the base salary it is considered moonlighting. Any J-1 moonlighting is in violation of our contract with the residents and the ACGME guidelines which both forbid forced moonlighting.

### **NEW HIRE, PROMOTION, AND TERMINATION PAPERWORK**

All new hires, promotions, non-promotions and terminations within a program must have all completed paperwork to the GME office prior to June 1st. Clearance for hire must be issued once an individual has completed the required pre-employment drug screening. All new hire packets must be completed with proper signatures before house officers can begin the training program. All PER 3's to promote, terminate, or transfer house officers must be completed by June 1st. Information on spreadsheets is requested and they are due by the specified due dates or attached to PER 3.

All of the paperwork is required to:

1. Pay the new house officers for the first pay period of July.
2. Pay the continuing house officers at their promoted levels.
3. Pay the terminating house officers their last check, and make them eligible to receive their deferred compensation contribution if they elect to deduct the funds.
4. Pay the transferring house officers at their correct level of pay and transfer them to the correct program for July 1.

## NEW INNOVATIONS COMPUTER SOFTWARE PROGRAM

New Innovations is the software package that has been chosen by the Office of Graduate Medical Education to collect and maintain resident records for ACGME accreditation and compliance purposes. To comply with institutional policies, House Officer must record duty hours in the Duty Hours module of New Innovations. Additionally, many departments require the use of the software program for completion of evaluations, recording of case and procedure logs, and informing residents of events at which their attendance is required. Information about how to use New Innovations can be obtained at [http://www.medschool.lsuhs.edu/medical\\_education/graduate/NI](http://www.medschool.lsuhs.edu/medical_education/graduate/NI). Additionally, instructions on use of New Innovations will be given at the House Officer Orientation. Failure to comply with GME and departmental policies regarding the use of New Innovations may result in disciplinary action.

## NOTIFICATION (MANDATORY) OF FACULTY POLICY (PATIENT CARE) (EFFECTIVE 7/1/2011)

In certain cases faculty must be notified of a change in patient status or condition. The table below outlines those instances in which faculty must be called by PGY level.

Condition	PGY 1	PGY2	PGY 3 and above
Care of complex patient			
Transfer to ICU			
DNR or other end of life decision			
Emergency surgery			
Acute drastic change in course			
Unanticipated invasive or diagnostic procedure			
Add more as needed			

### How monitored

Chief Residents, faculty, and programs will monitor by checking for proper implementation on daily rounds, morning reports, and other venues as well as solicitation of reports from faculty on lack of appropriate use of the policy.

## OUT-OF-COUNTRY/OUT-OF-STATE ROTATIONS (APPROVED BY GMEC JANUARY 15, 2015)

Out of state / country rotations that are approved by the programs and sponsoring institution as being beneficial to the trainee may be permitted provided appropriate funding, malpractice, health and liability insurance and legal documents are completed prior to any such rotation. For trainees to do out of state rotations there must be a document in place that outlines conditions of the rotations such as who covers salaries, malpractice, general liability and other necessary items. Usual LSU affiliated hospital salary lines may not be used for such purposes without express permission from the hospital and GME Office. It is preferred we use the standard (approved) affiliation agreement for LSUHSC New Orleans. In those cases where the institution allowing our resident to rotate insists on using their own contract (affiliation agreement) we will attempt to accommodate that wish but will require additional time for legal review and

negotiation between institutions because there are often provisions to which we cannot agree. A common example of conditions the University cannot agree to is to be bound by the laws of another state. Another common item the University cannot agree to is malpractice requirements that exceed the Louisiana state cap.

In order to assure timely processing of these agreements the following policies must be adhered to:

1. All out of state rotations should begin with the departmental Business Manager in coordination with the program opening a dialog with the LSU School of Medicine Contracts Office. They will initiate a discussion with the host institution regarding the agreement to be used. If it is the LSU Affiliation Agreement, it will be routed as usual. If it is the host institution's agreement, it should be completed by the program and forwarded to Contracts for review and referral to HSC Counsel as needed. These discussions with the Contracts Office and the host institution must begin at least 3 months before the rotation begins.
2. After all parties agree on the final language it will be routed for signatures. Please remember contracts (including affiliation agreements) must be signed by appropriate institutional officials and not simply by the program or GME Office.
3. During this time there should also be discussions between the program and the Vice Chancellor for Community and Security Affairs Office to assure that all issues regarding malpractice coverage are resolved. It may be that additional malpractice insurance in excess of our state cap will need to be purchased.
4. Any out of country rotations must additionally be approved by the International Travel Committee

These steps will often take months as the host institution and our institution must negotiate any changes in the agreements. It is best to not formally establish a firm date for the rotation until these agreements are executed.

For rotations done during vacation:

Any time spent on vacation may not be counted as part of the educational program for credit purposes towards Boards. If applicable, the resident/fellow should be notified in writing that the rotation does not count towards satisfying educational requirements. Approved GMEC August 16, 2012

**STATE MALPRACTICE DOES NOT COVER ROTATIONS DONE DURING VACATION TIME. IF A RESIDENT EXCEEDS ALLOWABLE VACATION TIME DURING A ROTATION, THE DEPARTMENT WILL BE LIABLE FOR THE SALARY.**

#### **PAY LINES AND RESIDENT NUMBERS**

Programs, through their departmental business offices are responsible for keeping resident numbers within the numbers agreed to in the contracts with each institution where they are sending residents. Variances will be the responsibility of the department. This information is attested to each month by departments and programs via the attestation statement.

## **PERMITS - PROVISIONAL TEMPORARY**

The LSBME may issue these permits to individuals pending application for VISA or for those individuals pending results of Criminal History Record Information.

Licensure is available to graduates of medical school who complete PGY 1 or PGY 2 program, pass USMLE Step 3 and meet all other requirements of the LSBME.

## **PROFESSIONALISM AND LEARNING ENVIRONMENT POLICY (EFFECTIVE 7/1/2011)**

In keeping with the Common Program Requirements effective 7/1/2011 our GME programs wish to ensure:

1. Patients receive safe, quality care in the teaching setting of today.
2. Graduating residents provide safe, high quality patient care in the unsupervised practice of medicine in the future.
3. Residents learn professionalism and altruism along with clinical medicine in a humanistic, quality learning environment.

To that end we recognize that patient safety, quality care, and an excellent learning environment are about much more than duty hours. Therefore, we wish to underscore any policies address all aspects of the learning environment not just duty hours. These include:

1. Professionalism including accepting responsibility for patient safety
2. Alertness management
3. Proper supervision
4. Transitions of care
5. Clinical responsibilities
6. Communication / teamwork

Residents must take personal responsibility for and faculty must model behaviors that promote:

1. Assurance for fitness of duty
2. Assurance of the safety and welfare of patients entrusted in their care
3. Management of their time before, during, and after clinical assignments
4. Recognition of impairment (e.g. illness or fatigue ) in self and peers
5. Honest and accurate reporting of duty hours, patient outcomes, and clinical experience data

The institution further supports an environment of safety and professionalism by:

1. Providing and monitoring a standard Transitions Policy as defined elsewhere.
2. Providing and monitoring a standard policy for Duty Hours as defined elsewhere.
3. Providing and monitoring a standard Supervision Policy as defined elsewhere.
4. Providing and monitoring a standard master scheduling policy and process in New Innovations.
5. Adopting and institution wide policy that all residents and faculty must inform patients of their role in the patient's care.
6. Providing and monitoring a policy on Alertness Management and Fatigue Mitigation that includes:
  - a. On line modules for faculty and residents on signs of fatigue.

- b. Fatigue mitigation, and alertness management including pocket cards, back up call schedules, and promotion of strategic napping.
7. Assurance of available and adequate sleeping quarters when needed.
8. Requiring that programs define what situations or conditions require communication with the attending physician.

*(Professionalism and Learning Environment policy adopted from ACGME Quality Care and Professionalism Task Force AAMC Teleconference July 14, 2010. )*

### **Process for implementing Professionalism Policy**

The programs and institution will assure effective implementation of the Professionalism Policy by the following:

1. Program presentations of this and other policies at program and departmental meetings.
2. Core Modules for faculty and residents on Professionalism, Duty Hours, Fatigue Recognition and Mitigation, Alertness Management, and Substance Abuse and Impairment.
3. Required LSBME Orientation.
4. Institutional Fitness for Duty and Drug Free Workplace policies.
5. Institutional Duty Hours Policy which adopts in toto the ACGME Duty Hours Language.
6. Language added specifically to the Policy and Procedure Manual, the House Officer manual and the Resident Contract regarding Duty Hours Policies and the responsibility for and consequences of not reporting Duty Hours accurately.
7. Comprehensive Moonlighting Policy incorporating the new ACGME requirements.
8. Orientation presentations on Professionalism, Transitions, Fatigue Recognition and Mitigation, and Alertness Management.

### **Monitoring Implementation of the Policy on Professionalism**

The program and institution will monitor implementation and effectiveness of the Professionalism Policy by the following:

Evaluation of residents and faculty including:

- a. Daily rounding and observation of the resident in the patient care setting.
- b. Evaluation of the residents' ability to communicate and interact with other members of the health care team by faculty, nurses, patients where applicable, and other members of the team.
- c. Monthly and semi-annual competency based evaluation of the residents.
- d. By the institution in Annual Reviews of Programs and Internal Reviews.

- e. By successful completion of modules for faculty and residents on Professionalism, Impairment, Duty Hours, Fatigue Recognition and Mitigation, Alertness Management, and others.
- f. Program and Institutional monitoring of duty hours and procedure logging as well as duty hour violations in New Innovations.

### **RECORDS RETENTION POLICY**

The LSU Health Sciences Center records retention policy allows for records to be archived on microfilm and permission may be obtained to shred the physical copies. Permission may be obtained from the Secretary of State, Archives and Records Services. This policy is defined by Louisiana state law LSA-R.S. 44:411.

### **RELEASE OF RECORDS POLICY**

We will not routinely respond to requests for information on resident performance without a properly executed release or a properly executed subpoena and, then, only after conferring with LSU Counsel if necessary. In most cases we will insist on the LSU Release of Information form found in the Coordinator Documents section of the GME website.

### **RESIDENT FILES - ACCESS AND COPIES POLICY**

Residents should have access to view their records during normal business hours. In the case of appeals in which the resident invokes the Due Process outlined in the House Officer Manual, the resident may be granted copies of items from the folder necessary to present his/her case. In the case of resident files subpoenaed there may be an applicable page charge. (GMEC 7/08)

### **REQUEST FOR ADVERSE ACTION AND NOTICE - *REQUIRED ELEMENTS, FORMAT AND SUGGESTIONS***

1. This Due Process is for non-promotion, non-reappointment and termination but NOT probation.
2. **IMPORTANT** - This Due Process consists of 2 parts:
  - a. The **Request for Adverse Action** – described below. The Request for Adverse Action is sent to the DEPARTMENT HEAD, not resident. After the department head has reviewed, if they agree, they create a short letter called the **Notice**
  - b. The **Notice** – a short letter from the department head saying he/she supports the proposed action of XXXXX.

THIS NOTICE IS ATTACHED to The Request for Adverse Action and **BOTH** are sent to the house officer by mail or hand delivered **AND** sent by email with a read receipt notice.

3. LSU GME Due Process is complex and has a very tight timeline. Print out a copy of the relevant section and place on your desk for frequent reference. It is vital that you follow

the Due Process as outlined exactly including content, required times, etc. Not following the Due Process is one of the major reasons cases are overturned when legal action occurs.

4. Following the correct format makes it much easier for someone to understand all of the details of the action later on in case there is a need.
  - a. Follow the Request for Adverse Action template below in Appendix A. It should be detailed with specific examples, specific dates, specific witnesses, etc. Again, this will really help those that come after you when they are trying to understand the reasons and details of the action.
5. The required **FOUR** components of The Request for Adverse Action are:
  - a. The **proposed disciplinary action** - if possible have the CCC decide it and say the CCC met on XX/XX/XXXX and recommended you not be reappointed or whatever it is. It is always better to have a committee decision.
  - b. **A list of deficiencies / Reasons for Action** (usually by competency and usually fairly detailed) – see examples below.
  - c. List of **all known documentary materials** that you would use at a hearing - this may just say “resident file” but that means you will have to give the whole file to the resident which we do not routinely allow except in appeal cases where the whole file is listed as the materials to be used.
    - i. Most Requests have a long list of deficiencies and documents such as letters, test scores, evaluations, emails, incident reports and other documents are appended that refer to each allegation .
  - d. **List of witnesses** to be called and **brief summary of their expected testimony**. In cases where the documentary evidence is the resident record the summary for the witness may be “will attest to accuracy of information in the file or an incident in the file.” Or you may list the deficiency, then list a witness that will attest to that deficiency or incident. Example – Incident 4 - Dr. XXXXX was late for OR on XX/XX/XXXX. In the list of witnesses say “Dr Jones will attest to his arriving late for OR as described in number 4 above.”
6. A great way to collect and list deficiencies is by competency. Most will be for patient care, medical knowledge, professionalism, communication. For example:
  - a. Patient Care
    - i. List specific occurrences in OR / wards, etc. and dates
    - ii. Include residents statement about not being safe in OR
    - iii. Other specific instances in the past – always put specifics including dates and even who will testify about it
    - iv. Inability to make decisions
    - v. Lack of integrity
    - vi. Poor judgment
    - vii. Specific things they can’t do that they should be able to do – start IV, induce anesthesia, etc.
  - b. Professionalism – listing specific examples
    - i. Unexcused absences



- ii. Unprofessional behavior with staff or families or other docs
  - iii. Repeated tardiness
  - iv. Lying
  - v. Email, Facebook , HIPAA violations, etc.
  - vi. Other unprofessional behavior –
  - vii. Failure to keep CAP contract in effect
  - viii. Failure to meet terms of probation
  - ix. Failure to comply with rules, regulations, resident contract, resident manual
  - x. Noncompliance with program or school policies – e.g. moonlighting
- c. Medical knowledge
- i. Failure to provide care equivalent to peers
  - ii. Milestone issues
  - iii. Evaluation issues – may include other competencies
  - iv. Failure to meet program requirement – certain score on in service exams, failure to meet program time line – e.g. pass USMLE by some specific date
  - v. Not complying with terms of probation – e.g. reading certain things
7. The most unique and perhaps best way of setting up a request for Adverse Action was done in table form as follows:

A useful template for this is very similar to the example in the Probation Policy. Please also see the examples above for other reasons for the action. A sample Request for Adverse Action has been included in Appendix A.

THIS REQUEST FOR ADVERSE ACTION GOES TO THE DEPARTMENT HEAD WHO TYPES THE NOTICE AND THEN THE REQUEST FOR ADVERSE ACTION AND THE NOTICE FROM THE DEPARTMENT HEAD SUPPORTING THE ADVERSE ACTION BOTH GO TO THE RESIDENT AND ASSOCIATE DEAN FOR ACADEMIC AFFAIRS BY CAMPUS EMAIL. You can also give them to the resident in person.

### **SALARY POLICY FOR HOUSE OFFICER**

House officers may not be appointed gratis or self funded to ACGME approved programs. House officers will be paid the LSUHSC approved base salary at the assigned academic level in the training program regardless of the number of postgraduate years completed in other training programs. House officers training at the same academic level in the training program must receive the same salary amount. No one will be paid more or less than another trainee in that program at the same academic level.

All first year residents and fellows will be paid a base salary no higher than the approved base salary for a first year resident or fellow in the training program and a base salary no higher than the approved base salary for all other academic levels in the training program.

All trainees will be appointed in the personnel system with the approved base salary for his/her academic level of training. Programs that have approval to pay residents or fellows a salary

greater than the approved base salary can do so by paying the difference between the approved base salary and the greater amount by submitting a PER 3. The source of funds for this difference can be department/section funds, funds from an executed contract, a grant or another source of funds. All trainees at the same academic level are to receive the same salary amount. A separate executed contract must be done. An existing or renewed house officer contract cannot be used to pay a higher salary than the approved base salary.

### **RESIDENT SCHEDULER SYSTEM AND SYSTEM FUNCTIONS (PS-RTS)**

The PS-Resident Scheduler System (PS-RTS) provides the Payroll system the information required to issue a paycheck to all house officers.

The following information are guidelines for programs to follow to appoint house officers & input rotation schedules in the Resident Scheduler System. Program Coordinators must send New Hire packets to all new hire house officers entering their program(s). House officers are to complete the New Hire packet and return the packet with all required documents to the Program Coordinators. The Program Coordinators must attach a completed Personnel Form 2 (PER 2) to the New Hire packets and send the packet with the Per 2 to the GME Coordinator to review and forward to the Dean's Office for signature. The Dean's Office signs and forwards the New Hire paperwork and PER 2 to Human Resource Management (HRM) to forward to the Chancellor's Office for signature. It is returned to HRM to input the data contained in the New Hire Packet and on the PER 2 into the PeopleSoft Personnel system.

- Once the house officer's information has been inputted into the PeopleSoft Personnel system, the Program Coordinator can enter the house officer rotation schedules into PS-RTS.

A check will not be issued for any house officer that is assigned to a non-paying account, or assigned to Leave of Absence Action in the resident scheduler system. If a House Officer is assigned for less than 100% effort, his/her check will be issued based on the percent of effort he/she is assigned in PS-RTS.

**Account Codes** – Account Codes are issued by accounting once a fully executed contract for the rotation site is received. Accounting enters the account code information in PeopleSoft to be used when scheduling House Officers.

**Facility Numbers** – Facility Numbers identify the Facility the House Officer is assigned to each month and is entered in the PS-Resident Scheduler System when the program Coordinator enters the schedule for the month.

The PS-RTS is locked to all Coordinators every payday for the next pay period and it is locked to the GME Coordinator a week prior to the House Officer payday. The information in PS-RTS is used by payroll to issue a paycheck to the House Officers. When the PS-RTS System is locked, any changes related to that payroll must be made on a PER 3 submitted by the Program Coordinator to the GME Coordinator. The PS-RTS must be locked for paychecks to be issued.

## **SCHEDULES - VERIFICATION AND ENTERED IN RTS**

Program Coordinators are encouraged at the beginning of every month to begin entering their House Officer Schedules for the next month. Coordinators can use the Unassigned/Under Assigned option in PS-RTS to view if they have any un-assigned or under-assigned house officers for a particular month or range of dates. The GME Coordinator also reviews the Un-Assigned/Under-Assigned option in PS-RTS before locking the PS-Resident Scheduler System. If any problems are seen, the GME Coordinator contacts the program coordinator for clarification before corrections are made and the system is locked by the GME Coordinator.

Program Coordinators are encouraged to have the schedules for a particular month entered in PS-RTS by the last day of the previous month. Program Coordinators can begin scheduling for the next fiscal year when the Account Codes have been activated in PS-Resident Scheduler System to begin scheduling for the next fiscal year. The Program Coordinator can only schedule the new House Officer if the New Hire packet has been received by HR and the information has been entered into the PS Personnel System. Once the House Officer's information is entered in PS-Personnel, he/she will appear in PS-RTS and the rotation schedule can be entered. The GME Coordinator can update past and present PS-RTS schedules, except when PS-RTS system has been locked by the GME Coordinator.

After payroll runs that includes the last day of the month, the Program Coordinator must run and print the Certification Report with signature page for that month. The report is reviewed by everyone that must sign and corrections are to be made to the report. House Officers in each Residency and Fellowship training program review the Certification Report and sign by his/her name; or send an electronic response to the Program Coordinator certifying the information on the report is or is not correct. The Program Coordinator submits the Certification Report with the House Officer signatures; and/or the House Officer responses; and the signed signature page to the GME Office by a deadline. If leave was taken during the month and it is not included on the report, the house officer notifies the Program Coordinator and the Program Coordinator enters the leave information on the Certification report. If the rotation site/hospital is not correct on the report, the house officer notifies the program coordinator and the program coordinator makes the account code correction on the report. If there are account code changes, a PER 3 noting the account code change must be attached to the Certification report and submitted to the GME Office. The GME Office enters leave and account code corrections in PS-RTS. When all reports are received and all corrections made, the GME Office notifies accounting and accounting can begin their invoice process.

Discrepancies between the invoice and the information the hospitals have must be investigated and corrected and new invoices printed.

## **SOCIAL MEDIA POLICY**

All personnel employed by the LSUHSC School of Medicine – New Orleans (SOM) should abide by the SOM's published Social Media Guidelines in all social media interactions. The latest version of the Social Media Guidelines can be found at the SOM website at <http://www.medschool.lsuhs.edu>.

## **STAYING LONGER THAN 24+4 RESIDENT POLICY (EFFECTIVE 7/1/2011)**

PGY 1 residents' duty periods may be no longer than 16 hours and there are no exceptions allowed. Upper level residents are not allowed to stay longer than 24 hours with 4 hours for transitions. In those rare and extenuating cases where a resident absolutely must remain after 24+4 the resident must contact the Program Director for a specific exemption. If that is permitted verbally then the resident must communicate by email with the Program Director telling:

1. the patient identifying information for which they are remaining,
2. the specific reason they must remain longer than 24+4 ,
3. assurance that **all** other patient care matters have been assigned to other members of the team,
4. assurance that the resident will not be involved in any other matter than that for which the exemption is allowed and
5. assurance that the resident will notify the program director when they are complete and leaving.

In the event that the Program Director does not hear from the resident in a reasonable time (time specified by program), the Program Director or designee will locate the resident in person and assess the need for any further attendance by the resident. Residents caught in violation of this policy or who abuse this rare privilege will be subject to disciplinary action for unprofessional behavior.

### **How Monitored:**

The program director will directly monitor each of these cases. It is anticipated these requests will be infrequent at most. The Program Director will collect and review the written requests on a regular basis on each case and all cases in aggregate. The institution will monitor numbers and types of exceptions of this during annual reviews of programs and Internal Reviews.

## **SUPERVISION AND PROGRESSIVE RESPONSIBILITY POLICY (EFFECTIVE 7/1/2011)**

Several of the essential elements of supervision are contained in the Policy of Professionalism detailed elsewhere in this document. The specific policies for supervision are as follows.

### **Faculty Responsibilities for Supervision and Graded Responsibility:**

Residents must be supervised in such a way that they assume progressive responsibility as they progress in their educational program. Progressive responsibility is determined in a number of ways including:

1. GME faculty on each service determine what level of autonomy each resident may have that ensures growth of the resident and patient safety.
2. The Program Director and Chief Residents assess each residents level of competence in frequent personal observation and semi-annual review of each resident.
3. Where applicable progressive responsibility is based on specific milestones.

4. Use of simulation labs and OSCEs where applicable before allowing the residents to perform procedures on patients.

The expected components of supervision include:

1. Defining educational objectives.
2. The faculty assessing the skill level of the resident by direct observation.
3. The faculty defines the course of progressive responsibility allowed starting with close supervision and progressing to independence as the skill is mastered.
4. Documentation of supervision by the involved supervising faculty must be customized to the settings based on guidelines for best practice and regulations from the ACGME, JACHO and other regulatory bodies. Documentation should generally include but not be limited to:
  - a. progress notes in the chart written by or signed by the faculty
  - b. addendum to resident's notes where needed
  - c. counter-signature of notes by faculty
  - d. a medical record entry indicating the name of the supervisory faculty.
5. In addition to close observation, faculty are encouraged to give frequent formative feedback and required to give formal summative written feedback that is competency based and includes evaluation of both professionalism and effectiveness of transitions.

**The levels of supervision are defined as follows:**

- **Direct Supervision by Faculty** - faculty is physically present with the resident being supervised.
- **Direct Supervision by Senior Resident** – same as above but resident is supervisor.
- **Indirect with Direct Supervision IMMEDIATELY Available – Faculty** – the supervising physician is physically present within the hospital or other site of patient care and is **immediately** available to provide Direct Supervision.
- **Indirect with Direct Supervision IMMEDIATELY Available – Resident** - same but supervisor is resident.
- **Indirect with Direct Supervision Available** - the supervising physician is not physically present within the hospital or other site of patient care, but is immediately available by means of telephonic and/or electronic modalities, and is available to provide Direct Supervision.

**Oversight** – The supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered.

Programs must specify level- and service type-specific criteria using the grids below.

**Inpatient Services**

<i>PGY</i>	<i>Direct by Faculty</i>	<i>Direct by senior residents</i>	<i>Indirect but immediately available - faculty</i>	<i>Indirect but immediately available - residents</i>	<i>Indirect available</i>	<i>Oversight</i>
<b>I</b>						
<b>II</b>						
<b>III</b>						
<b>IV</b>						
<b>V</b>						

**Intensive Care Units**

<i>PGY</i>	<i>Direct by Faculty</i>	<i>Direct by senior residents</i>	<i>Indirect but immediately available - faculty</i>	<i>Indirect but immediately available - residents</i>	<i>Indirect available</i>	<i>Oversight</i>
<b>I</b>						
<b>II</b>						
<b>III</b>						
<b>IV</b>						
<b>V</b>						

**Ambulatory Settings**

<i>PGY</i>	<i>Direct by Faculty</i>	<i>Direct by senior residents</i>	<i>Indirect but immediately available - faculty</i>	<i>Indirect but immediately available - residents</i>	<i>Indirect available</i>	<i>Oversight</i>
<b>I</b>						
<b>II</b>						
<b>III</b>						
<b>IV</b>						
<b>V</b>						

**Consult Services**

<i>PGY</i>	<i>Direct by Faculty</i>	<i>Direct by senior residents</i>	<i>Indirect but immediately available - faculty</i>	<i>Indirect but immediately available - residents</i>	<i>Indirect available</i>	<i>Oversight</i>
<b>I</b>						
<b>II</b>						
<b>III</b>						
<b>IV</b>						
<b>V</b>						

**Operating Rooms:**

<i>PGY</i>	<i>Direct by Faculty</i>	<i>Direct by senior residents</i>	<i>Indirect but immediately available - faculty</i>	<i>Indirect but immediately available - residents</i>	<i>Indirect available</i>	<i>Oversight</i>
<b>I</b>						
<b>II</b>						
<b>III</b>						
<b>IV</b>						
<b>V</b>						

**Procedure Rotations**

<i>PGY</i>	<i>Direct by Faculty</i>	<i>Direct by senior residents</i>	<i>Indirect but immediately available - faculty</i>	<i>Indirect but immediately available - residents</i>	<i>Indirect available</i>	<i>Oversight</i>
<b>I</b>						
<b>II</b>						
<b>III</b>						
<b>IV</b>						
<b>V</b>						

**PGY 1 residents may not be unsupervised by either faculty or more senior residents in the hospital setting.**

**How Monitored:**

The institution will monitor implementation of the policies through Annual Review of Programs and Internal Reviews. Furthermore the institution monitors supervision through a series of

questions in the Annual Resident Survey. The program will monitor this through feedback from residents and monitoring by Chief Residents and Program Directors. Supervision will be added to the annual review of programs.

#### **TRANSITIONS/HAND-OFF POLICY (EFFECTIVE 7/1/2011)**

The transitions policy is created in recognition that multiple studies have shown that transitions of care create the most risk or medical errors (ACGME teleconference July 14, 2010.) In addition to the below specific policies, promotion of patient safety is further ensured by:

1. Provision of complete and accurate rotational schedules in New Innovations
2. Presence of a backup call schedule for those cases where a resident is unable to complete their duties.
3. The ability of any residents to be able to freely and without fear of retribution report their inability to carry out their clinical responsibilities due to fatigue or other causes.

#### Policy and Process

Residents receive educational material on Transitions in Orientation and as a Core Module.

In any instance where care of a patient is transferred to another member of the health care team an adequate transition must be used. Although transitions may require additional reporting than in this policy a minimum standard for transitions must include the following information:

1. Demographics
  - a. Name f. Weight
  - b. Medical Record Number g. Gender
  - c. Unit/room number h. Allergies
  - d. Age i. Admit date
  - e. Attending physician – Phone numbers of covering physician
2. History and Problem List
  - a. Primary diagnosis(es)
  - b. Chronic problems (pertinent to this admission/shift)
3. Current condition/status
4. System based
  - a. Pertinent Medications and Treatments
  - b. Oral and IV medications
  - c. IV fluids
  - d. Blood products
  - e. Oxygen
  - f. Respiratory therapy interventions
5. Pertinent lab data
6. To do list: Check x-ray, labs, wean treatments, etc - rationale
7. Contingency Planning – What may go wrong and what to do
8. **ANTICIPATE** what will happen to your patient. Ex:
  - a. *“If patient seizes > 5 minutes, give him Ativan 0.05mg/kg. If he still seizes load him with 5mg/kg of fosphenytoin.”*



9. Code status/family situations
10. Difficult family or psychosocial situations
11. Code status, especially recent changes or family discussions

This information is found on pocket cards delivered to each house officer. The process by which this information is distributed is via Core Modules and Orientation presentations to residents and via a Compliance Module for faculty. In addition this information is presented in program/departmental meetings.

***Programs must periodically sample transitions including a sample of a patient's chart and interview of incoming team to ensure that key elements are transmitted and have been understood.***

### **How monitored:**

Faculty are required to answer a question on effectiveness of witnessed transitions on each evaluation. ***Programs must add to the end of each monthly evaluation form in New innovations the following language: "I have witnessed effective transitions in person and attest the essential elements as defined in the Transitions Policy was transmitted to and understood by the receiving team."*** The process and effectiveness of each program's system is monitored through the Annual Program Review and the Internal Review process. The institution and program will monitor this by periodic sampling of transitions, as part of the Annual Review of Programs and as part of the Internal Review Process.

### **VISITING RESIDENT – PARTICIPATING IN PATIENT CARE ACTIVITIES**

Visiting participating resident periods should be for one month in duration and must not exceed 3 months in a year.

The following information is criteria and required documentation for a visiting resident:

1. A letter from the LSUHSC department acknowledging/ informing the GME office of the status of the visiting resident which includes the following:
  - Full name of visiting resident/fellow.
  - Start date and end date visiting resident/fellow will be participating in the short-term training.
  - Paragraph stating what the training will include (for example, participating in clinics, scrubbing in Surgery, attending various academic conferences connected with the program, along with all the hospitals the visiting resident/fellow will be rotating to during the visit, (see attached sample).
  - Paragraph stating there is no re-numeration or salary offered and that any costs incurred, including transportation, all living expenses and mandatory health insurance is the visiting resident's responsibility, (see attached sample).
  - Approval of rotation with signature line for Chairman, Program Director, Director of Graduate Medical Education, and visiting resident.

2. Must have a valid Louisiana Medical permit/license before beginning the short-term training as a visiting resident/fellow. Visiting resident/fellow must contact the LSBME at (504) 568-6820 to obtain information on getting a temporary permit to practice medicine in LA. This is a lengthy process (a few months), therefore it should be done as soon as the visiting resident decides he/she wants to come to LA. Permit/license is to be attached to the letter (#1).
3. If the visiting resident/fellow is a foreign medical graduate (FMG), he/she must have a valid ECFMG certificate and it should also be attached to the letter (#1) along with the LA license/permit.
4. Have an ID badge to be worn while on campus and in hospitals, or obtain a visiting ID badge from LSUHSC Human Resource Management Department. Department should contact HRM department for instructions for obtaining a visiting ID badge
5. Must submit a MCL Appointment for Visiting House Officer Form to the LSUGME Office to approve and forward to MCL.

Once the Chairman, Program Director, and visiting resident have signed the letter, it is sent to the attention of GME Coordinator to obtain the signature of the Director of Medical Education. After all parties have signed, copies are sent to Medical Education Office at MCLANO for observation privileges at MCL/University Hospital; Vice Chancellors Office for malpractice issues; the GME Office keeps a copy and the original is returned to the program.

#### **VENDOR POLICY**

Relations to vendors and all other private entities are covered by the Code of Government Ethics and the policies promulgated by the LSUHSC Conflict of Interest Committee via various Chancellors Memoranda. All state employees are bound by the ethics statutes with the most relevant being Louisiana Code of Governmental Ethics Title 43, Chapter 15 number 6 page 14 – Gifts. To paraphrase - “no public employee shall solicit or accept directly or indirectly anything of economic value as a gift or gratuity from any person if the public employee does or reasonably should know such a person conducts activities or operations regulated by the public employees agency or has substantial economic interests which may be substantially affected by the performance or nonperformance of the public employees duty. “ When in the various training sites the resident is further bound by the rules and policies of that institution.

#### **AMA CODE OF MEDICAL ETHICS, OPINION 8.061, “GIFTS TO PHYSICIANS FROM INDUSTRY.”**

(1) Any gifts accepted by physicians individually should primarily entail a benefit to patients and should not be of substantial value. Accordingly, textbooks, modest meals, and other gifts are appropriate if they serve a genuine educational function. Cash payments should not be accepted. The use of drug samples for personal or family use is permissible as long as these practices do not interfere with patient access to drug samples. It would not be acceptable for non-retired physicians to request free pharmaceuticals for personal use or use by family members.

- (2) Individual gifts of minimal value are permissible as long as the gifts are related to the physician's work (eg, pens and notepads).
- (3) The Council on Ethical and Judicial Affairs defines a legitimate "conference" or "meeting" as any activity, held at an appropriate location, where (a) the gathering is primarily dedicated, in both time and effort, to promoting objective scientific and educational activities and discourse (one or more educational presentation(s) should be the highlight of the gathering), and (b) the main incentive for bringing attendees together is to further their knowledge on the topic(s) being presented. An appropriate disclosure of financial support or conflict of interest should be made.
- (4) Subsidies to underwrite the costs of continuing medical education conferences or professional meetings can contribute to the improvement of patient care and therefore are permissible. Since the giving of a subsidy directly to a physician by a company's representative may create a relationship that could influence the use of the company's products, any subsidy should be accepted by the conference's sponsor who in turn can use the money to reduce the conference's registration fee. Payments to defray the costs of a conference should not be accepted directly from the company by the physicians attending the conference.
- (5) Subsidies from industry should not be accepted directly or indirectly to pay for the costs of travel, lodging, or other personal expenses of physicians attending conferences or meetings, nor should subsidies be accepted to compensate for the physicians' time. Subsidies for hospitality should not be accepted outside of modest meals or social events held as a part of a conference or meeting. It is appropriate for faculty at conferences or meetings to accept reasonable honoraria and to accept reimbursement for reasonable travel, lodging, and meal expenses. It is also appropriate for consultants who provide genuine services to receive reasonable compensation and to accept reimbursement for reasonable travel, lodging, and meal expenses. Token consulting or advisory arrangements cannot be used to justify the compensation of physicians for their time or their travel, lodging, and other out-of-pocket expenses.
- (6) Scholarship or other special funds to permit medical students, residents, and fellows to attend carefully selected educational conferences may be permissible as long as the selection of students, residents, or fellows who will receive the funds is made by the academic or training institution. Carefully selected educational conferences are generally defined as the major educational, scientific or policy-making meetings of national, regional, or specialty medical associations.
- (7) No gifts should be accepted if there are strings attached. For example, physicians should not accept gifts if they are given in relation to the physician's prescribing practices. In addition, when companies underwrite medical conferences or lectures other than their own, responsibility for and control over the selection of content, faculty, educational methods, and materials should belong to the organizers of the conferences or lectures. (II)
- (Approved GMEC: July 21, 2007)

IGMEC 4/05

Approved GMEC 4/07, 6/07, 10/07, 7/08, 2/11

**HOUSE OFFICERS ARE TO REFER TO THE LSU HOUSE OFFICER MANUAL OR THE GME WEBSITE [http://www.medschool.lsuhsu.edu/medical\\_education/graduate/](http://www.medschool.lsuhsu.edu/medical_education/graduate/) FOR A COMPLETE LIST OF REQUIREMENTS, POLICIES, AND PROCEDURES PERTAINING TO THEIR TRAINING.**



**APPENDIX A**  
**SAMPLE REQUEST FOR ADVERSE ACTION**

June 23, 20XX  
John Doe, M.D.  
1 Audubon Place  
New Orleans, LA 70XXX

**Re: Request for Adverse Action**

Dear Dr XXXXXXXX:

**Proposed Action:**

After carefully reviewing your nurse, resident, and student evaluations and discussing your portfolio with a committee of XXXXXX faculty, the XXX Program is non-renewal of your contract (or termination or non-promotion as the case may be) effective July 1, 20XX.

**List of Deficiencies / Reasons for Action:**

This recommendation for non-renewal is based on the recommendations of the XXXX committee and is due to your substandard performances in the following competencies:

- 1) Patient Care:
  - a. Weak XXXXX (specialty) knowledge as demonstrated by your substandard in service exam scores both in July 20XX and February 20XX compromising patient care,
  - b. Inability to apply your knowledge for both teaching students and interns, and for providing sound patient care. Examples of this include:
    - i. XXXX
    - ii. XXXX
  - c. Lack of attention to detail compromising patient care. Examples of this include:
    - i. XXXX
    - ii. XXXX
  - d. Poor organizational and time-management skills reflected in:
    - i. Inability to write timely and accurate orders. Examples of this include:
      1. XXXX
      2. XXXX
    - ii. Execute the staff and resident's therapeutic plans causing the supervisory residents to do much of your work. Examples of this include:
      1. XXXX
      2. XXXX
    - iii. Inability to work effectively as a team player. Examples of this include:
      1. XXXX
      2. XXXX
  - e. Failure to consistently follow through on orders that you were specifically instructed to complete on your patients. Examples of this include:
    - i. Failure to look up the doses. This was seen :

1. XXXX
  2. XXXX
- f. Use of incorrect or deliberately approximate dosing in critical situations.  
Examples of this include:
- i. XXXX
  - ii. XXXX
- g. Failure to follow a specific order on a medicine. Examples of this include:
- i. XXXX Rocephin
- 2) Medical Knowledge:
- a. Weak XXSPECIALTYXX medical knowledge evidenced by
    - i. Poor performance on xxxxx in-service exams in July 2009 and February 2010
    - ii. Overall clinical performance on XXXX ward month in October 2009 and the XXXX team wards in June 2010.
    - iii. Lack of insight into areas of weakness as evidenced by comments made about your performance by peers and supervisory residents on “check out “rounds and other rounds where you are directly observed. Specific examples of this include:
      1. XXXX
      2. XXXX
- 3) Interpersonal Skills/Communication Skills:
- a. Disrespectful, condescending behavior with fellows, residents, and students.  
Examples include
    - i. XXXX
    - ii. XXXX
  - b. When questioned about the behavior you rationalized this behavior as a defense mechanism used for survival. Specific examples of this include:
    - i. XXXX
    - ii. XXXX
  - c. Continued disrespectful behavior after counseling by myself and others. This was specifically sees:
    - i. XXXX
  - d. Lack of insight into your behaviors and performance level as reflected above as reflected in the following examples:
    - i. XXXX
    - ii. XXXX
  - e. Rude and abrasive behavior with patients, families and peers as evidenced by
  - f. Several peers strongly dislike working with you because of your failure to adequately and consistently complete the tasks assigned to you. Examples of this include:
    - i. XXXX
    - ii. XXXX
- 4) Professionalism:
- a. Rude and disrespectful behavior. Examples include
    - i. XXXX
    - ii. XXXX

- b. Inability of your peers to trust you. Examples include
    - i. XXXX
    - ii. XXXX
  - c. Untruthful behavior. Examples include:
    - i. XXXX
    - ii. XXXX
  - d. Your cavalier, overconfident behavior without the essential knowledge base is a dangerous combination that many residents feel will result in poor outcome for patients if you are not heavily supervised at all times.
  - e. Failure to arrive on time.
  - f. Unauthorized absences.
- 5) Practice-Based Learning:
- a. Failure to read assigned materials as seen:
    - i. XXXX
    - ii. XXXX Web MD, XXXXX etc
  - b. Failure to recognize, reflect on and correct mistakes despite being specifically counseled. Examples of this include
    - i. xxxx
    - ii. xxxx

**List of all known documentary materials to be used in a hearing**

1. The above listing assumes there would be attached documentation supporting each or many of the listed deficiencies. If so you would say see attached documentation.
2. You may add letters, evaluations, or anything collected to prove your point, but they would be added as an addendum if not already in the above mentioned documentation.
3. If you do not plan to list and attach a lot of documentation (a mistake!) then you can simply refer to the “resident file” which means you need to introduce the whole thing or select parts and attach to the request.

**List of Witnesses and Expected Testimony**

1. It is assumed that in many of the above specific instances a specific person will be named as making the complaint or turning in the evaluation etc. that led to the item being included. If so you can simply state something like “The witnesses who may testify are included in the charges listed under reasons and will testify to the validity of the information listed in that charge.”
2. Otherwise list them and say something brief like “they will attest to the evaluations in the file”, or “they will attest the resident didn’t show up” or “they will attest the resident lied” or whatever they will attest to.

Sincerely,

Jane Doe  
Program Director