Psychiatry Residency Program Handbook
2016 – 2017
Policies, Procedures and Program Requirements
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Appendix A American Psychiatric Association: The Principles of Medical Ethics with Annotations Especially Applicable to Psychiatry
The Morehouse School of Medicine General Psychiatry Residency Program is committed to training excellent psychiatrists with an expertise in community-based health delivery and advocacy, aimed at promoting lifelong health habits that decrease health disparities in poor, rural, racial, and economically disadvantaged populations.

Morehouse School of Medicine seeks to provide students with disabilities equal opportunities and equal access to academic programs, services, and activities. If you have a disability for which you wish to request academic adjustments/accommodations, please contact the Office of Disability Services at the beginning of each semester (or as soon as practicable). The Office of Disability Services is located in NCPC, Room 408. You may contact the office at (404) 756-5200 or via e-mail at ODS@msm.edu.
Program Overview

Introduction
Welcome to the Psychiatry Residency Program at Morehouse School of Medicine (MSM). We are excited to have you as a member of our residency team. Our residency environment will provide you with the clinical case experience, didactic information, and confidence to enter the practice of general psychiatry as a competent, board-eligible physician.

Residency is much different than any prior training you may have experienced. You will learn the skills and didactic information that will enable you to diagnose and treat a diverse patient population with a wide variety of disorders. The skills you learn here will become the foundation of your medical career.

It should be your goal to acquire as much clinical experience in all areas as possible. You should develop a concentrated study program to ensure the steady accumulation of knowledge required to care for your patients.

In the following pages, you will find suggestions for accomplishing your goal of becoming a competent, board-certified psychiatrist. In addition to general program information, this manual provides policies and procedures for the residency. The manual is updated with new information, schedules, and department rosters as they are made available. All goals and objectives are/will be uploaded into your rotation curriculum available through New Innovations online. As always, we welcome your input, constructive criticism, and comments.

Program Mission
Our mission is to train psychiatric residents to provide excellent and quality healthcare to all, especially the underserved. The Psychiatry Residency Program is designed to provide a comprehensive learning experience that prepares psychiatrists to meet the demands of contemporary psychiatric practice. Emphasis is placed on the development of psychiatrists who have acquired their knowledge, skills, and competencies predominantly through community-based learning experiences.

This is a novel approach because our residents gain a significant amount of experience in the community as opposed to traditional residency programs that may focus more on the hospital environment. The program allows residents the opportunity to explore the many facets of psychiatric care in the 21st century.

The city of Atlanta is a multicultural city with a variety of people from different races and ethnicities, and the program benefits from this diversity. Residents benefit from a variety of patient experiences, whether patients are from the inner city, suburbia, foreign countries, or rural areas.

Graduates of the MSM Psychiatry Residency Program, while expected to become excellent clinicians, are equipped to adapt to the rapidly evolving dynamics of health care.

Residency Setting
Our program hospital partners include:
- Grady Memorial Hospital (GMH)
- Atlanta VA Medical Center (VA)
- Georgia Regional Hospital (GA REG)
- Laurel Heights Hospital (LHH)
- East Point CBOC (branch of Atlanta VA)

In addition, we have a host of private and public sector partners for our outpatient rotations.
Administrative Structure
The following sections describe the roles and responsibilities of the members of our administration.

Program Director
The program director provides the overall leadership, development, and implementation of the residency program. The program director ensures that the program is compliant with all Accreditation Council for Graduate Medical Education (ACGME) requirements for a psychiatry residency training program. The program director is responsible for residents’ progression and matriculation from the program. The program director tracks and reviews all resident evaluations, patient logs, and duty hours to ensure overall resident and program compliance.

Other responsibilities of the program director include:
- Overseeing all aspects of the residency program and resident education
- Creating and maintaining the affiliation agreements and alliances with the necessary educational and clinical entities, hospitals, clinics, and individual physicians to provide the highest quality training opportunities in the field of psychiatry
- Updating and modifying educational goals and curricula
- Overseeing and approving topics for lectures and instruction as deemed fit by the program and the emerging guidelines of the Residency Review Committee (RRC) and the American Board of Psychiatry and Neurology
- Directly supervising the program manager and the core psychiatry faculty and staff involved with the residency program implementation
- Working closely with the department’s chairperson and other officials at MSM to ensure that the program reflects the mission of the institution as well as the department
- Overseeing the resident selection and promotion process

Associate Program Director
The associate program director is responsible to:
- Support the training director and program manager with administrative duties within the Psychiatry Residency program.
- Review program policies.
- Review rotation and didactic goals and objectives.
- Assist with six (6) month resident performance reviews.
- Assist the chief resident in developing the Wednesday Academic Activity schedule, inclusive of case conferences, journal club, and Grand Rounds.
- Encourage, monitor, and assist residents in identifying and participating in appropriate scholarly activities.
- Attend the Residency Training Committee Meetings each month.
- Assist the Psychiatry program with recruitment and active participation in the interview process of applicants for the residency program.
Chief Resident
The chief resident supports resident teaching activities such as Grand Rounds, weekly didactics, Journal Club, and Clinical Case Conferences. The chief resident supervises the development and modification of resident schedules, including vacation requests and arranging back-up coverage for unplanned absences. The chief resident attends Residency Training Committee meetings of the department and serves as the resident liaison. A new chief resident is either appointed for each academic year from the graduating class (or PGY-3 class if no graduate is selected). Interested candidates are encouraged to contact the program director as early as possible for consideration.

The chief resident is responsible to:

- Set and maintain the standard of professional conduct for the entire program.
- Support the training director, associate training director, and program manager with administrative duties within the Psychiatry residency program.
- Develop the Wednesday Academic Activity schedule, inclusive of case conferences, journal club, and Grand Rounds.
- Act as liaison between the residency and the program manager, training director, associate training director, and Program Evaluation Committee with regard to policies and procedures within the program.
- Support and enact the policies and procedures of the Psychiatry residency program, the MSM system, and the ACGME to ensure that residents are fulfilling ACGME competencies and ensure continued accreditation as well as the success of the program.
- Attend the Residency Training Committee Meeting the third Wednesday of each month and Administrative Supervision biweekly with the training director and/or associate training director.
- Conduct monthly resident meetings to assess resident progress, needs, and concerns.
- Provide an avenue of communication for an educational environment in which interns and residents may raise and resolve issues without fear of intimidation or retaliation.
- Assist with orientation of the interns to ensure continuity of service and care for all Psychiatry patients. Assist residents with transitions to next clinical sites.
- Ensure that the upper level residents are helping in the education of medical students and lower level residents within the Psychiatry Department and rotations of clinical services system.
- Assist the VA Chief in completion of the call schedule for Morehouse residents and interns. Provide the training director and program manager with the monthly call schedule every six (6) months.
- Assist the Psychiatry program with recruitment and active participation in the interview process of applicants for the residency program.
- Lead peer selection process of Resident Association (RA) Members at Large per RA bylaws and deadlines.
- Assist the RA by selecting members at large to represent the program and residents as members to institutional and hospital committees as requested by the Graduate Medical Education Committee.

The chief resident is also responsible for the following duties specific to the VA:

- Share responsibility with Emory chief to complete and tend to call schedules and vacation requests for Emory and Morehouse interns, residents, and med students.
- Share responsibility with Emory chief for the orientation of residents and students (computer codes, unit orientation with CPRS note formats, obtaining keys, photo IDs, etc.).
- Set up multisource evaluation meetings for residents twice a year.
• Share responsibility with Emory chief to be available by pager for residents after hours for any on-call clinical issues.
• Track and address vacation and call swaps.
• Tally meal tickets every month for Mr. Ratcliffe.
• Mutually serve as back-up for the co-chief during absences.
• Share in teaching duties, which include attending team meetings for MSM interns and teaching for MSM interns separately about clinical information gathering and clinical basics.
• Assist with student orientation.

**Program Manager**
The program manager manages the daily operational activities of the residency program and interacts with different personnel at various affiliated institutions as needed. The program manager ensures that the residents complete all required paperwork, including obtaining evaluations. The program manager also ensures that residents’ master files, evaluations, immunization certificates, visa documents and United States Medical Licensing Examination (USMLE) scores are kept up to date.

The program manager is responsible for completing and filing all required paperwork and communications from internal and external entities (e.g., MSM Graduate Medical Examination [GME] office, American Board of Psychiatry and Neurology, American Psychiatric Association). The program manager coordinates the resident recruitment activities in conjunction with the program director.

**Program Assistant**
The program assistant provides administrative support to the program director, associate program director, and the residency program manager. The residency program assistant provides professional and prompt completion of data entry, expense requests, travel support, program documentation, and meeting logistics.
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<th>Internal Medicine Chief Residents (404) 756-1325/(404) 756-1229 48 Armstrong Street, Atlanta, GA 30303</th>
</tr>
</thead>
<tbody>
<tr>
<td>Latoya Carter Program Manager 404-756-1368 office <a href="mailto:lacarter@msm.edu">lacarter@msm.edu</a></td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>MSM Department of Internal Medicine Resident Information</th>
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<tbody>
<tr>
<td>Chief Resident Dr. Kamal Nayyar <a href="mailto:KNayyar@msm.edu">KNayyar@msm.edu</a></td>
</tr>
<tr>
<td>Chief Resident Dr. Benjamin Renelus <a href="mailto:brenelus@msm.edu">brenelus@msm.edu</a></td>
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<tr>
<th>Graduate Medical Education</th>
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<tr>
<td>Yolanda Wimberly, M.D. Designated Institutional Official (DIO) <a href="mailto:ywimberly@msm.edu">ywimberly@msm.edu</a> 404-756-1373 (office)</td>
</tr>
<tr>
<td>Tammy Samuels, MPA Director, GME 404-752-1011 (office) 404-752-1088 (fax) <a href="mailto:tsamuels@msm.edu">tsamuels@msm.edu</a></td>
</tr>
<tr>
<td>Jenay Hicks Program Mgr. 404-752-1857 office <a href="mailto:jhicks@msm.edu">jhicks@msm.edu</a></td>
</tr>
<tr>
<td>Paulette Neal-Parham 404-756-1324 (office) <a href="mailto:pneal-parham@msm.edu">pneal-parham@msm.edu</a></td>
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</tbody>
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<tr>
<th>PGY-4 Electives</th>
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<tbody>
<tr>
<td>Adriana Hermida, M.D. Geriatrics 678-372-0597 <a href="mailto:ahermida@emory.edu">ahermida@emory.edu</a></td>
</tr>
<tr>
<td>Barbara Little Sickle Cell Elective 678-380-4103</td>
</tr>
<tr>
<td>Wesley Woods/Geriatric Psych Michele Miles <a href="mailto:mlmiles@emory.edu">mlmiles@emory.edu</a> 404-728-6948 (office)</td>
</tr>
<tr>
<td>Chris Crowe, M.D. Psychotherapy Attending/Elective 404-321-6111 x6888 <a href="mailto:Chris.crowe@va.gov">Chris.crowe@va.gov</a></td>
</tr>
<tr>
<td>Amy Cromwell Coordinator-Addiction, Psychosomatic Med, and Geriatric Fellowships Wesley Woods Rm 412 404-728-6470 <a href="mailto:acromwe@emory.edu">acromwe@emory.edu</a></td>
</tr>
<tr>
<td>Sunjay Sharma, M.D. Grady HIV/AIDS Clinic 404-616-9706 office 404-616-9710 <a href="mailto:Ssharma02@emory.edu">Ssharma02@emory.edu</a></td>
</tr>
<tr>
<td>Martha Ward, M.D. Grady Med Psych Clinic PGY-4 Elective <a href="mailto:mcraig@emory.edu">mcraig@emory.edu</a> 404-616-6279 office</td>
</tr>
<tr>
<td>Funmi Rachal, M.D. Behavioral Medicine Institute of Atlanta (BMI) <a href="mailto:fachal@bmiatlanta.com">fachal@bmiatlanta.com</a> 404-872-7929 - phone</td>
</tr>
<tr>
<td>Robert Cotes, M.D. Grady Clozaril Clinic <a href="mailto:robert.o.cotes@emory.edu">robert.o.cotes@emory.edu</a> (404)616-4752 pic#14164</td>
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<tr>
<td>Department</td>
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<td>Human Resource Office</td>
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<td>Information Technology</td>
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Psychiatry Residents 2016-2017

PGY-1 Residents

Olasupo Adedapo, M.D.
Je Ajayi, M.D.
Jay Bhimani, M.D.
Siddharth Shah, M.D.

PGY-2 Residents

Christopher Hoffman, M.D.
Kevin Simon, M.D.
Christopher Smith, M.D.
Otega Edukuye, M.D.

PGY-3 Residents

Simran Brar, M.D.
Vipan Kumar, M.D.
Brittnie Fowler, M.D.
Hena Bukhari, M.D.

PGY-4 Resident

Jordan Howard, M.D.
Chief Resident
Swathi Krishna, M.D.
Kanaka Meyyazhagan, M.D.
Chief Resident
General Information

Certifications

Residents are required to be certified in Advanced Cardiac Life Support (ACLS) and Basic Life Support (BLS) throughout their residency. Residents must apply for a National Provider Identifier number (NPI) and use this number for writing prescriptions.

Counseling Services

The stress associated with residency programs is well recognized. MSM offers an Employee Assistance Program (EAP) through the insurance carrier United Healthcare. The EAP provides confidential assistance to all MSM employees and their families. Through the EAP, residents and their families can receive confidential, professional help.

To make inquiries regarding assistance, contact MSM’s Human Resources Department.

In the event that a resident is reported as one who appears to be persistently sleepy or fatigued while on duty, the program director and the resident’s faculty member mentor will counsel the resident individually to determine if there are some medical, physical, or psychosocial factors affecting his or her performance. Residents may be directed to the office of Disability Services based on findings if needed.

Disputes with Personnel

In the event of interpersonal conflict that is not mutually and adequately resolved, the dispute should be brought to the attention of the Attending faculty. All parties involved will be assembled to resolve any disagreement. In the event that the dispute cannot be resolved, the matter will be presented to the program director, who will then act as arbitrator.

Leave Information—Vacation, Holiday, Sick Leave, Post Call, and Availability

Residents are expected to perform their duties as resident physicians for a minimum of 11 months each calendar training year. Absences from the training program for vacation, illnesses, or personal business must not exceed a combined total of four (4) weeks per academic year, or extra time will be extended onto the residency.

For successful completion of the program in time for board eligibility in July following graduation, the American Board of Psychiatry and Neurology does not permit more than 30 days leave time per year. Leave time is any time away from the residency training program that is unrelated to educational purposes. Leave time in excess of 30 days is at the discretion of the program director. Absences from the residency program in excess of one (1) month within the academic year must be made up before the resident advances to the next level. In addition, time is added to the date of completion of the required 48 months of training.

As a rule, leave must be approved 30 days in advance.

Note: Do not make any travel plans before the leave request is approved!

Complete the paper leave form and have ALL supervisors sign it (this includes all the clinical services from which you will be absent) and submit to the Residency Training Program for PD’s signature. The program manager will send an e-mail after the leave has been approved, then you must enter that time in KRONOS. Vacation leave must be submitted in advance, and sick leave should be entered into KRONOS on the same day of absence, not later. The KRONOS system will not allow time entry after the pay period has ended; only HR can enter that time.

See Leave Form, under Departmental Forms.
**Vacation**

Each resident is allowed 15 days of vacation. Vacation requests are granted on a first-come, first-served basis using the official form approved by the program.

Vacation time is scheduled during designated rotations. Any request for leave outside of designated rotations or blocks should be discussed with the program director. All requests for exceptions should be in a letter addressed to the program director detailing the request and specific reasons for the deviation from the aforementioned policies. If any changes in the on-call schedule are necessitated by a leave request, it is the resident’s responsibility to secure coverage in advance. The names of the physicians covering the clinic or call hours must appear on the request form.

Submit the leave request in the following sequence:

1. Submit the request to your site supervisor(s) for approval and signature;
2. After you obtain your supervisor(s) signature, submit the leave request to the PM or PA;
3. Then submit the form to the program director or associate program director for approval.

All requests must be made at least 30 days in advance. Requests will be considered in the order in which they are received. No travel plans should be made until the program director approves the request.

Vacation days not used will not carry over to the next academic year (the will not be accrued). Vacation leave is not subject to an accumulated “pay out” upon the completion of training or upon a resident’s termination from the program.

**Holidays**

Approved MSM holidays do not apply to your rotation holidays. Check with your particular rotation to determine what days are considered holidays. For example, MSM celebrates Good Friday, but other practices may not. The rotation schedule supersedes any MSM holiday.

**Post Call**

Each resident is responsible to inform the RTP if he or she is post-call on a Wednesday the night before via e-mail to the program manager and the didactics instructor, copying the program assistant.

**Program Duty Hour Logging Requirements**

Duty hour logs are recorded **DAILY** into New Innovations by the residents. Failure to log duty hours for seven (7) or more consecutive days **WILL** results in an administrative day for the resident.

There are seven (7) types of duty hours that should be entered into New Innovations

- Shift/rotation—all schedule activities (including lectures) associated with rotation
- Clinic—
- Conference/workshops/lecture—**Wednesday** didactics, Board review, noon conference, and Grand Rounds only
- Back-up call in—any time a resident is called in for a shift as back-up
- Vacation
- Holiday/Day off

**Time Management and Administrative Responsibilities**
In recent years, ACGME requirements have significantly changed, moving towards resident documentation of competencies and programs’ verification of residents’ competencies. In addition, duty hours have become more restrictive to ease resident fatigue and optimize physical readiness of performing and learning.

Not only are residents and program obligated to follow these rules, but often credentialing agents request competency-based evaluation of former residents presented before them. Because of this, it is very important that all of the administrative duties, logging of duty hours, patient/procedure logs and participation in learning opportunities are met and documented by the resident. Below are the requirements that residents are obligated to complete, being excused only per the policy outlined in this manual in the corresponding section:

- Duty hours to be logged on a daily basis
- Patient logs to be logged as outlined
- **Seventy (70%)** attendance to Grand Rounds and Didactics on a quarterly basis *

* Excused absences (e.g., sick, vacation, ER shifts, etc.) will not be counted against the resident.

Please be advised that Duty Hours do not include self-study activities.

It is strongly advised that you set aside a minimum of 2-3 hours per weekday (or 10-15 hours per week) to complete these administrative program requirements. The Apple iPad provided by the Program can be used to facilitate all of these activities. Like all professionals, it is expected that residents manage their time appropriately. If you are feeling overwhelmed, we suggest setting up a designated time during the week to complete the activities, setting up your Microsoft Outlook calendar to send automated reminders and meeting with your advisors and fellow residents for suggestions.

**Administrative Call**

Be advised that each of the listed responsibilities will be reconciled on a quarterly basis; that is the program director will collect and review the information to ensure that each resident is in compliance, with the EXCEPTION of duty hours, which are monitored weekly. If you are found to be out of compliance (i.e. logs are more than two (2) weeks out of date, less than 70% Grand Rounds/didactic attendance) you will be placed on an “Administrative shift” to complete or review missed materials. Administrative shifts will be done on Saturday or Sunday at Atlanta VA Medical Center for 12 hour shifts. If the resident completes requirements before 12 hours, the remaining time will then be devoted to reviewing professionalism modules and/or patient care.

**Sick Leave**

Each resident is allowed a maximum of 15 paid sick days per academic year. This time can be taken for illness, injury, and medical appointments for the resident or for the care of an “immediate” family member. Sick leave can only be used for sick days. A missed call for sick leave must be made up.

Other than a missed call, sick days are not required to be made up as long as they do not prevent the resident from receiving a satisfactory evaluation and appropriate exposure to the rotation as determined by the program director and curriculum committee. It is the resident’s responsibility to notify the chief resident by 8 a.m. when he or she is out sick.

It is also the resident’s responsibility to notify his or her attending physician and supervising resident. If three or more sick days are taken during a rotation, or if it appears that sick days are abused, a physician’s excuse must be provided. Sick leave is not accrued from year to year.

A combination of sick leave and vacation leave may be used to care for oneself or an immediate family member. When these two leave categories are exhausted, any additional leave days are uncompensated (see GME Policy Handbook). You must complete the leave form for all sick days as soon as possible, either when physically better or on the first day back to work.
Leave of Absence (without Pay)
Requests must be submitted in writing to the residency training director for disposition. The request shall identify the reason for the leave and the duration. Requests for a leave of absence without pay are approved only if the residency training director is reasonably sure that the resident’s position is expected to be available when the resident returns. A leave of absence without pay when approved shall not exceed six (6) months in duration. If the absence extends over six (6) months, the resident must re-apply to the residency program.

Other Leave
Other leave types are explained in detail in the MSM Human Resources employment manuals. The resident is advised that in order to fulfill the “special requirements” of training and of the specialty certification board, it may be necessary for a resident to spend additional time in training to make up for time lost while he or she used vacation, sick leave, the various types of emergency leave, or leave of absence without pay.

Residents are discouraged from taking vacation on timed rotations such as:

- Inpatient Geriatrics Experience (Dr. Frank, Attending)—(PGY-1)
- Neurology (PGY-1)
- Child (outpatient and inpatient)
- Forensic (PGY-3)

*Administrative leave can be granted per program director’s discretion. Keep this in mind when planning for any leave regarding Step III.*

Kronos Instructions for requesting leave
You can also access Kronos through MSM Connect from the MSM Home Page. See links and instructions below:

http://www.msm.edu OR https://myportal.msm.edu/cp/home/displaylogin

1. Log into MSM Connect with your MSM Network ID and password.
2. Click on the Employee Tab.
3. Under Employee, click on Kronos Time and Attendance Login.
4. Input your username: first initial entire last name. e.g., jsmith.
5. Input your password: your initial password is kronos.
6. Select My Information.
7. Select time stamp.
8. Clear the checkbox titled: Log off after stamping.
9. Click Record Time Stamp. The time will automatically populate on your timecard.
10. To view your timecard, select My Information, then My Timecard.

NOTES:

- If you are an hourly employee, you must time stamp on a daily basis as the event occurs.
- If you are a salaried employee, you must enter exception time only (hours not worked). e.g., sick, vacation, etc.
- Both hourly and salaried employees must sign off on their time on Friday of each week by close of business.

See Full Resident Leave Policy including Family and Medical Leave, under Program Policies.
Library Multi-Media Center

The MSM Multi-Media Center is located in the Medical Education Building on campus. The library's collection (both electronic and non-electronic) includes access to Psychiatry Online, textbooks, reference books, journals, videos, audiotapes, and color slides. A qualified medical librarian staffs the library full-time. The MSM Multi-Media Center and the Atlanta University Center Woodruff Library are available for residents.

Moonlighting

Moonlighting is defined as any employment for compensation that is unrelated to the MSM Psychiatry Residency Program. Limited outside work for compensation is allowed as long as it does not adversely affect the resident’s home or professional life. This work must not interfere with the resident’s regular duties and on-call availability. Residents must not be required to engage in moonlighting and this opportunity is only available to eligible PGY-4 residents.

At no time should the resident leave a rotation early, begin late, or allow performance to be impaired by fatigue or lack of sleep as a result of a moonlighting experience. Moonlighting is not allowed during a leave of absence. The program director must ensure that moonlighting does not interfere with the ability of the resident to achieve the goals and objectives of the educational program. The director of the program must approve and monitor all moonlighting work. The program director must provide a prospective, written statement of permission to moonlight which must be included in the resident’s file. The resident’s performance must be monitored for the effect of these activities. Adverse effects may lead to withdrawal of permission to moonlight.

MSM’s malpractice insurance does not cover the resident for moonlighting work.

- The program director must comply with the sponsoring institution’s written policies and procedures regarding moonlighting, in compliance with the ACGME Institutional Requirements.
- Any hours a resident works for compensation at the sponsoring institution or any of the sponsor’s primary clinical sites must be considered part of the 80-hour weekly limit on duty hours.

A resident who wants to moonlight must discuss this activity with the program director. No moonlighting is allowed during the resident’s first year.

See Moonlighting Policy.

On-Call Hours

When psychiatric residents are admitting new patients or on night shifts, they are expected to remain on the hospital premises until the start of the new shift. If they are on other rotations and are starting on-call at the hospital, they are expected to arrive for the sign-out rounds at the designated sign-out time for that campus and remain there until the end of their shift.

Pagers

The program provides pagers and holders to all residents at no charge. The pagers are alphanumeric and receive three types of messages: text, numeric, and voicemail messages.

- When your pager number is displayed on the pager, you have a voicemail message. Call your pager, press zero, and enter your access code, which is “1234.” Press “3” to listen to messages and “2” to delete messages.
- To change your greeting, dial your pager number, press zero, enter your access code (“1234”), and then press “11” for greeting menu. Press “30” to record, “1” to stop recording, and “40” to playback.

Text messages are sent on the American Messaging Web site www.myairmail.com. You can also send text messages via e-mail by using the e-mail address as “pager number@myairmail.com.” For example, if you want to e-mail to pager number (404) 555-1234, you would enter the e-mail address 4045551234@myairmail.com.
Malfunctioning pagers are replaced at no additional charge to the resident. The units are exchanged in the residency office. Residents will be charged a $42 fee for lost or stolen pagers.

NOTE: You are expected to wear and respond to your pagers at all times while on duty. You are expected to return a page within ONE (1) hour.

**SPOK On-Call**

Amcom Web utilizes the Amcom Console database to provide web-based access to on-call schedules and to send paging messages to individuals who are on call.

http://SPOK-IWEB-PD/Amcom/Amcomweb

*Note: Options and displays for your facility may be different than those displayed in the examples provided*

**DIRECTORY TAB**

**HOW TO SEARCH THE DIRECTORY**
1. Access Spok Web
2. Select your search criteria
3. Click in the **Search** field
4. Type information to be searched and then press **ENTER** key or click the **Search** button
5. Click on a name to display additional information

PAGING A PERSON FROM THE DIRECTORY SCREEN

A person may be paged from the Directory screen by clicking on the pager icon. NOTE: If a person has a status that does not allow pages, the phrase “Not Pageable” displays next to the pager icon and the icon cannot be clicked.

1. Access the Directory screen and search for a person.

2. Click on the pager icon or pager ID. The paging screen displays.

3. From the Select Device list box, select the pager to which the message should be sent.

4. Enter the page message in the field. Note that the name of the operator currently logged into Spok Web is automatically included at the end of the message as a signature.
6. Click the **Send** button. A send message displays at the bottom of the dialog. The dialog closes automatically.

7. You can verify that the page was sent by clicking on the **Transactions** tab to display the **Transactions** screen. The current status of the page displays in the **Status** column.

<table>
<thead>
<tr>
<th>IN QUEUE</th>
<th>This displays if the page has not left the paging queue.</th>
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</thead>
<tbody>
<tr>
<td>DONE</td>
<td>If there was a successful hand-off to your paging vendor, DONE displays in the <strong>Status</strong> column and a date and time display in the <strong>Completed</strong> column.</td>
</tr>
<tr>
<td>ERROR</td>
<td>If there was an error in the transaction, ERROR displays in the <strong>Status</strong> column and E-PAGSVR displays in the <strong>Done By</strong> column. This error has been reported to the operator, however the page will not be delivered and another contact method should be tried.</td>
</tr>
</tbody>
</table>
ONCALL TAB

FIND OUT WHO IS ON CALL RIGHT NOW
1. Click the OnCall tab
2. Select the appropriate department from the drop-down list.

The person(s) currently on call will display in red.

3. Click on a person’s name to display additional information for that person
4. Click the X in the upper-right corner or press the Esc key to close the window.

5. If displayed, click the Show All Records option to see individuals who either were on call or will be on call.

6. Click a date on the calendar to view a different day’s schedule. The selected day displays orange on the calendar.
7. Select the Calendar option to view the entire month

8. From the Grid view, select the Dashboard option to view all OnCall schedules on one screen

9. Slide the Select The Scheduled Time arrow to change the time and/or click a date on the calendar to change the date you are viewing.

Note: Individuals currently oncall are highlighted in yellow. You may click on a name to display additional information for that individual.
10. Click **Collapse All** and then click individual departments to view only the selected schedules

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**PAGE AN INDIVIDUAL CURRENTLY ON CALL** (must be in Grid or Dashboard view)

1. Select the appropriate department from the drop-down list. The persons(s) currently on call will display in red.
2. Click the pager icon to display the paging window
3. If available, select the appropriate device from the drop-down list

4. If you have selected an Alpha device, type your message in the message field. Remember to include your name and any callback information.

OR

If you have selected a Numeric device, type the callback number in the message field
Parking

Parking cards are issued during the Graduate Medical Education Orientation for personal parking at Grady Hospital. Residents must pay a $10 deposit and the first month’s fee of $21. Subsequent months are paid through a payroll deduction. Free parking is available at other work sites (Georgia Regional, Atlanta VA) via a hospital ID badge.

Physician Impairment and Health (Substance Abuse)

The Psychiatry Residency Program follows MSM and GME policies on this topic which can be found at http://www.msm.edu/Education/GME/index.php.

Problems or Difficulties—What to Do?

As a resident, you may encounter clinical or personal situations or problems that are difficult to handle. This is usually due to a lack of adequate experience or situations that arise beyond your control. If you have any problems, please ask for help and advice from your resident colleagues, chief residents, Attending physicians, the program manager, or the program director. The program director maintains an open-door policy toward all residents. We are here to assist you with any problem that arises. It is important to notify us so that we can help.

Professional Organizations

The program provides support for the resident’s first annual membership in the American Psychiatric Association (APA), as well as to the Georgia Chapter of the APA (GPPA). Membership includes a yearly subscription to The American Journal of Psychiatry and Psychiatric News.

Resident Faculty Advisor Responsibilities

Psychiatry residents are assigned to a faculty advisor throughout their four years of training. The advisor’s role is to be the resident’s mentor in issues of professional training and career planning, as well as to assist in the resident’s ongoing training and evaluation process.

The faculty advisor undertakes the following primary responsibilities:

- Set up a schedule for regular meetings with the resident for the academic year, focusing on plans for self-assessment, and monitoring progress; provide residents with advice to help them study for the
psychiatric boards and prepare for in-service exams and quizzes starting early in their PGY-1 year and follow-up on these plans over time. The minimum frequency of meetings is once per month.

- Discuss resident’s performance on the PRITE and annual Psychotherapy exams. For those residents who fall below the national mean, the resident and faculty advisor will develop a remediation plan to correct the identified areas of weakness. The plan will be closely monitored to assist the resident in attaining scores at or above the national mean.

- Guide the resident to an appropriate mentor for his or her research project. The goal is for each resident to develop a research interest and become involved in an independent research study under the guidance of a mentor. The mentor also assists the resident in becoming part of any ongoing projects by the end of the PGY-1.

- Review copies of all the advisee’s evaluations from different rotations and give additional recommendations and constructive criticism. The residency program office sends a form to document meetings with the resident at the beginning of each academic year. The form must be completed quarterly in our electronic evaluation database, New Innovations.

- Provide additional focus on career guidance to residents in the PGY-2 through -4 years. After exploring their interests and future plans, it may be necessary to direct residents to other faculty members who may provide additional guidance in the resident’s field of interest.

**USMLE Policy**

Residents must pass USMLE Step 3 by their 20th month of residency. Residents must present the official results of their USMLE Step 3 examination to the residency program director before the last working day of the resident’s 20th month which, in a normal appointment cycle, is February. Residents who have not passed Step 3 by the end of the 20th month will not receive a reappointment letter to a residency program at the regular time. Residents who pass USMLE Step 3 between the 21st and 24th month, may receive a reappointment letter to a residency program at the time of receipt of the results, if this is the sole reason for not receiving an appointment letter.


**When to Call for Help**

For clinical help, seek your supervising resident or chief resident first. If the situation is not resolved or if no supervising resident is available, call your Attending physician.

If personal problems arise, you may discuss them with the program director and/or you may contact Human Resources and ask for the Employee Assistance Program (EAP). We maintain an open door policy for any problems.

**Work Hours**

Unless otherwise specified by the clinical supervisor, the work day generally begins at 8 a.m. and continues until the end of the clinical work day for the rotation. Ending times may vary from rotation to rotation, but in general, ending time is usually between the hours of 5 p.m. and 6 p.m.
Morehouse School of Medicine is committed to maintaining an environment where open, honest communication is the expectation. You will have access to a phone and internet-based reporting system that is administrated and managed by a third party, NAVEX EthicsPoint, Inc. With this comprehensive reporting tool, I believe that it will assist us in working together to proactively address compliance concerns and potential violations of regulations and policies. Any information you provide to NAVEX EthicsPoint will remain confidential and reports can be made through NAVEX EthicsPoint easy to use, 24-hour website at [www.msm.ethicspoint.com](http://www.msm.ethicspoint.com) or by at the NEW phone number 855-279-7520 (in both English and Spanish). You can also locate the link on the MSM homepage by going to:

- About MSM
- Then click on “Administration”
- Then click “Compliance”
- Then click then “Compliance Hotline” link

To immediately learn more about the system and how Ethics Point works, please read the attached Compliance Hotline FAQ. We will also be hosting webinars, distributing posters and pocket cards to spread awareness very soon. In the meantime, I ask that as a “Compliance Deputy” you help us spread awareness of this new resource.

Three things you can do today to help your fellow peers become acclimated to this new reporting tool (administrated and managed by a third party, NAVEX EthicsPoint Inc.):

1. Remove old compliance hotline posters from offices, elevators and any public spaces that you see. These posters will have the old number: 1-888-756-1364
2. Send us any questions regarding the Hotline via: fchapman@msm.edu or dramirez@msm.edu
3. Spread awareness. Tell a fellow peer about this amazing new tool in 60 seconds or less:
   a. Managed by a Third Party
   b. 100% Confidential
   c. 24/7 reporting
   d. Phone and Web based to meet all your technical needs
**Program Goals**

**Overall Residency Program Goals**

The MSM Psychiatry Residency Program develops psychiatrists who are proficient in the details of medical management as well as sensitive and responsive to the special circumstances that often prevail in medically and psychiatrically underserved and disadvantaged communities.

**PGY-1 Residents**
This is a transitional year during which residents rotate in neurology, inpatient medicine, and family medicine. Rotations also include inpatient and geriatric psychiatry training at the Atlanta Veterans Health Care Systems. Residents are introduced to patient safety and quality improvement curriculums and ACGME core competency expectations.

**PGY-2 Residents**
This year provides training and experience in outpatient community psychiatry. Experiences in child and adolescent psychiatry, addiction psychiatry, psychosocial rehabilitation, and community outreach services are included. Residents participate in patient safety and quality improvement activities/projects and begin work within the different psychotherapy competencies.

**PGY-3 Residents**
Residents will complete an emergency psychiatry rotation, consultation-liaison rotation, forensic rotation, adult inpatient rotation with the severe and persistently mentally ill at the state hospital, inpatient child and adolescent rotation, and a substance abuse-trauma recovery rotation. Residents will continue care for long term supervised psychotherapy cases and patient safety/quality improvement projects.

**PGY-4 Residents**
Residents in their fourth year of training will complete a psychotherapy rotation at the Atlanta VA/CBOC, VA/COE and customize the remainder of their training with elective clinical experiences.

**Competencies**

The Accreditation Council for Graduate Medical Education (ACGME) has developed formal guidelines for competencies, both general and specialty-specific, as well as acceptable methods for evaluating these in-training programs across the United States. A list of the critical information can be obtained from the ACGME Web site (http://www.ACGME.org). These competencies should serve as a guide for the skills that you should strive to develop as you progress in your subspecialty education.
Educational Competencies

Residents must demonstrate the following general competencies to begin the independent practice of this specialty.

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

- Communicate effectively and demonstrate caring and respectful behaviors when interacting with patients and their families.
- Gather essential and accurate information about their patients.
- Make informed decisions about diagnostic and therapeutic interventions based on patient information and preferences, up-to-date scientific evidence, and clinical judgment.
- Develop and carry out patient management plans.
- Counsel and educate patients and their families.
- Use information technology to support patient care decisions and patient education.
- Perform competently all medical and invasive procedures considered essential for the practice of psychiatry.
- Provide healthcare services aimed at preventing health problems or at maintaining health.
- Work with healthcare professionals, including those from other disciplines, to provide patient-focused care.

**Medical Knowledge**
Residents must demonstrate knowledge about established and evolving biomedical, clinical, and cognate (e.g., epidemiological and social-behavioral) sciences and then apply it to patient care. Residents are expected to:

- Demonstrate an investigatory and analytic thinking approach to clinical situations.
- Know and apply the basic and clinically supportive sciences that are appropriate to their disciplines.

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

- Analyze practice experience and perform practice-based improvement activities using a systematic methodology.
- Locate, appraise, and assimilate evidence from scientific studies related to their patients’ health problems.
- Obtain and use information about their population of patients and the larger population from which their patients are drawn.
- Apply knowledge of study designs and statistical methods to the appraisal of clinical studies and other information on diagnostic and therapeutic effectiveness.
- Use information technology to manage information, access online medical information, and otherwise support their education.
- Facilitate the learning of students and other health care professionals.
Interpersonal and Communication Skills
Residents must demonstrate interpersonal and communication skills that result in effective information exchange, and the ability to team with patients, their patients’ families, and professional associates. Residents are expected to:

- Create and sustain a therapeutic and ethically-sound relationship with patients.
- Use effective listening skills as well as elicit and provide information using effective nonverbal, explanatory, questioning, and writing skills.
- Work effectively with others as a member or leader of a healthcare team or other professional group.

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

- Respect, compassion, and integrity
- A responsiveness to the needs of patients and society that supersedes self-interest
- Accountability to patients, society, and the profession
- A commitment to excellence and ongoing professional development
- A commitment to ethical principles pertaining to the provision or withholding of clinical care, confidentiality of patient information, informed consent, and business practices
- Sensitivity and responsiveness to the patient’s culture, age, gender, and disabilities

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

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

Scheduled Rotations
Each clinical rotation involves specific time scheduling and administrative requirements. The residency program office must be able to locate all residents during scheduled working hours. Should a resident fail to report to the scheduled rotation site during scheduled work hours without prior notification to the supervisor for approval, disciplinary measures will be taken that might include documentation of poor professional conduct in his or her permanent file or dismissal from the program, if necessary.

If a resident fails a rotation, he or she is placed on remediation. Failed remediation/other failures may result in other disciplinary action, including the dismissal from the program.

Resident assignments for each post-graduate year are described in the following sections.
PGY-1
- Internal Medicine—Ward/Grady Memorial Hospital (two months)
- Family Medicine—Outpatient/Grady East Point Clinic (two months)
- Neurology—Inpatient and Outpatient/Grady Memorial Hospital/Dekalb Medical (two months)
- Psychiatry—Inpatient/Atlanta VA Medical Center (six months)

PGY-2
- Community Psychiatry—Outpatient/Grady Behavioral Health/Park Place (twelve months), Drs. Cosby and Bharmal
- Infectious Disease Program (IDP)—GBH/PP, Dr. Cooke
- Psychosocial Rehab (PSR)—GBH/PP, Dr. Bharmal
- Assertive Community Treatment (ACT), Dr. Vickerson
- Psych OB—Grady Memorial Hospital, Dr. Herbert
- Child Psychiatry—Grady, Dr. Vinson

PGY-3
- Emergency Psychiatry—Grady Memorial Hospital (two months), Dr. Amar
- Consultation Liaison—Grady Memorial Hospital (three months), Drs. Gaston and Schwartz
- Adult Inpatient Psychiatry—Georgia Regional Hospital (two months), Dr. Mendoza
- Substance Abuse Treatment Program (SATP)—Atlanta VA Medical Center, Dr. Shongo (6 weeks)
- Trauma Recovery Program (TRP)—Atlanta VA Medical Center, Dr. Kurlyandchik (6 weeks)
- ECT Observership—Peachford Hospital (2x/week for 3 weeks), Dr. Aleem
- Child Psychiatry—Laurel Heights Hospital (1 month), Dr. Sewell

PGY-4
- East Point CBOC, Drs. Roohi Abubaker and Kristine McDaniel
- Grady Psychiatry Electives
- Other Electives
**Educational Requirements**

**Didactics**

All conferences are mandatory for residents to attend. Residents are expected to attend a **minimum of 70% of mandatory conferences**. As special circumstances occur, trainees must notify the program director or associate director prior to the conference in order to be excused from a particular conference for personal reasons.

All group educational conferences will take place on Wednesdays (unless otherwise noted) in the first floor Psychiatry Board Room at the Buggyworks Building 100-A.

Interns will attend all Wednesday didactic sessions and are excused from their rotation duties during that time. Exceptions include the following reasons:

- Post-call or post—shift
- Sickness
- Vacation

It is still necessary to remind the chief and the Residency Training Program office when you are going to be absent on a Wednesday or during a scheduled educational activity (as a result of one of the above excused absences).

Residents are required to sign in when they arrive. An attendance report is prepared for the program director who provides feedback to residents during the required semi-annual Resident Reviews. Faculty is encouraged, but not required to attend the Wednesday conferences.

For missed conferences, residents should review the lecture handouts. Please see colleagues, chief resident, or presenter for handouts.

The table on the next pages shows the Wednesday Academic Activity Schedule for 2016-2017; both morning and afternoon activities to include journal clubs, seminars, grand rounds, and clinical case conferences that are a part of the Psychiatry training program.
A Year in the Life of a Residency Program

July
- July 1 is the beginning of the academic year in all GME programs.

September
- Fall Residency Retreat
- 1st Mid Rotation 360 VA meeting
- Fall Residency Retreat

October
- PRITE Exam
- Interview Season Pep Rally

November
- Interview Season Begins

December
- Semi-Annual Reviews & Milestones Narratives
- Department Holiday Party
- Flu Vaccinations
- IHI modules

January
- Interview Season Ends

February
- NRMP Rank Order List

March
- NRMP Match Day
- 2nd Mid Rotation 360 VA meeting

April
- PPCT: Psychotherapy Exam
- Dewitt Alfred Research Symposium
- Spring Residency Retreat
- Annual PPD and Immunizations begin
- Continuing Resident Orientation (Session 1)

May
- End- of- the-year evaluations (semiannual)
- APA Annual Meeting
- Continuing Resident Orientation (Session 2)

June
- GME Joint Graduation Ceremony
- Resident Compact Ceremony
- Department Graduation Luncheon
- William E. Booth Research Day
- Wine and Cheese with the Dean
- Department Orientation for New Interns
Patient Logs—Guidelines and Requirements

Residents are expected to complete a log of their patients in New Innovations. The resident should update his or her patient log entries no less than once per week. In the log entry, the resident should note the site where the patient encounter occurred, the diagnosis and diagnostic code, patient demographics, patient identification (initials only), and select a treatment option from the drop-down menu.

The patient logs are to be reviewed by the site supervisor for accuracy and by the supervisor and resident to verify that the patient is getting a broad patient exposure in terms of patient demographic and diagnoses. The logs will also be reviewed by the associate program director and program director no less frequently than quarterly to verify completion and broadness of exposure, and to identify deficiencies in experiences.

Patient Safety/Quality Improvement

Patient Safety is the delivery of healthcare in a manner that employs safety methods and minimizes the incidence and impact of adverse events while maximizing recovery from such events.

Quality Improvement is a formal approach to assess the degree to which services provided by healthcare professionals for individuals and populations increases the likelihood of the desired outcome and are consistent with evidence-based standards of care and the systematic effort to improve performance.

The goal of this curriculum is to educate psychiatry residents at Morehouse School of Medicine on the principles and practices of patient safety and quality improvement.

The curriculum’s objectives: By the end of this curriculum, learners will be able to:

- Discuss the historical background of Patient Safety/Quality Improvement.
- Define terminology pertaining to PS/QI (including near miss and adverse events).
- Define PS/QI problems specific to Psychiatry.
- Demonstrate a high quality hand-off by the end of intern year.
- Formulate a Quality Improvement project or participate in a project that is already in progress.
- Demonstrate behaviors associated with effective teamwork and interpersonal and communication skills.
Curriculum

Core content

1. Knowledge
   a. History
   b. Terminology
   c. Root cause analysis
   d. Error reporting
   e. Safety culture inclusive of documentation of medication reconciliation, completion of suicide risk assessments, and use of seclusion and restraints

2. Skills
   a. Root cause analysis
   b. Formulate QI question
   c. QI project
   d. Identify types of medical errors
   e. Proper handoff
   f. Effective teamwork, interpersonal skills and communication

3. Attitude
   Appreciation of patient safety and quality improvement

Strategies

- Psychiatry orientation in June
- GME orientation
- Quarterly didactics
- Psychiatry Grand Rounds and Case Conferences
- QI projects
- Direct observation of hand-offs
- Weekly supervision with psychotherapy supervisor

PGY-1
During the six (6) month VA experience, residents will complete Patient Safety modules from the Institute for Healthcare Improvement online program and observe senior resident handoffs to inpatient treatment team during 7:30 morning report.

PGY-2
Residents will attend morbidity and mortality conferences at Grady Healthcare System. Residents will prepare one case conference per year that incorporates patient safety and quality improvement issues. Residents should complete QI modules from Institute for Healthcare Improvement online program.

PGY-3/4
Residents will prepare one case conference per year that incorporates patient safety and quality improvement issues. Residents will design a QI project with the assistance of a mentor (faculty) or will participate in an already established QI project at VA, Grady, or GRH/A. PGY-3 are also to attend the M and M conferences if on a rotation at Grady.

Learner Assessment

- Direct clinical observation and clinical skills verifications during years 1-4
• Psychotherapy evaluations during years 2-4
• 360 degree evaluations of teamwork, interpersonal, and communication skills
• Present QI project prior to leaving program

**Program Evaluation**

- Resident feedback on faculty and clinical experience
- Faculty evaluation on educational resources
Psychiatry Residency Program-Level
Policies and Procedures
2016-17

The psychiatry residency follows and complies with all policies, procedures, and processes of Morehouse School of Medicine MSM Human Resources and Graduate Medical Education.

All residents are responsible for reviewing and adhering to policies, procedures, and processes of the MSM and affiliate training sites.

The Graduate Medical Education policy manual can be found at http://www.msm.edu/Education/GME/index.php.
Resident Concern, Complaint, and Due Process Policy

I. PURPOSE:

1.1. The Psychiatry Residency Program follows all MSM and GME policies for resident due process, concerns, and complaints available in the GME policy manual on the MSM website: http://www.msm.edu/Education/GME/index.php.

1.2. Refer to the online version of the MSM GME Policy Manual for detailed information regarding the Adverse Academic Decisions and Due Process policy.

II. RESIDENT CONCERN AND COMPLAINT PROCESS:

To ensure that residents are able to raise concerns, complaints, and provide feedback without intimidation or retaliation, and in the confidential manner as appropriate, the following options and resources are available and communicated to residents and faculty annually.

2.1. Step One

Discuss the concern or complaint with your chief resident, clinical service director, program manager, associate program director and/or program director as appropriate.

2.2. Step Two

If the concern or complaint involves the program director and/or cannot be addressed in Step One, residents have the option of discussing issues with the department chair, Dr. Gail Mattox (gmattox@msm.edu) or (404) 756-1440) or chief of service of a specific hospital as appropriate.

2.3. Step Three

If you are not able to resolve your concern or complaint within your program, the following resources are available:

2.3.1. For issues involving program concerns, training matters, or work environment, residents can contact the Graduate Medical Education Director, Tammy Samuels (tsamuels@msm.edu or (404) 752-1011).

2.3.2. For problems involving interpersonal issues, the Resident Association president or president elect may be a comfortable option to discuss confidential informal issues apart and separate from the Psychiatry Department.

2.3.3. Residents can provide anonymous feedback/concerns/complaints to any department at MSM by completing the online form—GME Feedback (http://fs10.formsite.com/bbanks/form33/index.html). Comments are anonymous and cannot be traced back to individuals.

2.3.4. Personal follow-up regarding how feedback/concerns/complaints have been addressed by departments and/or GME will be provided only if residents elect to include their name and contact information in the comments field.
2.3.5. MSM Compliance Hotline, 1 (888) 756-1364 is an anonymous and confidential mechanism for reporting unethical, noncompliant, and/or illegal activity. Call the Compliance Hotline to report any concern that could threaten or create a loss to the MSM community including:

- Harassment—sexual, racial, disability, religious, retaliation
- Environment Health and Safety—biological, laboratory, radiation, laser, occupational, chemical and waste management safety issues
- Other—misuse of resources, time, or property assets; accounting, audit and internal control matters; falsification of records; theft, bribes, and kickbacks
Duty Hour Policy

I. **PURPOSE:**
   1.1. Duty hours are defined as all clinical and academic activities related to the program, including inpatient and outpatient patient care assignments, administrative duties, call, scheduled activities such as conferences and moonlighting.
   1.2. Duty hours do not include reading and preparation time spent away from the duty site.
   1.3. Residents must adhere to all duty hour restrictions and requirements as outlined below:
      1.3.1. Duty hours must be limited to 80 hours/week, averaged over a four week period.
      1.3.2. Residents must have one (1) day in seven (7) free from all educational and clinical responsibilities, averaged over a four (4) week period.
      1.3.3. Residents should have 10 hours, must have eight (8) hours, free between all daily duty periods and call assignments.
      1.3.4. In-house call must occur no more frequently than every fourth night for psychiatry rotations (no more frequently than every third night for medicine rotations), averaged over a four (4) week period.
      1.3.5. Continuous on-site duty must not exceed 16 consecutive hours for PGY-1 residents and 24 consecutive hours for PGY-2 and above residents. Residents may remain on duty for up to four (4) additional hours to maintain continuity of medical care as needed.
      1.3.6. No new patients may be accepted after 24 hours of continuous duty.
      1.3.7. Moonlighting is permitted for PGY-4 residents in good standing, with an independent medical license, and proper malpractice coverage. Residents wishing to moonlight must obtain written permission from the program director. See Moonlighting Policy for additional details. Moonlighting must not interfere with the ability of the resident to achieve the goals/objectives of the educational program nor interfere with duty hours. Internal moonlighting is considered part of the duty hour limitations.
      1.3.8. Residents must log duty hours daily into New Innovations. Failure to log for five (5) days out of seven (7) will result in an e-mail notification of non-compliance to the program director and manager. Logging requirements include:
         1.3.8.1. Logging should be consistent with no gaps (for example, for lunch or travel).
         1.3.8.2. Conferences should be logged consistently as other duties with no gaps in between.
         1.3.8.3. Log “Call” duty type for in house call.
         1.3.8.4. For back-up call assignments, if the resident has to go into the hospital, use “Back Up-Called In” duty type. Back-up residents do NOT log if they do not go into the hospital.
1.3.8.5. If your 24-hour shift is extended duty to post call transitions of patient care or mandatory conferences, avoid a violation by logging the following two duty types (1) post call and (2) conferences for the hours that extend beyond the 24 hour period.

1.3.8.6. Log appropriate duty types for moonlighting, vacation, holiday/day off, or sick days.

1.3.8.7. Each resident must enter written Justification or Cause in the event of a violation. Justifications apply to violations of 24+ or short break rule. Causes apply to any violation. Make sure to submit to the program director.

II. PROTOCOL FOR EPISODES WHEN RESIDENTS REMAIN ON DUTY BEYOND SCHEDULED HOURS:

2.1. 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.

2.2. 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:

2.2.1. Appropriately hand over the care of all other patients to the team responsible for their continuing care.

2.2.2. Document the reasons in New Innovations for remaining to care for the patient in question.

2.2.3. The program director reviews each submission of additional service and tracks both individual resident and program-wide episodes of additional duty.

2.3. Failure to Comply

2.3.1. In all cases the program director should be informed of the occurrence and nature of the situation in which the respite rule might have been an issue regarding duty hour standards compliance.

2.3.2. All duty hour violations are monitored and recorded in New Innovations. Violations are automatically reported to the program director, chair, and manager electronically.

2.4. For residents at the PGY-2 level and above, 2011 ACGME requirements include duty hours work limit of 24 continuous hours on duty.

2.4.1. Residents may stay beyond that period for four (4) additional hours in order to carry out an effective patient care transfer.

2.4.2. Beyond a 24-hour period of duty in the hospital the resident must have at least 14 hours free from duty.

2.4.3. If a resident is in the situation where she or he will be out of compliance with the policy, the resident is required to document the reasons for remaining to care for the specific patient and submit the information into New Innovations.

2.4.4. This documentation will allow the program director and/or the program manager to discuss the resident’s schedule with the resident with the goal of preventing future occurrences. In the short term, however, duty hour restrictions should not serve as a reason to jeopardize patient safety.

2.4.5. Repeated instances of non-compliance will be regarded as failure to adhere to accepted standards of professionalism.
2.5. New Innovation notifies the program director of duty hour violations automatically. The residents are then asked to submit a justification for the violation into New Innovations. The program director notes if the justification is acceptable, the program director, chief resident(s), and resident meet to review the cause for the violation. The program director and chief resident then work with the resident(s) and service administrator to resolve future duty hour violations.

2.6. Reference the MSM GME policy handbook for all eligibility, selection and appointment requirements and policies at http://www.msm.edu/Education/GME/index.php that include:

- Technical standards and essential functions for appointment and promotion
- Non-immigrant applicants to residency programs
Evaluation and Promotion Policy

I. PURPOSE:
1.1. Psychiatry residents are evaluated throughout their four (4) years of training.
1.2. The purpose of the evaluation process is to determine the value of the residency education process. The following sections outline the components of the evaluation system.

II. RESIDENT EVALUATION AND PROMOTION:
2.1. Resident evaluations are performed monthly and reflect achievement of the six (6) core competencies of Patient Care, Medical Knowledge, Interpersonal Skills, Practice-Based Learning, Professionalism, and Systems-Based Practice.
2.2. Evaluations concerning performance and progression in the residency program will be provided to the resident throughout the duration of the program. Evaluations will measure performance based on milestone assessments.
2.3. Residents will be provided with a mid-point evaluation for each rotation in an effort to identify deficiencies early. This requirement serves to provide the resident with an opportunity to cure the deficiency noted.
2.4. Residents will be provided with a final, global evaluation for each rotation and didactic experience within two (2) weeks of completion of the assignment. These evaluations must be immediately available for review by the resident. Resident notification of completed evaluations should be set up in New Innovations by requiring that residents sign off electronically on the evaluation.
2.5. There must be an opportunity to review evaluations with supervisors and to attach a written response, preferably in the form of reflection and planning for improvement.
2.6. Additionally, multisource methods and evaluators will be used to provide an overall assessment of the resident’s competence and professionalism. Methods and evaluators include:
   - Faculty evaluations of rotation and didactic performance
   - Direct resident evaluations
   - 360 evaluations/narrative evaluations by faculty and non-faculty evaluators (the RTP requests one 360 per clinical rotation)
   - Peer evaluations
   - Patient feedback
   - Resident self-assessment (completed quarterly)
   - Clinical skills verifications
   - PRITE and Psychotherapy examinations
2.7. Additionally, each resident will maintain and submit a portfolio of assessment tools to document the core competencies and all academic activity during residency that is maintained in New Innovations.

2.8. Evaluations are accessed on New Innovations by the residents and the supervisors. Evaluations of both the residents and Attendings will be compiled. An electronic copy will be sent to the resident, and a hard copy will be placed in each resident’s file.

2.9. A Clinical Competency Committee will be appointed by the program director. This committee will meet quarterly to review all evaluative information regarding each resident and make recommendations to the program director regarding resident progress, promotion, remediation, and dismissal.

2.10. Semi-Annual Evaluation—At least twice in each post graduate year, the associate program director or program director will provide each resident with a performance evaluation summary incorporating input from the Clinical Competency Committee and ACGME Milestone Summaries.

2.11. Summative Evaluations—The program director will provide a summative evaluation for each resident upon completion of the program. This evaluation will verify that the resident has demonstrated sufficient competence to enter practice without direct supervision and will become part of the resident’s permanent record maintained by the program and will be accessible for review by the resident in accordance with institutional policy.

III. RESIDENT PROGRESSION:

3.1. Resident promotion is determined by recommendation from the CCC.

3.2. Promotion/progress is determined based on:
   - Clinical performance (i.e., evaluations)
   - PRITE performance
   - Annual Psychotherapy Exam
   - Participation in any mandatory program requirements
   - CCC recommendations

3.3. Academic support and counseling is available to residents and should be sought on an individual, as-needed basis.

3.4. Resident promotion for all PGY levels is based on the following criteria:
   3.4.1. The resident must pass a complete clinical skills assessment (direct observation by faculty).
   3.4.2. The resident must receive an overall “Satisfactory” evaluation in all of his or her required rotations.
   3.4.3. The resident must not have any professionalism or ethical issues that preclude him or her from being moved to the next level of residency in the opinion of the Clinical Competency Committee.
   3.4.4. The resident must be continually eligible to practice medicine on a limited license in Georgia.
   3.4.5. The resident must complete the GME returning resident orientation.
   3.4.6. The resident must be compliant with all MSM Psychiatry Residency Program policies including, but not limited to being up to date with his or her duty hour and patient logs.
3.5. Additional criteria for promotion from PGY-2 to PGY-3 include that the resident must pass USMLE Step 3 by the 24th month of residency.

3.6. The following resident graduation criteria apply to all PGY-I4 residents and PGY-3 residents transferring into a Child and Adolescent Fellowship Program:

3.6.1. The resident must fulfill all above promotion criteria.

3.6.2. The resident must have completed an approved scholarly activity.

3.6.3. The resident must have completed three (3) Clinical Skills Verifications with Board Certified Psychiatrists.

3.6.4. The resident must complete GME, HR, and MSM Psychiatry exit procedures.

3.6.5. The resident must demonstrate a Satisfactory performance in all six ACGME competencies.

3.6.6. For graduating residents, the program director must determine that the resident has had sufficient training to practice medicine independently as evidenced by meeting the goals above, completion of training criteria on program-specific criteria set forth by the ACGME-RRC, and a final summative assessment.

3.7. Final decisions on promotion to the next level of residency are made by the Clinical Competency Committee, Program Evaluation Committee, and the program director.

IV. FACULTY EVALUATION:

4.1. Faculty evaluations are performed annually by department chairs, in accordance with the faculty bylaws.

4.2. Annually, the program director will evaluate faculty performance as it relates to the educational program. This evaluation will include a review of the faculty’s participation in educational activities, professionalism (including, but not limited to, evaluation completion in a timely manner), and scholarly activities. This information will be provided to the chair for inclusion in the faculty's evaluation.

4.3. Residents will be given the opportunity at least annually to submit a confidential written evaluation of faculty. In order to maintain confidentiality of faculty performance evaluations, the program director will provide a generalized resident summary to avoid identifying specific resident feedback.

4.4. The program director will maintain continuous and ongoing monitoring of faculty performance via automated alerts regarding low evaluation scores on end of rotation evaluations by residents, regular surveillance of evaluations, and regular verbal communication with residents regarding their experiences. The Psychiatry Department chair will be notified by the program director of resident feedback for review and discussion during the annual faculty evaluation.

V. PROGRAM EVALUATION:

5.1. The program is monitored in accordance with ACGME Psychiatry and MSM Graduate Medical Education standards.

5.2. Faculty and residents are provided the opportunity to confidentially review the program, program director, and associate program director at least annually.

5.3. The program director appoints a Program Evaluation Committee (PEC) to oversee the educational activities of the program, curriculum, resident/faculty performance and development, and program quality via the Annual Program Evaluation.
5.4. The program director and the PEC will submit a written Annual Program Evaluation report to the GME office to document initiatives to improve program performance and delineate how these initiatives will be monitored.

5.5. The Office of Graduate Medical Education and the GMEC are tasked with ensuring MSM programs’ compliance with ACGME accreditation and training standards and to provide oversight of programs’ annual program evaluation processes per Institutional, Common, and Specialty Specific program requirements.

5.6. **The Document Review Meeting** is the 1st phase of the MSM GMEC APR process which is a meeting with the program manager/assistant and GME Director/Manager to review program compliance with administrative functions such as required content and items of resident training files; completion of required set up, data, and information in the New Innovations system; Program Letters of Agreement, program policy manual, etc. The effectiveness and quality of the program’s overall administrative work and monitoring of Duty Hours and Evaluation completion are also assessed.

5.7. **The APR Meeting** is the 2nd phase where the GMEC Review Team comprised of the GME DIO and Director, and PD and PM of another program meet with the leadership of the program being reviewed to assess APE efforts that include detailed review and discussion of the programs’ scorecards and APE reports from the last 3 years, with focus on identified data trends, areas of improvement, best practices, action plans to address issues, future goals, needed resources, and results of the document review meeting. Interviews with residents and faculty also occur for Special Review programs and/or programs identified by the DIO.
Fatigue Management and Mitigation Policy

I. PURPOSE:
This policy is designed to increase awareness of the faculty and residents in recognizing the signs of fatigue and sleep deprivation, the negative effects of sleep deprivation and fatigue on their ability to provide safe and effective patient care, and to identify strategies to minimize the effects of fatigue.

II. DEFINITION:
2.1. Fatigue is defined as a feeling of weariness, tiredness, or lack of energy than can impair a physician's judgment, attention, and reaction time.
2.2. Signs and symptoms of fatigue include, but are not limited to: moodiness, depression, irritability, apathy, impoverished speech, flattened affect, impaired memory and confusion, difficulty focusing on tasks, sedentary nodding off during conferences or while driving, and repeatedly checking work. These harmful effects can lead to medical errors and compromise patient safety.

III. POLICY ON PROGRAM RESPONSIBILITIES:
3.1. The resident and faculty will be educated on the hazards of sleep deprivation and fatigue in the workplace and in their personal lives during GME and Departmental Orientations annually, Semi-Annual Departmental Patient Safety Didactics, and through the completion of Professionalism and Patient Safety modules at least annually, faculty presentations during the Annual Program Review, and/or Faculty Meetings.
3.2. A presentation on Sleep Deprivation and Fatigue Management should be available for residents in the Drop Box for review at any time and for the faculty on the department’s SharePoint.
3.3. Residents will be provided with sound didactic and clinical education planned and balanced with concerns for patient safety and resident wellbeing. The program will ensure that the learning objectives of the program are not compromised by excessive reliance on residents to fulfill service obligations. Didactic and clinical education must have priority in the allotment of resident's time and energy.
3.4. Faculty will assess if residents are sleep deprived and make appropriate recommendations for the resident to correct this problem.
3.5. Faculty members are to assist in enforcing the limitations of the role of a resident under the duty hour mandates.

IV. POLICY ON RESIDENT RESPONSIBILITIES:
4.1. The resident is expected to:
   4.1.1. Adopt habits that will provide him or her with adequate sleep in order to perform the daily activities required by the program.
   4.1.2. Adhere strictly to Duty Hour limitations.
4.1.3. Discuss time and stress management with their faculty advisors at least monthly.

4.2. In the event that the resident is at the end of a work period and is too sleepy to drive home, he or she is encouraged to use another form of transportation or nap prior to leaving the training site.

4.2.1. The resident should contact the chief resident, program director, or associate program director for assistance if neither of the aforementioned options is feasible.

4.2.2. MSM provides access to appropriate and confidential counseling and medical and psychological support services. Residents are encouraged to utilize EAP or their own physician and the Office of Disability Services when indicated.
Moonlighting Policy

I. PURPOSE:

1.1. The General Psychiatry Residency Training Program at Morehouse School of Medicine recognizes that because residency education is a full-time endeavor, the institution and the program director must ensure that moonlighting does not interfere with the ability of the resident to achieve goals and objectives of the educational program.

1.2. Professional and patient care activities that are external to the educational program are called moonlighting.

1.3. Moonlighting activities, whether internal or external, may be inconsistent with sufficient time for rest and restoration to promote the residents' educational experience and safe patient care.

1.4. In addition, Morehouse School of Medicine abides by the ACGME institutional requirements which set policies for moonlighting. The following policy will define the parameters that are to be used in monitoring and approving moonlighting activities.

II. POLICY:

2.1. Only PGY-4 residents in good standing with the program are eligible to moonlight.

2.2. Residents are not required to engage in moonlighting.

2.3. PGY-4 residents must obtain PD approval before engaging in moonlighting activities.

2.4. A statement that this policy is understood must be signed by the trainee and the program director and maintained in the resident's file. Non-compliance with the signed policy may result in disciplinary action including probation, termination of contract, or dismissal.

2.5. Moonlighting requests must be documented in writing to the training director, specifically to detail what the responsibilities are, what the time requirements are, and who the supervisor(s) will be. The training director must also approve (by signing off in writing) the specific moonlighting job.

2.6. The resident's performance will be monitored for the effect of these activities upon performance and that adverse effects may lead to withdrawal of permission to moonlight.

2.7. Any moonlighting, internal and/or external (within any of the major participating institutions), must be considered within the 80-hour work week.

2.8. Morehouse School of Medicine will not provide liability coverage to residents while on professional activities (moonlighting) outside of the training program.
Professionalism Policy

I. **PURPOSE:**

Residents must demonstrate a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population.

II. **EXPECTATIONS:**

2.1. Residents are expected to demonstrate respect, compassion, and integrity towards all individuals.

2.2. Residents should demonstrate sensitivity and responsiveness to the patient’s culture, age, gender, race, linguistics, religion, sexual orientation and disabilities.

2.3. Residents must also:

   2.3.1. Protect and respect the legal and ethical rights of patients.
   
   2.3.2. Respect individual patient concerns and perceptions.
   
   2.3.3. Maintain a work environment that is free of harassment of any sort.
   
   2.3.4. Refrain from discussing patient information in public areas, including elevators and cafeterias, over the phone, e-mail, and social media.
   
   2.3.5. Respect colleagues by maintaining effective communication.

2.4. Residents are also expected to demonstrate a responsiveness to the needs of patients and society that supersedes self-interest. Residents must also:

   2.4.1. Ensure that proper hand-off procedures are followed.
   
   2.4.2. Ensure continuity of care when a patient is discharged from a hospital by documenting who will provide that care and informing the patient of how the caregiver can be reached.
   
   2.4.3. Respond promptly to phone messages, pages, e-mail, and all other correspondence.
   
   2.4.4. Provide reliable coverage when not available.

2.5. Residents are also expected to demonstrate accountability to patients, society, and the profession. Residents must also:

   2.5.1. Introduce him- or herself to the patient and the patient’s family members and explain role in the patient’s care.
   
   2.5.2. Wear name tags that clearly identify names and roles.
   
   2.5.3. Maintain legible and up to date medical records, including completion of records within the approved hospital guidelines.
2.5.4. Complete all hospital, GME, and program educational and administrative assignments by the given deadline. This includes but is not limited to:

- Timely completion of evaluations and program documentation;
- Timely logging of duty hours and patient logs;
- Arriving promptly for educational, administrative, and service/patient care activities;
- Meeting with psychotherapy supervisors (weekly) and advisors (monthly).

2.5.5. Maintain and promote physician/patient boundaries.

2.5.6. Adhere to the policy that states that the use of alcoholic beverages, illegal use of drugs or abuse of pharmaceuticals that impair judgment while on duty or reporting for duty under the influence of any agent that may impair judgment is strictly prohibited.

2.5.7. Encourage team based care.

2.6. Residents are also expected to demonstrate a commitment to ethical principles pertaining to the provision of withholding of clinical care, confidentiality of patient information, and informed consent. Residents must also:

2.6.1. Respect patients’ autonomy and the right of a patient and a family to be involved in care decisions.

2.6.2. Ensure patient and family understanding and informed consent for use of neuroleptic agents.

2.6.3. Always obtain informed consent for use of prescribed medications.

2.7. Residents are also expected to demonstrate a commitment to excellence and ongoing professional development. Residents must also:

2.7.1. Respect the systems in place to improve quality and safety of patient care.

2.7.2. Report all adverse events within a timely fashion.

2.7.3. Improve systems and quality of care through critical self-examination of care patterns.

2.7.4. Adhere to ABPN and APA codes of professionalism.

2.7.5. Strive for personal growth and improvement through attention to constructive criticism and awareness of opportunities for improvement. Residents should be open to feedback.

2.7.6. Demonstrate a commitment to lifelong learning.

III. **DRESS CODE:**

3.1. Identification: Unaltered ID badges must be visible at all times. If using a lanyard, it should be the break-away variety.

3.2. White coats are worn while in the hospital and at the discretion of the clinical service.

3.3. Scrubs are acceptable on call only and should not be worn outside of the hospital.

3.4. Clothing must reflect a professional image:

- Dress or casual pants and shirts must be free of insignia bearing a political, controversial, inflammatory, or provocative message. Ties are optional, unless required by the Attending physician.
- Skirts and/or dresses must be knee level or below.
- Tops should cover back, shoulders, and midriff.
• Necklines should be modest (no cleavage).
• Shoes should be clean and in good repair. No open toed shoes may be worn; shoes must have fully enclosed heels or secured with a strap heel for safety. Clean tennis shoes are acceptable when on call.

3.5. Personal Hygiene:
• Hair must be kept clean and well groomed.
• Avoid extreme hair color or style.
• Facial hair must be neat, clean, and well-trimmed.
• Fingernails must be kept clean and appropriate length.
• Avoid overpowering perfume, cologne, creams or lotions.

3.6. The following clothing items are unacceptable:
• Flip-flops or sandals
• Jeans
• Suggestive, revealing, or tight fitting clothing; mini-skirts

IV. SOCIAL MEDIA:
4.1. Social Media includes but is not limited to social networking sites, wikis, blogs, content communities, and virtual communities.
4.2. Utilize best judgment when posting; residents are responsible for anything they post to social media sites either professionally or personally:
   4.2.1. Be respectful.
   4.2.2. Remember your audience.
   4.2.3. Ensure your account’s security.
   4.2.4. Do not post confidential information about MSM, students, faculty, staff, patients, or alumni.
   4.2.5. Do not post information that is proprietary to an entity other than yourself.
   4.2.6. Be aware of copyright and intellectual property rights of others and the university. Refer to MSM policies for additional information.
4.3. Do not imply MSM endorsement. MSM’s logo, word mark, iconography, or other imagery shall not be used on personal social media nor shall the MSM name be used to promote a product, cause, or political party/candidate.

See MSM, Department of Psychiatry Social Media Policy for further details.
Resident Eligibility and Selection Policy

I. RESIDENT ELIGIBILITY:

1.1. Applicants must meet one or more of the qualifications set forth by the MSM Graduate Medical Education Office in order to be eligible for appointment to the MSM, Psychiatry and Behavioral Health Department.

1.2. These qualifications include but are not limited to:

   1.2.1. Graduates of medical schools in the United States accredited by either the LCME or the AOA; graduates of Canadian medical schools approved by the LMCC;

   1.2.2. Graduates of medical schools outside of the United States and Canada with a current and valid ECFMG certificate;

   1.2.3. All applicants must be either a United States citizen, lawful permanent resident, refugee, asylee, or possess the appropriate documentation to allow the resident to legally train at MSM.

II. RESIDENT SCREENING AND SELECTION:

2.1. All Psychiatry PGY-1 positions shall be made available for application through the NRMP. All PGY-1 applicants must apply through ERAS.

2.2. Available positions are dependent on the current number of positions authorized by the ACGME and space available.

2.3. Applicants from the United States or Canadian-accredited medical schools must supply an original copy of a letter of recommendation or verification from the dean of the medical school for submission with their ERAS application.

2.4. Applicants from an LCME or AOA accredited United States medical school must provide proof of graduation or pending “on-time” graduation. This verification, via transcripts, diplomas, or statements within or separate from the dean’s letter, should be submitted with the ERAS application.

2.5. Applicants shall provide official proof of passing both USMLE Step 1 and USMLE Step 2–CK and CS before they are eligible to begin the Psychiatry Residency Program.

   2.5.1. The Department of Psychiatry requires that applicants successfully complete Step 1 and Step 2 CK within two (2) attempts and Step 2 CS on the first attempt.*

   2.5.2. Applicants cannot begin the Residency Program without passing Step 2 CS.

   2.5.3. These expectations must be met by the time of submission of the Rank Order List by the program director to the NRMP.

2.6. The Psychiatry Residency Program also requires that applicants submit three letters of recommendation from within the last 18 months; at least one (1) of these letters should be from a psychiatrist.

2.7. Applicants will be screened and evaluated based on their academic record, leadership, and evidence of community service.
2.8. The Psychiatry Residency Program will consider transfer residents for vacant positions.

2.8.1. The State of Georgia and MSM consider any time spent in a residency program as time that must be declared by the applicant when applying for a temporary Resident Postgraduate Training Permit.

2.8.2. A letter of explanation/verification is required by the applicant and the past residency program director.

2.8.3. Before accepting a transfer resident, the program director of MSM, Department of Psychiatry, must obtain written or electronic verification of previous educational experiences and a summative competency-based performance evaluation from the current/previous program director.

2.9. Personal interviews of applicants shall be conducted by at least two (2) faculty members assigned to the program.

2.9.1. The interviews will be documented for the residency program files and be retained for the period determined by MSM management policies.

2.9.2. These interviews also become a permanent part of a selected applicant’s file.

2.9.3. If telephone interviews are performed, the same standards and documentation criteria are used to record the interview.

2.10. A faculty consensus is formed on the selections for entry into the NRMP Rank Order Listing or for departmental selection for those positions not placed in the match (PGY-2 and above). Final disposition for applicant selection and ranking is done by the program director, associate program director, and chair.

*The number of attempts for completion of USMLE Steps 1 and 2 (CK and CS) is at the discretion of the program director and Program Evaluation Committee. Exceptions may be made for evidence of outstanding performance and/or service in other areas.
Social Media Policy

I. PURPOSE:

1.1. Online social media allow faculty, staff, and residents to engage in professional and personal conversations. These guidelines apply to residents participating in the Morehouse School of Medicine (MSM) Psychiatry Residency Program (MSMPRP) who identify themselves with MSM and/or use their MSM e-mail address in social media platforms such as professional society blogs, LinkedIn, Facebook, etc. for deliberate professional engagement or casual conversation.

1.2. These guidelines apply to private and password-protected social media platforms as well as to open social platforms.

II. SCOPE:

2.1. In general, Morehouse School of Medicine Psychiatry Residency Program (MSMPRP) views Internet social networking sites positively. This includes Facebook, MySpace, Twitter, YouTube, and LinkedIn, as well as personal websites, podcasts, wikis, and blogs (individually and collectively considered "social media") among others.

2.2. MSMPRP respects the right of residents to use them as media of self-expression. However, social media can also be abused by individuals who enter information on it or by those who access and read it with a result that MSM Psychiatry RTP or its affiliates could be viewed negatively or be subject to other adverse consequences.

2.3. The term "affiliate" means any entity or person that works directly with the MSMPRP or MSM to supervise residents or deliver services and goods to the program.

III. POLICY:

The following guidelines apply to any MSM Psychiatry resident who engages in the use of social media:

3.1. Residents must be respectful in all social media communications. Residents should not use obscenities, profanity, or vulgar language, nor may they engage in threatening behavior online or make defamatory statements.

3.2. Residents should only use their work e-mail for work-related forums (e.g., following a professional organization, like MSM, on Facebook). Otherwise, we strongly suggest using personal e-mail for personal communication.

3.3. “Friending” is a way to establish online communication with others on social media sites. It is highly recommended that you do not allow patients (former or current) to be added to your personal friend list.

3.3.1. This may compromise patient privacy and confidentiality as well as overstep appropriate physician-patient boundaries.

3.3.2. It is always acceptable to refuse inappropriate “friend” requests (University of Maryland).
3.4. Residents may not comment through social media in any manner that conveys an impression that he or she is acting as a representative or spokesperson for MSMPRP, MSM, or any of its affiliates. The social media policy applies to personal activity and/or professional activity that is not part of official MSMPRP communication, and where the affiliate identifies him- or herself as an MSMPRP resident, either through a bio, comments, or by using an MSM e-mail address.

3.5. The following disclaimer should be added whenever you identify yourself as part of MSM while not officially acting on behalf of the medical center:

*The views and opinions expressed here are not necessarily those of Morehouse School of Medicine nor its affiliates, and they may not be used for advertising or product endorsement purposes.*

3.6. If you list Morehouse School of Medicine as your employer on your Facebook info tab, you must add the disclaimer on the tab as well.

3.7. If you do not identify yourself as being affiliated in any way with MSMPRP, MSM, nor any of its affiliates, the policy does not apply.

3.8. Residents must not use social media to disparage the MSM faculty, program, other residents, or other affiliates of MSMPRP, or its parent institution, Morehouse School of Medicine.

3.9. Residents must follow the same MSM guidelines in regard to:
- Compliance (HIPAA and the protection of patient information)
- Conflict of Interest Policy

3.10. Residents must follow general civil behavior guidelines with respect to:
- Copyrights
- Disclosures
- Refraining from revealing proprietary financial or intellectual property
- Refraining from revealing information about patient care or similar sensitive or private content (Vanderbilt)

3.11. Residents must not use social media to harass, threaten, or intimidate others. Behaviors that are prohibited include, but are not limited to:
- Comments that are derogatory regarding race, sex, religion, color, age, disability, or any other protected status
- Any sexually suggestive, humiliating, or demeaning comments
- Threats or bullying comments (such as threats to stalk, haze, or physically injure others)

3.12. Residents must not use social media to discuss engaging in conduct that is prohibited by MSMPRP and MSM policies, including but not limited to:
- The improper or illegal use of drugs or alcohol
- Any harassing, discriminatory, or retaliatory behavior that might violate MSMPRP and MSM policies against harassment and discrimination

3.13. Residents must not post pictures or videos of faculty, program staff, other residents, patients, or any affiliates on a website or other social media venue without first obtaining written permission from the person or entity whose picture or video is being used.

3.14. Residents should be aware that pictures, videos, and comments posted on social media sites are often available for viewing by third parties and could be considered detrimental to MSMPRP, MSM, or our affiliates. Therefore, in addition to the other requirements of
this policy, residents must review their privacy settings on the various social media sites they use, and make any adjustment to those settings or edit the content of those sites in order to be in full compliance with this policy.

3.15. Residents must comply with any applicable federal or state trademark, copyright, trade secret, or other intellectual property laws.

3.16. The use of MSMPRP and MSM name, logo, or any copyrighted material of our organization is not allowed without prior written permission of MSM.
Supervision Policy with Resident Position Descriptions

I. PURPOSE:
The purpose of this policy is to define the process for resident supervision, including progressive responsibilities of residents for patient care and faculty responsibility for supervising resident patient care.

II. PROCESS:
2.1. Faculty physicians assigned as full-time, part-time, or adjunct MSM faculty by the MSM, Department of Psychiatry Executive Committee supervise all patient care.

2.2. Attending faculty supervision is provided, appropriate to the skill level of the resident on service.

2.3. Specific responsibilities for patient care are included in the written description of each service/rotation by program year. This information is available in the program handbook at any time.

2.4. For daily clinical activities, faculty and/or the chief resident(s) are on-site and available for Direct Observation as required for PGY-1 residents. As the resident’s competency and skill set advances, faculty and/or chief residents continue to be on-site, however Indirect Observation is allowed. For PGY-2 residents and above, a faculty member and/or chief resident provides direct and/or indirect supervision based on the resident’s competency.

2.5. For call activities, a senior resident is on site for supervision and a faculty physician is available to supervise the entire team.

2.6. A rapid, reliable system for communication with the supervisory faculty is available.

2.7. On-call responsibilities, assignments, and supervision are documented through the call schedule.

III. LEVELS OF SUPERVISION:
To ensure oversight of resident supervision and graded authority and responsibility, the program must use the following classification of supervision:

3.1. Direct Supervision—The supervising physician is physically present with the resident and patient.

3.2. Indirect Supervision with direct supervision immediately available—The supervising physician is physically within the hospital or other site of patient care, and is immediately available to provide...
3.3. Direct Supervision 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.

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

IV. PATIENT LOGS:

4.1. Residents are to keep a daily log of all patient encounters.

4.2. These logs are subject to oversight supervision by the supervising Attending, associate program director, and/or program director periodically to ensure a variety of cases, treatment options, and appropriateness of care.

4.3. Faculty observation of Clinical Assessment with case presentation is an important form of supervision. Faculty and residents are encouraged to provide a minimum of one (1) supervisory session per rotation of an entire patient interaction. Direct supervision in this manner allows for specific feedback and can be used for Clinical Skills Verifications.

V. FACULTY INVOLVEMENT:

Residents MUST communicate with the appropriate supervising faculty in the following circumstances/events:

- Hospital admissions
- Civil commitments
- Family wishes to speak to the Attending physician
- Significant change in the clinical status of a patient
- Any uncertainty regarding diagnosis and/or management
- Any patient safety concern/issue
- AMA discharge
- Medical errors

VI. INPATIENT SETTING:

6.1. Regarding faculty supervision, in the inpatient setting, residents receive direct supervision by an Attending physician caring for a specific patient or by the physician on service or on call through the 24/7 coverage schedule.

6.2. Resident graduated responsibility for patient care:

6.2.1. Depending on the patient’s complexity, inpatients are initially evaluated by the more junior resident.

6.2.2. This resident may then present the patient history and plan to the chief resident, senior resident, or faculty physician who will evaluate the patient and review the note before significant plans are enacted.

6.2.3. Residents are to contact the supervising Attending and present their plan whenever significant changes in patient status occur, or before initiating new medication, or admitting or discharging patients.
VII. EMERGENCY SETTING:

7.1. Regarding faculty supervision in the emergency department, residents may receive direct supervision or indirect supervision with direct supervision immediately available by the Crisis Intervention service Attending caring for a specific patient or by the physician on call through the 24/7 coverage schedule.

7.2. Regarding resident graduated responsibility for patient care, patients are initially evaluated by the resident physician and the patient history, safety, and ability to care for self-assessment, and plan are presented to the Attending physician.

VIII. CONTINUITY SETTING:

8.1. Faculty Supervision:

8.1.1. A supervising Attending is assigned to the resident clinics every session.

8.1.2. The Attending is available for direct supervision and indirect supervision with direct supervision immediately or non-urgently available.

8.1.3. Each Attending documents his or her level of involvement on each case through the electronic medical record.

8.2. Resident graduated responsibility for patient care:

8.2.1. Residents have individualized assignments for patient care in the continuity clinic, with each resident assigned for a minimum of 1.5 to 2 days per week.

8.2.2. Patients are initially evaluated by the resident physician.

8.2.3. The case is then presented to the faculty Attending and depending on complexity, the Attending will assess the patient and guide the resident in developing a care plan and follow up.

IX. PSYCHOTHERAPY SUPERVISION:

9.1. Residents are expected to meet with their supervisor once a week for indirect clinical supervision.

9.2. The sessions should include but are not limited to:

- Patient selection
- Key elements in setting the foundation for psychotherapy
- Case formulation and treatment planning
- Review of process notes
- Identification of relevant transference, countertransference, and boundary concerns
- Identification of key elements and processes of the individualized psychotherapy plan
Position Description for Resident Physicians

General Principles of the Training Program for Residents in Psychiatry at Morehouse School of Medicine:

1. The house staff physician meets the qualifications for resident eligibility outlined in the Essentials of Accredited Residencies in Graduate Medical Education in the AMA Graduate Medical Education Directory.

2. As the position of house staff physician involves a combination of supervised, progressively more complex and independent patient evaluation and management functions and formal educational activities, the competence of the house staff physician is evaluated on a formal semi-annual basis as required by the Residency Review Committee (RRC). The program maintains a confidential record of the evaluation.

3. The position of house staff physician entails provision of care commensurate with the house staff physician’s level of training and competence, under the general supervision of appropriately privileged Attending teaching staff. This includes:
   - Participation in safe, effective, and compassionate patient care;
   - Developing an understanding of ethical, socioeconomic, and medical/legal issues that affect graduate medical education and how to apply cost-containment measures in the provision of patient care;
   - Participation in the educational activities of the training program and, as appropriate, assumption of responsibility for teaching and supervising other residents and students;
   - Participation in institutional orientation and education programs and other activities involving the clinical staff;
   - Participation in institutional committees and councils to which the house staff physician is appointed or invited; and performance of these duties in accordance with the established practices, procedures, and policies of the institution, and those of its programs, clinical departments, and other institutions to which the house staff physician is assigned, including, among others, state licensure requirements for physicians in training, where these exist;
   - Follow the rules and guidelines as directed by the MSM Psychiatry department resident protocol.
Position Descriptions for Resident Physicians Specific to Level

PGY-1 on Ward
- Writes admission orders
- Examines every assigned patient (daily exam)
- Performs the main write-up on every admitted patient
- Schedules tests; reviews lab data
- Reports to resident at work rounds
- Reports to Attending at Attending rounds (if no student)
- Supervises student on writing orders, collecting labs, physical exam
- Writes/supervises daily progress note
- Performs procedures under supervision of resident or Attending until proficient
- Outpatient or subspecialty consult service
- Takes history, examines patient, writes basic note
- Reports to Attending
- Ensures that all work is directly checked by Attending
- Writes prescriptions, lab/imaging orders
- Reviews results with Attending
- Communicates with referring physicians/other consultants

PGY-2/3 on Ward
- Supervises PGY-1 and students
- Organizes, directs ward team
- Primary contact with Attending unless designated to PGY-1
- Fills in when PGY-1 not adequate
- Direct teaching and supervision of students
- Reviews all student work-ups
- Instructs students in physical and patient management
- Directs students to information resources
- Provides outpatient/subspecialty consult service
- Takes history/examines patient, writes note
- Reports to Attending
- Writes prescriptions, lab/imaging orders
- Reviews results with Attending
- Communicates with referring physicians/other consultants
Psychiatry PGY-1 on Internal Medicine/Neurology/Family Medicine

- Writes admission orders
- Examines every assigned patient (daily exam)
- Performs main write-up on every admitted patient
- Schedules tests; reviews lab data
- Reports to resident at work rounds
- Reports to Attending at Attending rounds (if no student)
- Supervises student on writing orders, collecting labs, physical exam
- Writes/supervises daily progress note
- Performs procedures under supervision of resident or attending until proficient
- Provides outpatient neurology consult service
- Takes history, examines patient, writes basic note
- Reports to Attending
- Ensures that all work is directly checked by Attending
- Writes prescriptions, lab/imaging orders
- Reviews results with Attending
- Communicates with referring physicians/other consultants

PGY-1 on Psychiatry Service at Atlanta VA

- Examines assigned patients (history, physical, and psychiatric evaluation)
- Reviews admission orders with Attending physician
- Participates in team treatment planning and progress meetings
- Participates in patient conferences
- Follows patients for medication management and psychotherapy under supervision
- Participates in family conferences
- Presents patients in case conferences and grand rounds

PGY-2 Outpatient Psychiatry/Grady

- Performs psychiatric evaluations of patients including substance abuse history and mental status examination
- Plans and performs psychotherapy and psychopharmacologic treatments under supervision
- Participates in case conferences
- Participates in group and family therapy
- Participates in clinical out-patient research
- Participates in evaluation treatment and management of patients on the following services:
  - Community outreach
  - Child psychiatry
  - Psychosocial rehabilitation
PGY-3 on In-Patient Psychiatry—GA Regional Hospital

- Evaluates acute psychiatric patients for in-patient treatment including psychiatric evaluation, substance abuse history and mental status examination
- Plans and performs psychotherapy and psychopharmacologic treatments under supervision
- Participates in case conferences
- Participates in group and family therapy
- Participates in clinical out-patient research
- Evaluates acute/emergency psychiatric patients on:
  - Emergency psychiatry service and
  - Psychiatric consultation service (2 months) at Grady Memorial Hospital

PGY-4

Performs psychiatric evaluations, treatment, management, and coordination of care under appropriate supervision for patients in the following treatment settings:

- Psychiatric consultation service—Grady
- Substance abuse services—Grady
- Forensic psychiatric services—GA Regional
- Outpatient psychiatry—East Point VA CBOC
Transfer of Care and Patient Sign-Out Policy

I. **RATIONALE:**
   As modern medicine moves more towards a team approach to patient care and as we turn our focus toward patient safety, quality, and continuity of care, patient hand-off/transition of care communication has become increasingly important.

II. **DEFINITIONS:**

2.1. **Transition of Care**—A transfer is a real time, active process of conveying the responsibility for the care of a patient from one entity to another. It may involve the discharge from one entity and the admission to another along with the patient’s medical and/or psychiatric records.

2.2. **“Sign-out”** is the term that we use to refer to the verbal and written patient hand-off communication that takes place between the outgoing and on-coming teams at the change of shift and in transferring care to another service.

   2.2.1. **This may be done via a verbal and/or written sign-out.**

   2.2.2. **The sign-out/hand off is a way to provide information to facilitate continuity of care.**

   2.2.3. **The sign out will be conducted in conjunction with, but not limited to, changes in call status, when contacting another physician when there is a change in the patient’s condition, and transferring a patient from one care setting to another.**

III. **POLICY:**

3.1. **A standardized approach to handovers/transfers at Morehouse School of Medicine Hospital sites provides an opportunity to ask and respond to questions.**

3.2. **Caregivers involved in the sign-out/hand-off process include, but are not limited to, physicians, nurses, therapists, technicians, and transporters.**

3.3. **Key elements of patient information are included in the handover/transfer process as determined by the service or team of caregivers. Patient information related to current condition and present treatment patient information will include at a minimum:**

   - Patient name, location, age/date of birth
   - MR #
   - Diagnosis
   - Allergies, Medical History, and Psychiatric History
   - Important current labs and vitals; pending tests and studies which require follow-up
   - Level and commitment status
   - Medications
   - Potential seclusion/restraint issues
What to watch for or monitor during the next interval of care  
Important items planned between now and discharge

3.4. Handover/transfer communication may include verbal face-to-face or telephone reports accompanied by a written handoff; written reports or handover/transfer should be documented using the templates developed at the unit or departmental level.

3.4.1. Telephone hand-offs occur when transferring a patient on a civil commitment from the outpatient setting to the emergency receiving facility; however, a written hand-off must accompany the patient to the facility via staff and/or security.

3.4.2. Otherwise, telephone hand-offs are not acceptable.

3.4.3. Any time written communication is used in a handover/transfer, the name and contact number of the caregiver handing off or transferring care will be included to facilitate the asking of questions.

IV. PROCEDURE:

4.1. Caregivers will identify a quiet area, such as the resident workroom, to give report that is conducive to transferring information with limited interruptions.

4.2. Caregivers will have at hand any supporting documentation or tools, such as paper instructions, used to convey information and immediate access to the patient record.

4.3. All communication and transfers of information will be provided in a manner consistent with protecting patient confidentiality.

4.4. Caregivers will afford each other the opportunity to ask or answer questions and read or repeat back information as needed. If the contact is not made directly (face-to-face or by telephone), the caregiver must provide documentation of name and contact information (extension, pager, or e-mail address) to provide opportunity for follow-up call or inquiry.

4.5. The patient will be informed by the departing resident or Attending of any transfer of responsibility even if temporary or brief.

4.6. A resident physician must not leave the hospital until a hand-off has occurred.

4.7. Verbal Sign-out: This is the verbal status update of all patients admitted during the shift or being transferred to an emergency receiving facility. This sign-out includes all new admission, pertinent labs, and new developments that occurred during a shift. See the hand-off policy for the VA Health Care System below.

4.8. Written Sign-out: This is the written patient hand-off communication used to keep record of patients admitted or cared for during the residents call.

4.8.1. These written communications are updated throughout the shift as patients are admitted, have status changes, or are discharged.

4.8.2. Customarily, the written communication is printed for review during the verbal sign-out for visual re-enforcement and so that additional notes can be made.

4.9. Additional Procedures:

4.9.1. SBAR can be used to deliver or receive the information:

Situation: What is the problem?
Background: Pertinent information to the problem at hand
Assessment: Clinical staff’s assessment
Recommendation: What do you want done and/or think needs to be done?
4.9.2. ANTICIpate information needed for a hand off

Admission demographics (i.e. patient name, age, admission diagnosis, allergies)
Now: Current condition (stable vs. unstable), pertinent labs, current meds, and updated diagnosis and assessment
Tasks to be done overnight
Include time for receiver’s questions and clarifications on the patients
Contingency planning: Given the current condition and status of the patient, what are important events that can occur overnight and what can be done for the same (e.g., what has or has not worked in the past; difficult family or psychosocial situations; level/commitment status; complications)
Interruptions: Was the hand-off free from interruptions (e.g., noise, distractions, lack of dedicated space or time)

V. ATLANTA VA MEDICAL CENTER—GUIDE TO SHIFT HAND-OFF:

5.1. Shift hand-off ensures safe ongoing patient care.

5.2. The importance of shift hand-off is to communicate essential knowledge to oncoming providers so that errors are eliminated and relevant information is communicated in an efficient manner.

5.3. The ultimate goal of shift hand-off is to prevent mistakes and potential errors that may be avoided.

5.4. At the VAMC there are two major hand-off periods: AM and PM.

5.4.1. Morning (AM) hand-off: weekdays

5.4.1.1. At the VAMC, the first hand-off occurs at the Administrative meeting during the week. The point of this meeting is to account for the patients that were seen overnight.

5.4.1.2. This helps staff understand the disposition for all of the patients that were evaluated, arrange any follow up that is appropriate, and to highlight any systems issues. Additionally, if there are patient care concerns for the next shift, these should be communicated to the oncoming teams.

5.4.1.3. At this meeting, the resident will communicate information on all patients that were seen in the ED Annex or as a consult (either in the ED or on med/surgical floors).

5.4.1.4. Next, the resident will communicate any major medical or psychiatric issues that happened in the ED Annex or on the inpatient unit (e.g., patient placed in restraints, patient transferred to medicine for shock).

5.4.1.5. Finally, any issues that need follow up during the day should be communicated to one of the physicians starting the day shift (chief of service, chief resident, or one of the inpatient residents). An example would be, “I ordered a head CT for Mr. X due to a fall, but the result is not back yet. Serial cardiac enzymes are pending.”
5.4.2. Evening (PM) hand-off: weekdays

5.4.2.1. The evening hand-off begins at the beginning of the shift for the oncoming POD (16:00).

5.4.2.2. At the VAMC, all patients on a level 4 need sign-out; and any patient who is on a lower level, but has new issues that are significant, will also need sign-out.

5.5. The key information to sign-out on the patients includes:

- Reason for admission
- Concerns for any monitoring above Q15 minute checks
- Any risky or concerning behaviors
- Medication initiations or changes that could cause problems
- Restricted medications—are there medications the patient should not receive?
- F/U labs, imaging that may be important overnight
- Any medical conditions that may likely become unstable overnight

5.6. For patients that are on lower level, an example of a sign-out would be: “Patient X had an episode of syncope yesterday. BP has been stable. If episode returns, will need to contact MOD and check orthostatic.”

5.7. Admissions: if there is an admission to your team (transfer patient from another service or outside hospital) that has not arrived on your shift, sign the patient out to the POD since they will have to do the admission. If you have any paperwork, be sure to pass that on to the POD.

5.8. As a backup, information on all patients on the inpatient unit will be entered into the shift hand-off tool in the medical record and updated on a daily basis to reflect clinical changes. This will be available to the POD overnight should issues arise.

VI. WEEKENDS:

6.1. On the weekend, there is one major sign-out period at 08:00 AM. This should occur with the Attending physician, the outgoing POD, the incoming POD, a nursing representative, and sometimes a moonlighting physician.

6.2. The resident beginning the Saturday shift should print out the census for 4PSY. This census should be passed along on Sunday at hand-off and again at the Administrative meeting to the chief resident.

6.3. During the sign-out, all relevant issues will be communicated by both the verbal and written (shift hand-off tool) to the oncoming physicians. Any pending testing or evaluations will also be communicated at this time, similar to the hand-off during the week.
Graduate Medical Education
Policies, Procedures, Processes, and Program Templates
2016-2017
Adverse Academic Decisions and Due Process Policy

I. PURPOSE:
1.1. Morehouse School of Medicine (MSM) shall provide residents with an educational environment that MSM believes is fair and balanced.

1.2. This policy outlines the procedures which govern adverse academic decisions and due process procedures relating to residents and fellows during their appointment periods at Morehouse School of Medicine regardless of when the resident or fellow matriculated.

1.3. Actions addressed within this policy shall be based on an evaluation and review system tailored to the specialty in which the resident is matriculating.

II. SCOPE:
2.1. All MSM administrators, faculty, staff, residents, and administrators at participating affiliates shall understand and shall comply with this and all other policies and procedures that govern both Graduate Medical Education programs and resident appointments at MSM.

2.2. Residents shall be given a copy of this Adverse Academic Decisions and Due Process policy at the beginning of their training.

III. DEFINITIONS:
3.1. Academic Deficiency

3.1.1. A resident’s academic performance is deemed deficient if performance does not meet/does not satisfy the program and specialty standards.

3.1.2. Evidence of academic deficiency for a resident can include, but is not limited to:

3.1.2.1. Having an insufficient fund of medical knowledge

3.1.2.2. Inability to use medical knowledge effectively

3.1.2.3. Lack of technical skills based on the resident’s level of training

3.1.2.4. Lack of professionalism, including timely completion of administrative functions such as medical records, duty hour and case logging.

3.1.2.5. Unsatisfactory written evaluation(s)

3.1.2.6. Failure to perform assigned duties

3.1.2.7. Unsatisfactory performance based on program faculty’s observation

3.1.2.8. Any other deficiency that affects the resident’s academic performance
3.2. Opportunity to Cure—occurs when a resident corrects an academic deficiency and sustains the correction to the satisfaction of the faculty, program director, department chairperson, and Clinical Competency Committee of the program in which the resident is enrolled.

3.3. Day—a calendar day, except where the last day of any time period falls on a Saturday, Sunday, or MSM-recognized holiday; the time period will run until 5:00 p.m. of the next business day that is not a Saturday, Sunday, or an MSM-recognized holiday.

3.4. Corrective Action

3.4.1. Written formal action taken to address a resident’s academic, professional, and/or behavioral deficiencies and any misconduct.

3.4.2. Typically, “corrective action” includes/may include probation, of which can result in disciplinary action, such as non-promotion, non-renewal of residency appointment agreement or dismissal, pursuant to the due process guidelines outlined in this policy or in other appropriate MSM policies.

3.4.3. Corrective action does not include a written or verbal notice of academic deficiency.

3.5. Disciplinary Action—suspension, non-promotion, non-renewal of residency appointment agreement.

3.6. Dismissal—the immediate and permanent removal of the resident from the educational program for failing to maintain academic and/or other professional standards required to progress in or complete the program. This includes conduct described in section 4.2 below.

3.7. Due Process

3.7.1. For matters involving academic deficiency(ies) in resident performance, due process involves:

3.7.1.1. Providing notice to the resident of the deficient performance issue(s);

3.7.1.2. Offering the resident a reasonable opportunity to cure the academic deficiency; and

3.7.1.3. Engaging MSM in a reasonable decision-making process to determine the appropriate course of action to take regarding whether to impose corrective action.

3.8. GME—Graduate Medical Education

3.9. GME Office—Graduate Medical Education Office of Morehouse School of Medicine

3.10. Mail—to place a notice or other document in the United States mail

3.10.1. Notices mailed via first class mail, postage prepaid, unless returned to sender by the United States Postal Service, are presumed to have been received three (3) days after mailing.

3.10.2. Unless otherwise indicated, it is not necessary, in order to comply with the notice requirements in the policy to hand-deliver the notice or use certified or registered mail. However, such methods of delivery, when documented, will verify actual notice.

3.10.3. Mailing information to the resident's official MSM mailing address is sufficient to meet MSM’s obligations. It is the resident’s responsibility to ensure that his or her program possesses the resident’s most current mailing address.
3.11. Meeting

3.11.1. The appeals process outlined in this policy where a resident is provided an opportunity to present evidence and arguments related to why he or she believes the decision by the program director, department chairperson, or Clinical Competency Committee to take disciplinary action for non-renewal or dismissal is unwarranted.

3.11.2. It is also the opportunity for the program director, department chairperson, or Clinical Competency Committee to provide information justifying its decision(s) regarding the resident.

3.12. Misconduct

3.12.1. Misconduct involves violations of standards, policies, laws, and regulations that affect professional and ethical standards of a physician in training.

3.12.2. These violations constitute a breach of the MSM Resident Training Agreement.

3.13. Non-Renewal of Appointment—if the residency program determines that a resident’s performance is not meeting the academic or professional standards of MSM, the program, the ACGME program requirements, the GME requirements, or the specialty board requirements, the resident will not be reappointed for the next academic year. (Reappointment in a residency programs is not automatic; the program may decide to not reappoint a resident, in its sole discretion.)

3.14. Non-Promotion

3.14.1. Resident annual appointments are for a maximum of 12 months, year-to-year.

3.14.2. A delay in being promoted to the next level is an academic action used in limited situations. These limited situations include, but are not limited to, instances where a resident has an overall unsatisfactory performance during the academic year or fails to meet any promotion criteria as outlined by the program.

3.15. Notice of Deficiency—the residency program director may issue a written warning to the resident to give notice that academic deficiencies exist that are not yet severe enough to require a formal corrective action plan or disciplinary action, but that do require the resident to take immediate action to cure the academic deficiency. It is at the program director’s discretion as to whether a written remediation will be required.

3.16. CCC—Clinical Competency Committee reviews all resident evaluations at least semi-annually; prepares and ensures the reporting of Milestones evaluations of each resident semi-annually to ACGME; and advises the program director regarding resident progress, including promotion, remediation, and dismissal.

3.17. Probation—a residency program may use this corrective action when a resident’s violations include but are not limited to:

3.17.1. Providing inappropriate patient care;

3.17.2. Lacking professionalism in the education and work environment;

3.17.3. Failure to cure notice of academic deficiency or other corrective action;

3.17.4. Negatively impacting healthcare team functioning; or

3.17.5. Causing residency program dysfunction.
3.18. Remediation

3.18.1. Remediation cannot be used as a stand-alone action and must be used as a tool to correct a Notice of Academic Deficiency or probation and assists in strengthening resident performance when the normal course of faculty feedback and advisement is not resulting in a resident’s improved performance.

3.18.2. Remediation allows the resident to correct an academic deficiency(ies) that would adversely affect the resident’s progress in the program.

3.19. Suspension

3.19.1. Suspension is the act of temporarily removing a resident from all program activities for a period of time because the resident’s performance or conduct does not appear to be in the best interest of the patients or other medical staff.

3.19.2. While a faculty member, program director, chairperson, clinical coordinator, or administrative director, or other professional staff of an affiliate may remove a resident from clinical responsibility or program activities, only the program director makes the determination to suspend the resident and the length (e.g.: days) of the resident’s suspension.

3.19.3. Depending on circumstances, a resident may not be paid while on suspension. The program director determines whether a resident will be paid or not paid.

3.20. Reportable Adverse Actions—probation, suspension, non-renewal, and dismissal may be reportable actions for state licensing, training verifications, and hospital/insurance credentialing depending upon the state and entity.

IV. POLICY:

4.1. When a resident fails to achieve the standards set forth by the program, decisions must be made with regard to notice of academic deficiency, probation, suspension, non-promotion, non-renewal of residency appointment agreement, and in some cases, dismissal. MSM is not required to impose progressive corrective action, but may determine the appropriate course of action to take regarding its residents depending on the unique circumstances of a given issue.

4.2. Residents engaging in conduct violating the policies, rules, bylaws, or regulations of MSM or its educational affiliates, or local, state, and federal laws regarding the practice of medicine and the standards for a physician in training, may, depending on the nature of the offense, be dismissed.

4.2.1. Such misconduct will be considered a breach of the Resident Appointment Agreement or Reappointment Agreement.

4.2.2. In such instances, the Graduate Medical Education Office and Human Resources Department may be involved in the process of evaluating the violation.

4.3. A resident who exhibits unethical or other serious behaviors that do not conform to achieving the skills required for the practice of medicine may be summarily dismissed.
V. PROCEEDURES:

5.1. If any clinical supervisor deems a resident's academic or professional performance to be less than satisfactory, the residency program director will require the resident to take actions to cure the deficiencies.

5.2. Notice of Academic Deficiency

5.2.1. The residency program director may issue a Notice of Academic Deficiency to a resident to give notice that academic deficiencies exist that are not yet severe enough to require corrective action, disciplinary action, or other adverse actions but that do require the resident to take immediate action to cure the academic deficiency.

5.2.2. This notice may be concerning both progress in the program and the quality of performance.

5.2.3. Residents will be provided reasonable opportunity to cure the deficiency(ies) with the expectation that the resident’s academic performance will be improved and consistently sustained.

5.2.4. It is the responsibility of the resident, using necessary resources, including advisor, faculty, PDs, chairperson, etc., to cure the deficiency(ies).

5.2.5. The residency program director will notify the GME director in writing of all notices of deficiency(ies) within five (5) calendar days of the program director’s decision.

5.3. Probation

5.3.1. A residency program may use this corrective action when a resident’s actions are associated with:

5.3.1.1. Providing inappropriate patient care;

5.3.1.2. Lacking professionalism in the education and work environments;

5.3.1.3. Negatively impacting healthcare team functioning; or

5.3.1.4. Causing residency program dysfunction.

5.3.2. Probation can be used as an option when a resident fails to cure a notice of academic deficiency or other corrective action.

5.3.3. The program director must notify and consult with the GME DIO and/or director before issuing a probation letter to a resident.

5.3.3.1. A probation letter must be organized by ACGME core competencies and detail the violations and academic deficiencies.

5.3.3.2. A probationary period must have a definite beginning and ending date and be designed to specifically require a resident to correct identified deficiencies through remediation.

5.3.3.3. The length of the probationary period will depend on the nature of the particular infraction and be determined by the program director. However, the program director should set a timed expectation of when improvement should be attained. The duration will allow the resident reasonable time to correct the violations and deficiencies.

5.3.3.4. A probation period cannot exceed six (6) months in duration and residents cannot be placed on probation for the same infraction/violation for longer than 12 consecutive months (i.e.: maximum of two (2) probationary periods).
5.3.4. Probation decisions shall not be subject to the formal appeals process.

5.3.5. While on probation, a resident is not in good standing.

5.3.6. Remediation must be used as a tool for probation. Developing a viable remediation plan consists of the following actions:

5.3.6.1. The resident must be informed that the remediation is not a punishment, but a positive step and an opportunity to improve performance by resolving the deficiency.

5.3.6.2. The resident may be required to make up time in the residency if the remediation cannot be incorporated into normal activities and completed during the current residency year.

5.3.6.3. The resident must prepare a written remediation plan, with the express approval of the program director as to form and implementation. The program director may require the participation of the resident's advisor in this process.

5.3.6.3.1. The plan shall clearly identify deficiencies and expectations for reversing the deficiencies, organized by ACGME core competencies.

5.3.6.3.2. It is the responsibility of the resident to take actions to meet all standards, and to take the initiative to make improvements as necessary.

5.3.7. All residents placed on probation are required to meet with the Director for Graduate Medical Education.

5.3.8. If the deficiency(ies) persist during the probationary period and are not cured, the residency program director may initiate further corrective or disciplinary action including but not limited to: continuation of probation with or without non-promotion, non-renewal of residency appointment agreement, or dismissal.

5.3.9. The program director must notify and consult with the GME DIO and/or director before initiating further corrective or disciplinary action.

5.3.9.1. If the reasons for non-promotion, non-renewal of appointment, or dismissal occur within the last four (4) months of the resident’s appointment year, the program will provide the resident reasonable notice of the reasons for the decision as circumstances reasonably allow.

5.3.9.2. The decision of the program director will be communicated to the resident and to the Office of Graduate Medical Education.

5.3.9.3. The residency program director will notify the resident in writing of non-promotion, non-renewal of appointment, or dismissal decisions.

5.4. Suspension

5.4.1. Suspension shall be used as an immediate disciplinary action because of a resident’s misconduct. Suspension is typically mandated when it is in the best interest of the patients or professional medical staff that the resident be removed from the workplace.
5.4.2. A resident may be placed on paid or unpaid suspension at any time for certain violations in the workplace.

5.4.3. A resident may be removed from clinical responsibility or program activities by a faculty member, program director, department chairperson, clinical coordinator, or administrative director of an affiliate. At his or her sole discretion, that individual can remove the resident if he or she determines that one of the following types of circumstances exist:

5.4.3.1. The resident poses a direct detriment to patient welfare.

5.4.3.2. Concerns arise that the immediate presence of the resident is causing dysfunction to the residency program, its affiliates, or other staff members.

5.4.3.3. Other extraordinary circumstances arise that would warrant immediate removal from the educational environment.

5.4.4. All acts of removal from clinical responsibility or program activities shall be documented by the initiating supervisor or administrator and submitted to the program director in writing within 48 hours of the incident/occurrence, explaining the reason for the resident’s removal and the potential for harm.

5.4.5. After receiving written documentation of the incident/occurrence, the program director has up to five (5) days to determine if a resident will be suspended.

5.4.6. Only the program director has authority to suspend a resident from the program and decide the length of time of the suspension, regardless of individual hospital or affiliate policies and definitions of suspension.

5.4.7. The program director must notify and consult with the GME DIO and/or director before suspending a resident.

5.4.8. After a period of suspension is served, further corrective or disciplinary action is required.

5.4.8.1. The program director shall review the situation and determine what further disciplinary action is required.

5.4.8.2. Possible actions to be taken by the program director regarding a suspended resident may be to:

5.4.8.2.1. Return the resident to normal duty with a Notice of Academic Deficiency;

5.4.8.2.2. Place the resident on probation; or

5.4.8.2.3. Initiate the resident’s dismissal from the program.

5.5. Failure to Cure Academic Deficiency—if a resident fails to cure academic deficiencies through his or her own corrective action, formal corrective action plan (remediation), probation, or other forms of provided academic support, the program director may recommend including but not limiting the recommendation to one or more of the following actions:

5.5.1. Continued probation

5.5.2. Non-promotion to next the PGY level

5.5.3. Repeat of a rotation or other education block module
5.5.4. Non-renewal of residency appointment agreement
5.5.5. Dismissal from the residency program

5.6. The resident shall have the right to appeal only the following disciplinary actions:

5.6.1. Dismissal from the residency program
5.6.2. Non-renewal of the resident’s appointment

5.7. Appeal Procedures—Program and Department

5.7.1. All notices of dismissal from the residency program or a non-renewal of the resident’s appointment shall be delivered to the resident’s home address by priority mail and e-mail. A copy may also be given to the resident on site, as convenient.

5.7.2. If the resident wants to appeal the decision, he or she should communicate intent to do so in writing to the program director within seven (7) days upon receipt of the letter that identifies the decision.

5.7.3. The program director will notify the department chairperson.

5.7.4. A Departmental Appeal Committee will be convened to meet to review the resident’s training documents and hear directly from the resident and program director regarding the matter.

5.7.4.1. The resident may bring an advocate, such as a faculty member, staff member, or other resident.

5.7.4.2. Legal counsel is not permitted to attend the appeal because the process is an academic appeal.

5.7.4.3. Appeal meetings may not be recorded.

5.7.4.4. The Departmental Appeal Committee appointed by the department chairperson shall consist of a minimum of three (3) faculty members.

5.7.5. The Departmental Appeal Committee will present its recommendation to the program director, who will then forward the resident’s training documents, all information concerning the dismissal and appeal, and all other pertinent information to the chairperson.

5.7.6. The department chairperson will review all the materials and make the final departmental decision within seven (7) days of receipt of materials.

5.7.7. The department chairperson will communicate the final departmental decision to the program director.

5.7.8. The program director will then communicate the decision by written letter to the resident via first class United States mail and email. This should occur within ten (10) days of the final decision.

5.8. Appeal to the Dean—the resident may appeal the decision of the department chair.

5.8.1. If the resident is unsuccessful in his or her appeal with the chairperson, he or she may submit a written request to the dean for a review of due process involved in the program’s decision of dismissal or non-renewal of appointment. A request for appeal must be submitted in writing within seven (7) days of the notification by the residency program director to the resident of the decision by the chairperson. The appeal must be submitted to the dean and the program director.
5.8.2. The dean shall instruct the GME office to convene an Institutional Appeal Committee to review the case and provide an advisory opinion as to whether the residency program afforded the resident due process in its decision to dismiss or to not renew the resident’s appointment. This review is that of program protocol and documentation in the case. MSM’s Designated Institutional Officer, or his or her designee, shall chair the institutional appeal committee.

5.8.3. The residency program director shall provide the training documents and record of the proceedings to the appeal committee.

5.8.3.1. The institutional appeal committee shall give the resident an opportunity to present written or verbal evidence on his or her behalf to rebut the allegations that led to the adverse decision.

5.8.3.2. The resident may bring an advocate, such as a faculty member, staff member, or other resident.

5.8.3.3. Legal counsel is not permitted to attend the appeal because the process is an academic appeal.

5.8.3.4. Recording of meeting(s) and/or proceedings is prohibited.

5.8.4. The institutional appeals committee chair will submit a written report of the findings to the dean who will make the final determination regarding the status of the resident.

5.8.5. The final written determination by the dean may be that:

5.8.5.1. The resident is returned to the residency program without penalty.

5.8.5.2. The recommendation for dismissal or a non-renewal of appointment stands.

5.8.5.3. Other as deemed appropriate by the president and dean.

5.8.6. In the event that a recommendation for dismissal is confirmed, the resident is removed from the payroll effective the day of the dean’s decision.
Resident Concern and Complaint Policy

I. PURPOSE:

The purpose of this policy is to provide guidelines for communication of resident concerns and complaints as related to residency training and learning environment and to ensure that residents have a mechanism through which to express concerns and complaints. Note: For purposes of this policy, a concern or complaint should involve issues relating to personnel, patient care, and program or hospital training environment matters.

II. SCOPE:

2.1. All Morehouse School of Medicine (MSM) administrators, faculty, staff, residents, and academic affiliates shall understand and support this and all other policies and procedures that govern both Graduate Medical Education programs and resident appointments at Morehouse School of Medicine.

2.2. Template: Programs should utilize the Program Concern & Complaint Process template that follows this policy and include it in their program policy manual to meet ACGME requirements.

III. CONCERN AND COMPLAINT POLICY:

3.1. Morehouse School of Medicine and affiliated hospitals encourage the participation of residents in decisions involving educational processes and the learning environment. Such participation should occur in formal and informal interactions with peers, faculty, and attending staff.

3.2. Efforts should be undertaken to resolve questions, problems, and misunderstandings as soon as they may arise. Residents are encouraged to initiate discussions with appropriate parties for the purpose of resolving issues in an informal and expeditious manner.

3.3. With respect to formal processes designated to address issues deemed as complaints under the provisions of this policy, each program must have an internal process, known to residents, through which residents may address concerns. The Program Director should be designated as the first point of contact for this process.

IV. CONCERN AND COMPLAINT PROCEDURE:

4.1. If the resident is not satisfied with the program-level resolution, the individual should discuss the matter with the Department Chair or Service Chief of a specific hospital. If no solution is achieved, the resident may seek assistance from the Graduate Medical Education (GME) Designated Institutional Official (DIO). If the complaint is to formally notify the institution of an incident involving harassment or discrimination, see the Morehouse School of Medicine Non-Discrimination, Anti-Harassment, and Retaliation Policy for procedures to be followed.
4.2. If for any reason the resident does not want to discuss concerns or complaints with the Program Director, Associate Program Director, Department Chair, or Service Chief, the following resources are available:

4.2.1. For issues involving program concerns, training matters, or work environment, residents can contact the Graduate Medical Education Director (404-752-1011 or tsamuels@msm.edu).

4.2.2. For problems involving interpersonal issues, the Resident Association President or President Elect may be a comfortable option to discuss confidential informal issues apart and separate from the resident’s parent department.

4.2.3. Residents can provide anonymous feedback/concerns/complaints to any department at Morehouse School of Medicine by completing the online GME Feedback form (http://fs10.formsite.com/bbanks/form33/index.html).

4.2.3.1. Comments are anonymous and cannot be traced back to individuals.

4.2.3.2. Personal follow-up regarding how feedback/concerns/complaints have been addressed by departments and/or GME will be provided only if residents elect to include their name and contact information in the comments field.

4.2.4. MSM Compliance Hotline (1-888-756-1364) is an anonymous and confidential mechanism for reporting unethical, noncompliant, and/or illegal activity. Call the Compliance Hotline to report any concern that could threaten or create a loss to the MSM community including:

- Harassment—sexual, racial, disability, religious, retaliation
- Environment Health and Safety—biological, laboratory, radiation, laser, occupational, chemical and waste management safety issues
- Other Reporting Purposes:
  - Misuse of resources, time, or property assets
  - Accounting, audit, and internal control matters
  - Falsification of records
  - Theft, bribes, and kickbacks
Program Name_____________________________

Resident Concern and Complaint Process
To ensure that residents are able to raise concerns and complaints and to provide feedback without intimidation or retaliation, and in a confidential manner as appropriate, the following options and resources are available and communicated to residents and faculty annually.

Step One
Discuss the concern or complaint with your Chief Resident, Service Director, Program Manager, Associate Program Director, and/or Program Director as appropriate.

Step Two
If the concern or complaint involves the Program Director and/or cannot be addressed in step one, residents have the option of discussing issues with the Department Chair or Service Chief of a specific hospital as appropriate.

Step Three
If you are not able to resolve your concern or complaint within your program, the following resources are available:

- For issues involving program concerns, training matters, or work environment, residents can contact the Graduate Medical Education Director (404-752-1011 or tsamuels@msm.edu).
- For problems involving interpersonal issues, the Resident Association President or President Elect may be a comfortable option to discuss confidential informal issues apart and separate from the resident’s parent department.
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Personal follow-up regarding how feedback/concerns/complaints have been addressed by departments and/or GME will be provided only if the resident elects to include his or her name and contact information in the comments field.

- MSM Compliance Hotline (1-888-756-1364) is an anonymous and confidential mechanism for reporting unethical, noncompliant and/or illegal activity. Call the Compliance Hotline to report any concern that could threaten or create a loss to the MSM community including:
  - Harassment—sexual, racial, disability, religious, retaliation
  - Environment Health and Safety—biological, laboratory, radiation, laser, occupational, chemical and waste management safety issues.
- Other Reporting Purposes:
  - Misuse of resources, time, or property assets
  - Accounting, audit, and internal control matters
  - Falsification of records
  - Theft, bribes, and kickbacks

Refer to the online version of the MSM GME Policy Manual for detailed information regarding the Adverse Academic Decisions and Due Process policy.
Evaluation of Residents, Faculty, and Programs Policy

I. PURPOSE:

The purpose of this policy is to ensure that the quality of Graduate Medical Education programs at Morehouse School of Medicine (MSM) meets the standards outlined in the Graduate Medical Education Directory: “Essentials of Accredited Residencies in Graduate Medical Education” (AMA-current edition) and that MSM (the sponsor), residency programs, Residents, and faculty are evaluated as prescribed in the Accreditation Council for Graduate Medical Education (ACGME) “Institution Requirements” and “Program Requirements.”

II. SCOPE:

2.1. All Morehouse School of Medicine (MSM) administrators, faculty, staff, Residents, and accredited affiliates shall understand and support this and all other policies and procedures that govern both Graduate Medical Education programs and Resident appointments at Morehouse School of Medicine.

2.2. All MSM Residency Programs must:

2.2.1. Have a program-level evaluation policy and procedures for assessment and evaluation of residents, faculty, and program that are compliant with ACGME Common and Specialty Specific Requirements.

2.2.2. Utilize the New Innovations System for all required evaluation components.

2.3. The GME Office will monitor all evaluation components set up and completion rates and provide programs with a minimum of quarterly delinquent/compliance reports.

III. EVALUATION OF RESIDENTS

3.1. Clinical Competency Committee

3.1.1. The program director must appoint the Clinical Competency Committee.

3.1.2. At a minimum the Clinical Competency Committee must be composed of three members of the program faculty.

3.1.3. Others eligible for appointment to the committee include faculty from other programs and non-physician members of the healthcare team.

3.1.4. There must be a written description of the responsibilities of the Clinical Competency Committee that includes measuring/assessing the progress of each resident in collaboration with the program director by:

3.1.4.1. Reviewing all resident evaluations semi-annually
3.1.4.2. Preparing Milestones evaluations of each resident semi-annually and ensuring that the evaluations are reported to ACGME

3.1.4.3. Advising the Program Director regarding resident progress, including promotion, remediation, and dismissal.

IV. RESIDENT ASSESSMENT AND EVALUATION:

4.1. Evaluation concerning performance and progression in the residency program shall be provided to the resident throughout the duration of the program. Assessments and evaluations will measure performance against curricular standards.

4.2. One activity within a residency program is to identify deficiencies in a resident's academic performance. This requires ongoing monitoring for early detection, before serious problems arise. The requirement is to provide the resident with notice of deficiencies and the opportunity to cure.

4.3. The resident will be provided with a variety of supervisors, including clinical supervisors, resident trainers, and faculty advisors, with whom to discuss professional and personal concerns.

4.4. Besides personal discussions, the resident will receive routine verbal feedback and periodic written evaluations on his or her performance and progress in the program. These measurements should highlight both positive performance and deficiencies.

4.5. There must be an opportunity to review evaluations with supervisors and to attach a written response, preferably in the form of reflection and planning for improvement.

4.6. At the end of each rotation, the resident will have an ACGME, competency-based, global assessment of performance for the period of assignment.

4.6.1. The faculty must evaluate resident performance in a timely manner during each rotation or similar educational assignment and document this evaluation within 14 days of completion of the rotation/assignment.

4.6.2. Evaluations must be immediately available for review by the resident. Resident notification of completed evaluations should be set up in New Innovations by requiring that residents sign off electronically on the evaluation.

4.7. In addition to the global assessment evaluation by faculty, multisource methods and evaluators will be used to provide an overall assessment of the resident’s competence and professionalism. Methods and evaluators include:

- Narrative evaluations by faculty and non-faculty evaluators
- Clinical competency examinations
- In-service examinations
- Oral examinations
- Medical record reviews
- Peer evaluations
- Resident self-assessments
• Patient satisfaction surveys
• Direct observation evaluation

4.8. The program must provide objective assessments of competence in patient care and procedural skills, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice based on the specialty-specific Milestones; progressive resident performance improvement appropriate to educational level must be documented

4.9. Non-cognitive skills and behaviors are observed and measured as an integral part of the evaluation process. Professionalism must be demonstrated, including the possession of a positive attitude and behavior along with moral and ethical qualities that can be objectively measured in an academic/clinical environment.

4.10. A resident will be assigned supervisory and teaching responsibilities for medical students and junior residents as they progress through the program.

4.11. Residents will be evaluated on both clinical and didactic performance by faculty, other residents, and medical students.

4.12. Semi-Annual Evaluation—At least twice in each Post Graduate Year, the Residency Director, or his or her designee, must provide each resident with a document performance evaluation summary incorporating input from the Clinical Competency Committee.

Documentation of these meetings, supervisory conferences, results of all resident evaluations, and examinations will remain in the resident's permanent educational file and be accessible for review by the resident.

4.13. Summative (end of residency) Evaluation—The specialty-specific Milestones must be used as one of the tools to ensure residents are able to practice core professional activities without supervision upon completion of the program.

4.14. The program director must provide a summative evaluation for each resident upon completion of the program. This evaluation must:

4.14.1. Become part of the resident's permanent record maintained by the program, and must be accessible for review by the resident in accordance with institutional policy;

4.14.2. Document the resident's performance during the final period of education; and,

4.14.3. Verify that the resident has demonstrated sufficient competence to enter practice without direct supervision

V. EVALUATION OF FACULTY:

5.1. Faculty evaluations are performed annually by department chairs, in accordance with the faculty bylaws.

5.2. The program director must evaluate faculty performance as it relates to the educational program at least annually and include a review of the faculty’s clinical teaching abilities, commitment to the educational program, clinical knowledge, professionalism, and scholarly activities.
5.3. **Resident Evaluation of Faculty**—Residents must be given the opportunity to submit, at a minimum, annual written confidential evaluations of faculty.

5.3.1. Programs must not allow faculty to view these individual evaluations by residents. Resident evaluations of faculty must be aggregated and made anonymous and provided to faculty annually in a summary report. This summary may be released as necessary, with program director review and approval in instances where evaluations are required for faculty promotions.

5.3.2. In order to maintain confidentiality of faculty performance evaluations, small programs with four or fewer residents may use one of the following:

5.3.2.1. Generalize and group residents’ comments to avoid identifying specific resident feedback.

5.3.2.2. Aggregate faculty performance evaluations across multiple academic years.

5.3.3. Program directors must maintain continuous and ongoing monitoring of faculty performance. This may include automated alerts regarding low evaluation scores on end-of-rotation evaluations by residents, regular surveillance of end-of-rotation evaluations, and regular verbal communication with residents regarding their experiences.

5.3.4. Department chairs should be notified by the Program Director when faculty receive unsatisfactory evaluation scores. Faculty performance must be reviewed and discussed during the annual faculty evaluation review process conducted by the chair or Division.

VI. **EVALUATION OF PROGRAM AND IMPROVEMENT:**

6.1. Program directors must appoint the Program Evaluation Committee (PEC) to be composed of at least two core faculty members and should include at least one resident. There must be a written description of the PEC responsibilities to include:

6.1.1. Planning, developing, implementing, and evaluating educational activities of the program;

6.1.2. Reviewing and making recommendation for revision of competency-based curriculum goals and objectives;

6.1.3. Addressing areas of non-compliance with ACGME standards;

6.1.4. Reviewing the program at least annually using evaluation of faculty, residents, and others as specified below.

6.2. The program, through the PEC, must annually document formal, systematic evaluation of the curriculum and render a written Annual Program Evaluation (APE) report. The program must monitor and track:

6.2.1. Resident Performance;

6.2.2. Faculty Development;

6.2.3. Graduate performance, including board certification examination results;
6.2.4. Program Quality; and the program must:

6.2.4.1. Offer faculty and residents annual opportunities to provide confidential written evaluative input;

6.2.4.2. Use the results of residents’ and faculty members’ assessments of the program together with other program evaluation results to improve the program.

6.2.5. Progress on the previous year's action plan(s).

6.3. The PEC must prepare a written plan of action to document initiatives to improve performance in one or more of the areas listed above as well as delineate how they will be measured and monitored.

The action plan should be reviewed and approved by the teaching faculty and documented in the meeting minutes.

6.4. Program Evaluation Procedure

6.4.1. In order to maintain confidentiality of resident and faculty evaluation of program, the GME office provides facilitation and support by generating a standard program evaluation survey delivered to faculty and residents by the GME office.

6.4.2. Results are aggregated and available to the program to review during the annual program evaluation meeting.
Patient Hand-Off—Transitions in Care Policy

I. PURPOSE:
The purpose of this policy is to define a safe process to convey important information about a patient’s care when transferring care responsibility from one physician to another.

II. BACKGROUND:
2.1. In the course of patient care, it is often necessary to transfer responsibility for a patient’s care from one physician to another. Hand-off refers to the orderly transmittal of information, face to face, that occurs when transitions in the care of the patient are occurring.

2.2. Proper hand-off should prevent the occurrence of errors due to failure to communicate changes in the status of a patient that have occurred during that shift. In summary, the primary objective of a hand-off is to provide complete and accurate information about a patient’s clinical status, including current condition and recent and anticipated treatment. The information communicated during a hand-off must be complete and accurate to ensure safe and effective continuity of care.

III. SCOPE:
These procedures apply to all MSM physicians who are teachers or learners in a clinical environment and have responsibility for patient care in that environment.

IV. POLICY:
4.1. Transitions of Care—Programs must design clinical assignments to minimize the number of transitions in patient care and must ensure that residents are competent in communicating with team members in the hand-off process.

4.2. The sponsoring institution must ensure the availability of schedules that inform all members of the healthcare team of attending physicians and residents currently responsible for each patient’s care.

4.3. Sponsoring institutions and programs must ensure and monitor effective, structured hand-off processes to facilitate both continuity of care and patient safety.

4.3.1. Hand-offs must follow a standardized approach and include the opportunity to ask and respond to questions.
4.3.2. A hand-off is a verbal and/or written communication which provides information to facilitate continuity of care. A hand-off or "report" occurs each time any of the following situations exists for an inpatient, emergency room patient, clinic patient, observation patient, or any other patient:

- Move to a new unit
- Transport to or from a different area of the hospital for care (e.g.: diagnostic/treatment area)
- Assignment to a different physician temporarily (e.g.: overnight/weekend coverage) or longer (e.g.: rotation change)
- Discharge to another institution or facility

4.3.3. Each of the situations above requires a structured hand-off with appropriate communication.

V. CHARACTERISTICS OF A HIGH QUALITY HAND-OFF:

5.1. Hand-offs are interactive communications allowing the opportunity for questioning between the giver and receiver of patient information.

5.2. Hand-offs include up-to-date information regarding the patient’s care, treatment and services, condition, and any recent or anticipated changes.

5.3. Interruptions during hand-offs should be limited in order to minimize the possibility that information would fail to be conveyed or would be forgotten.

5.4. Hand-offs require a process for verification of the received information, including repeat-back or read-back, as appropriate.

VI. HAND-OFF PROCEDURES:

6.1. Hand-off procedures will be conducted in conjunction with (not be limited to) the following physician events:

- Shift changes
- Meal breaks
- Rest breaks
- Changes in on-call status
- When contacting another physician when there is a change in the patient’s condition
- Transfer of patient from one care setting to another

6.2. Hand-off procedures and information transfer forms and guidelines for physicians are developed and implemented by each service according to the needs of that service. The hand-off forms or guidelines may be in either paper or electronic format, and must include clinical information agreed upon by physicians on that service, as being integral to the provision of safe and effective patient care for that patient population.

6.3. Each service will develop and implement a hand-off process that is in keeping with the shift or rotation change practices of its physicians and that facilitates the smooth transfer of information from physician to physician.
6.4. Each service hand-off process must include an opportunity for the on-coming physician to ask pertinent questions and request information from the reporting physician.

6.5. Each hand-off process must be conducted discreetly and free of interruptions to ensure a proper transfer.

6.6. Each hand-off process must include at minimum a senior resident or Attending physician.

6.7. A resident physician must not leave the hospital until a face-to-face hand-off has occurred with the Attending physician or senior resident that is coming onto the service. Telephonic hand-off is not acceptable.

VII. STRUCTURED HAND-OFF:

7.1. Within each service, hand-offs will be conducted in a consistent manner, using a standardized hand-off form or structured guideline.

7.2. Hand-offs, whether verbal or written, should include, at minimum, specific information listed below (as applicable):

- Patient name, location, age/date of birth
- Patient diagnosis/problems, impression
- Important prior medical history
- DNR status and advance directives
- Identified allergies
- Medications, fluids, diet
- Important current labs, vitals, cultures
- Past and planned significant procedures
- Specific protocols/resources/treatments in place (DVT/GI prophylaxis, insulin, anticoagulation, restraint use, etc.)
- Plan for the next 24+ hours
- Pending tests and studies which require follow up
- Important items planned between now and discharge

VIII. FORMATTED PROCEDURE:

8.1. A receiving physician shall:

8.1.1. Thoroughly review a written hand-off form or receive a verbal hand-off and take notes.

8.1.2. Resolve any unclear issues with the transferring physician prior to acceptance of a patient.
8.2. In addition, the SBAR can be used to deliver or receive the information:

- **Situation**: What is the problem?
- **Background**: Pertinent information to problem at hand
- **Assessment**: Clinical staff’s assessment
- **Recommendation**: What do you want done and/or think needs to be done?

8.3. The following document is a suggested format for programs to document information with a sign-out process.

**A SAMPLE FORMAT**

**Shift Date:** _____ / _____ / _____  **Shift Time (24 hour):** ______________

By my signature below, I acknowledge that the following events have occurred:

1. Interactive communications allowed for the opportunity for questioning between the giver and receiver about patient information.

2. Up-to-date information regarding the patient’s care, treatment and services, condition, and any recent or anticipated changes was communicated.

3. A process for verification of the received information, including repeat-back or read-back, as appropriate, was used.

4. An opportunity was given for the receiver of the hand-off information to review relevant patient historical information, which may include previous care, and/or treatment and services.

5. Interruptions during hand-offs were limited in order to minimize the possibility that information would fail to be conveyed, not be heard, or forgotten.

____________________________________________________________________

Receiving Resident’s Name and Signature  Date/Time
____________________________________________________________________

Departing Resident’s Name and Signature  Date/Time
Professionalism Policy
(Resident Code of Conduct, Dress Code and Social Media Guidelines)

I. PURPOSE:

1.1. Residents are responsible for fulfilling any and all obligations that the GME office, Hospitals, and Residency Programs deem necessary for them to begin and continue duties as a resident, including but not limited to:

   1.1.1. Attending orientations, receiving appropriate testing and follow-up if necessary for communicable diseases, fittings for appropriate safety equipment, necessary training and badging procedures (all of which may be prior to appointment start date)

   1.1.2. Completing required GME, Hospital and Program administrative functions in a timely fashion and before deadlines such as medical records, mandatory on-line training modules and surveys or other communications

1.2. All GME program directors and faculty are responsible for educating, monitoring and providing exemplary examples of professionalism to residents.

1.3. Refer to the GME CONCERN AND COMPLAINT PROCEDURE: regarding specific professionalism reporting systems and resources.

II. SCOPE:

2.1. All Morehouse School of Medicine (MSM) administrators, faculty, staff, residents, and academic affiliates shall understand and support this and all other policies and procedures that govern both Graduate Medical Education programs and resident appointments at Morehouse School of Medicine.

2.2. Each program must have a program-level professionalism policy which describes how the program provides professionalism education to residents. The Program Director will ensure that all program policies relating to professionalism are distributed to residents and faculty. A copy of the program policy on professionalism must be included in the official Program Manual and provided to each resident upon matriculation into the program.

III. POLICY:

3.1. Professionalism—Code of Conduct

   3.1.1. Residents are responsible for demonstrating and abiding by the following professionalism principles and guidelines.

   3.1.2. Physicians must develop habits of conduct that are perceived by patients and peers as signs of trust. Every physician must demonstrate sensitivity, compassion, integrity, respect, and professionalism, and must maintain patient confidentiality and privacy.

   3.1.3. A patient’s dignity and respect must always be maintained.
3.1.4. Under all circumstances, response to patient needs shall supersede self-interest.

3.1.5. Residents are responsible for completing hospital, program, and GME educational and administrative assignments by given deadlines that include:
   - Timely completion of evaluations and program documentation;
   - Logging of duty hours, cases, procedures, and experiences; and
   - Promptly arriving for educational, administrative, and service activities.

3.1.6. A medical professional consistently demonstrates respect for patients by his or her performance, behavior, attitude, and appearance.

3.1.7. Commitment to carrying out professional responsibilities and an adherence to ethical principles are reflected in the following expected behaviors:
   - Respect patient privacy and confidentiality.
   - Knock on the door before entering a patient’s room.
   - Appropriately drape a patient during an examination.
   - Do not discuss patient information in public areas, including elevators and cafeterias.
   - Keep noise levels low, especially when patients are sleeping.

3.1.8. Respect patients’ autonomy and the right of a patient and a family to be involved in care decisions.

   3.1.8.1. Introduce oneself to the patient and their family members and explain role in the patient’s care.
   3.1.8.2. Wear name tags that clearly identify names and roles.
   3.1.8.3. Take time to ensure patient and family understanding and informed consent of medical decisions and progress.

3.1.9. Respect the sanctity of the healing relationship.

   3.1.9.1. Exhibit compassion, integrity, and respect for others.
   3.1.9.2. Ensure continuity of care when a patient is discharged from a hospital by documenting who will provide that care and informing the patient of how that caregiver can be reached.
   3.1.9.3. Respond promptly to phone messages, pages, e-mail, and other correspondence.
   3.1.9.4. Provide reliable coverage through colleagues when not available.
   3.1.9.5. Maintain and promote physician/patient boundaries.

3.1.10. Respect individual patient concerns and perceptions.

   3.1.10.1. Comply with accepted standards of dress as defined by each hospital.
   3.1.10.2. Arrive promptly for patient appointments.
3.1.10.3. Remain sensitive and responsive to a diverse patient population, including but not limited to diversity in gender, age, culture, race, religion, disabilities, and sexual orientation.

3.1.11. Respect the systems in place to improve quality and safety of patient care.

3.1.11.1. Complete all mandated on-line tutorials and public health measures (e.g.: TB skin testing) within designated timeframe.

3.1.11.2. Report all adverse events within a timely fashion.

3.1.11.3. Improve systems and quality of care through critical self-examination of care patterns.

3.1.12. A professional consistently demonstrates respect for peers and co-workers.

3.1.12.1. Respect for colleagues is demonstrated by maintaining effective communication.

3.1.12.2. Inform primary care providers of patient’s admission, the hospital content and discharge plans.

3.1.12.3. Provide consulting physicians all data needed to provide a consultation.

3.1.12.4. Maintain legible and up-to-date medical records, including dictating discharge summaries within approved hospital guidelines.

3.1.12.5. Inform all members of the care team, including non-physician professionals, of patient plans and progress.

3.1.12.6. Provide continued verbal and written communication to referring physicians.

3.1.12.7. Understand a referring physician’s needs and concerns about his or her patients.

3.1.12.8. Provide all appropriate supervision needed for those one is supervising, by informing and involving supervising faculty of any changes in patient status, and by providing informed and safe handoffs to colleagues who provide patient coverage.

3.1.12.9. Acknowledge, promote, and maintain the dignity and respect of all healthcare providers.

3.1.13. Respect for diversity of opinion, gender, and ethnicity in the workplace.

3.1.13.1. Maintain a work environment that is free of harassment of any sort.

3.1.13.2. Incorporate the opinions of all health professionals involved in the care of a patient.

3.1.13.3. Encourage team-based care.

3.1.13.4. In addition, professionals are held accountable to specialty-specific board and/or society codes of medical professionalism.
3.2. Professionalism—Dress Code

3.2.1. Residents must adhere to the following code elements to reflect a professional appearance in the clinical work environment; residents are also held accountable to relevant individual hospital/site and MSM institution policies.

3.2.2. Identification: Unaltered ID badges must be worn and remain visible at all times. If badge is displayed on lanyard, it should be a break-away variety.

3.2.3. White Coats: Long white coat that specifies the physician’s name and department should be worn.

3.2.4. Personal Hygiene:

3.2.5. Hair must be kept clean and well groomed. Hair color or style may not be extreme. Long hair must be contained as so to not drape or fall into work area.

3.2.6. Facial hair must be neat, clean, and well-trimmed.

3.2.7. Fingernails must be kept clean and of appropriate length.

3.2.8. Scent of fragrance or tobacco should be limited/minimized.

3.2.9. Shoes/footwear: Must be clean, in good repair, and of a professional style appropriate to work performed. No open-toed shoes may be worn. Shoes must have fully enclosed heels or secured with a heel strap for safety purposes.

3.2.10. Jewelry: Must not interfere with job performance or safety.

3.2.11. Inappropriate/not permitted: Pins, buttons, jewelry, emblems, or insignia bearing a political, controversial, inflammatory, or provocative message may not be worn.

3.2.12. Tattoos: Every effort must be made to cover visible tattoos.

3.2.13. Clothing: Must reflect a professional image, including: dress-type pants and collared shirts; skirt and dress length must be appropriate length; clothing should cover back, shoulders, and midriff; modest neckline (no cleavage).

3.2.14. Scrubs: Residents may wear scrubs in any clinical situation where appropriate. When not in a work area, a white coat should be worn over scrubs.

3.3. Professionalism: Social Media Guidelines

3.3.1. Because social media blurs the line between personal voice and institutional voice, these guidelines were created to clarify how best to protect personal and professional reputations when participating.

3.3.2. In both professional and institutional roles, employees need to adopt a common sense approach and follow the same behavioral standards online as they would in real life, and are responsible for anything they post to social media sites either professionally or personally.

3.3.3. For these purposes, “social media” includes but is not limited to social networking sites, collaborative projects such as wikis, blogs, and microblogs, content communities, and virtual communities.
3.3.4. Best practices for all social media sites, including personal sites

3.3.4.1. Think before posting—There is no such thing as privacy in the social media world. Before you publish a post, consider how it would reflect on you, your department/unit and on the institution.

Search engine databases store posts years after they were published, so posts could be found even if they were deleted; and comments may be forwarded or copied.

3.3.4.2. Be accurate—Verify your information for accuracy, spelling, and grammatical errors before posting. If an error or omission ends up being posted, post a correction as quickly as possible.

3.3.4.3. Be respectful—The goal of social media is to engage your audience in conversation. At times, that comes in the form of opposing ideas. Consider how to respond or disengage in a way that will not alienate, harm, or provoke.

3.3.4.4. Remember your audience—Though you may have a target audience, be aware that anything posted on your social media account is also available to the public at large, including prospective students, current students, staff, faculty, and peers.

3.3.4.5. Be a valuable member—Contribute valuable insights in your posts and comments. Self-promoting behavior is viewed negatively and can lead to you being banned from a website or group you are trying to participate in.

3.3.4.6. Ensure your accounts’ security—A compromised account is an open door for malicious entities to post inappropriate or even illegal material as though it were from you. If you administer a hospital/school/college/department/unit social media account, be sure to use a different password than for your personal accounts. Follow best practices in selecting and protecting your university account passwords.

3.3.5. Guidelines for all social media sites, including personal sites

3.3.5.1. Protect confidential and proprietary information—Do not post confidential information about MSM, students, faculty, staff, patients, or alumni; nor should you post information that is proprietary to an entity other than yourself.

3.3.5.2. Employees must follow all applicable Federal privacy requirements for written and visual content, such as FERPA and HIPAA. Failure to do so comes at the risk of disciplinary action and/or termination.

3.3.5.3. Respect copyright and fair use—When posting, be aware of the copyright and intellectual property rights of others and of the university. Refer to MSM System policies on copyright and intellectual property for more information/guidance.

3.3.5.4. Do not imply MSM endorsement—The logo, word mark, iconography, or other imagery shall not be used on personal social media channels. Similarly, the MSM name shall not be used to promote a product, cause, or political party/candidate.
Resident Eligibility, Selection, and Appointment

I. **PURPOSE:**

The purpose of this policy is to ensure that the quality of Graduate Medical Education programs at Morehouse School of Medicine (MSM) meet the standards outlined in the Graduate Medical Education Directory: “Essentials of Accredited Residencies in Graduate Medical Education” (AMA-current edition). The process for the selection of residents at MSM shall adhere to the standards outlined in the “Essentials” and this policy.

II. **SCOPE:**

All Morehouse School of Medicine (MSM) administrators, faculty, staff, residents, and accredited affiliates shall understand and support this and all other policies and procedures that govern both Graduate Medical Education programs and resident appointments at Morehouse School of Medicine.

III. **POLICY:**

(Note: the resident appointment policy was combined with resident eligibility and selection policy effective 06/01/2014)

3.1. This policy is bound by the parameters of residency education and is also affected by MSM Human Resources policy. Applicants to Morehouse School of Medicine (MSM) residency programs must be academically qualified to enter into a program.

3.2. The institution shall participate in the National Resident Matching Program (NRMP). All MSM Post Graduate Year One (PGY-I) resident positions shall be made available for application by all students graduating from United States and Canadian accredited medical schools as determined by the NRMP. Other applicants eligible to enter the “match,” including International Medical School Graduates (IMGs), may also apply.

3.3. MSM Residency Programs will select from among eligible applicants on the basis of their preparedness and ability to benefit from the program to which they have applied. Aptitude, academic credentials, the ability to communicate effectively, personal characteristics such as motivation and integrity, and the ability to function within parameters expected of a practitioner in the specialty shall be considered in the selection process.
3.4. Programs must include the following GME Programs’ Technical Standards and Essential Functions for Appointment and Promotion information:

3.4.1. Introduction

3.4.1.1. Medicine is an intellectually, physically, and psychologically demanding profession. All phases of medical education require knowledge, attitudes, skills and behaviors necessary for the practice of medicine and throughout a professional career. Those abilities that residents must possess to practice safely are reflected in the technical standards that follow. These technical standards/essential functions are to be understood as requirements for training in all Morehouse School of Medicine residencies and are not to be construed as competencies for practice in any given specialty.

3.4.1.2. Individual programs may require more stringent standards or more extensive abilities as appropriate to the requirements for training in that specialty.

3.4.1.3. Residents in Graduate Medical Education programs must be able to meet these minimum standards with or without reasonable accommodation (see Section III).

3.4.2. Standards—Observation

3.4.2.1. Observation requires the functional use of vision, hearing, and somatic sensations. Residents must be able to observe demonstrations and participate in procedures as required.

3.4.2.2. Residents must be able to observe a patient accurately and completely, at a distance as well as closely.

3.4.2.3. They must be able to obtain a medical history directly from a patient, while observing the patient’s medical condition.

3.4.3. Standards—Communication

3.4.3.1. Communication includes speech, language, reading, writing, and computer literacy.

3.4.3.2. Residents must be able to communicate effectively and sensitively in oral and written form with patients to elicit information as well as perceive non-verbal communications.

3.4.4. Standards—Motor

3.4.4.1. Residents must possess sufficient motor function to elicit information from the patient examination by palpation, auscultation, tapping, and other diagnostic maneuvers.

3.4.4.2. Residents must also be able to execute motor movements reasonably required for routine and emergency care and treatment of patients.
3.4.5. Standards—**Intellectual: Conceptual, Integrative, and Quantitative Abilities**

3.4.5.1. Residents must be able to measure, calculate, reason, analyze, integrate, and synthesize technically detailed and complex information in a timely fashion to effectively solve problems and make decisions, which are critical skills demanded of physicians.

3.4.5.2. In addition, residents must be able to comprehend three-dimensional relationships and to understand spatial relationships of structures.

3.4.6. Standards—**Behavioral and Social Attributes**

3.4.6.1. Residents must possess the psychological ability required for the full utilization of their intellectual abilities for: the exercise of good judgment; for the prompt completion of all responsibilities inherent to diagnosis and care of patients; and for the development of mature, sensitive, and effective relationships with patients, colleagues, and other health care providers.

3.4.6.2. Residents must be able to tolerate taxing workloads physically and mentally and be able to function effectively under stress.

3.4.6.3. They must be able to adapt to a changing environment, display flexibility, and learn to function in the face of uncertainties inherent in the clinical problems of patients.

3.4.6.4. Residents must also be able to work effectively and collaboratively as team members.

3.4.6.5. As a component of their education and training, residents must demonstrate ethical behavior consistent with professional values and standards.

3.4.7. Standards—**Reasonable Accommodation**

3.4.7.1. MSM will make a reasonable accommodation available to any qualified individual with a disability who requests an accommodation. A reasonable accommodation is designed to assist an employee or applicant in the performance of the essential functions of his or her job or MSM’s application requirements.

3.4.7.2. Accommodations are made on a case-by-case basis. MSM will work with eligible employees and applicants to identify an appropriate, reasonable accommodation in a given situation. Complete information is found on the MSM Human Resources Office of Disability Services web page at [http://www.msm.edu/Administration/HumanResources/disabilityservices/index.php](http://www.msm.edu/Administration/HumanResources/disabilityservices/index.php)

3.4.7.3. In most cases, it is the responsibility of the employee or applicant to begin the accommodation process by making MSM aware of his or her need for a reasonable accommodation. See the full MSM Accommodation of Disabilities Policy for information on how to request a reasonable accommodation.

*It is important to note that the MSM enrollment of non-eligible residents may be cause for withdrawal of residency program accreditation.*
3.4.8. Title IX Compliance

3.4.8.1. The residency education environment shall be free of undue harassment, confrontation, and coercion because of one’s gender, cultural and religious beliefs, other individual traits, and status or standing.

3.4.8.2. Therefore, in compliance with the Title IX of the Education Amendments of 1972, Morehouse School of Medicine (MSM) does not discriminate on the basis of sex in its education programs and activities, and is required under Title IX and the implementing regulations not to discriminate in such a manner. The prohibited sex discrimination covers sexual misconduct including, but not limited to, sexual harassment and sexual violence, and extends to employment in and admission to such programs and activities.

3.4.8.3. Also in compliance with federal law, including Title VII of the Civil Rights Act of 1964, the Age Discrimination Act of 1975, Section 504 of the Rehabilitation Act, and the Americans with Disabilities Act (and ADAAA amendments), it is the policy of MSM that discrimination against any person or group of persons on the basis of race, color, national origin, religion, gender, sexual orientation, marital status, ancestry, genetic information, age, disability, veteran or military status, or any other legally protected characteristic is specifically prohibited.

3.4.8.4. MSM also prohibits retaliation against members of the MSM community who raise concerns about or report incidents of discrimination based on legally protected characteristics. The following persons have been designated to handle inquiries about and reports made under MSM’s Sex/Gender Nondiscrimination and Sexual Harassment policy.

Marla Thompson, Title IX Coordinator, Direct Dial (404) 752-1871, Fax (404) 752-1639 Email: mthompson@msm.edu
Irma Stewart, Deputy Title IX Coordinator, Direct Dial: (404) 752-1606 Email: istewart@msm.edu
Morehouse School of Medicine, 720 Westview Drive, SW Harris Building, Atlanta, GA 30310

IV. RESIDENT ELIGIBILITY:

The following information is extracted from the Accreditation Council of Graduate Medical Education (ACGME) “Institutional Requirements” of the “Essentials of Accredited Residencies in Graduate Medical Education.”

Applicants with one of the following qualifications are eligible for appointment to accredited residency programs:

4.1. Graduates of medical schools in the United States accredited by either the Liaison Committee on Medical Education (LCME) or the American Osteopathic Association (AOA); graduates of Canadian medical schools approved by the Licentiate of the Medical Council of Canada (LMCC)

4.2. Graduates of medical schools outside the United States and Canada who have a current and valid certificate from the Educational Commission for Foreign Medical Graduates (ECFMG) prior to appointment or have a full and unrestricted license to practice medicine in a United States licensing jurisdiction in their current ACGME specialty/subspecialty program
4.3. United States citizen graduates from medical schools outside the United States and Canada who have successfully completed the licensure examination (USMLE Step 3) in a United States jurisdiction in which the law or regulations provide that a full and unrestricted license to practice will be granted without further examination after successful completion of a specified period of Graduate Medical Education.

4.4. Graduates of medical schools in the United States and its territories not accredited by the LCME but recognized by the educational and licensure authorities in a medical licensing jurisdiction who have completed the procedures described in the paragraph above.

4.5. Those who have completed the fifth pathway, a period of supervised clinical training for students who obtained their premedical education in the United States, received medical undergraduate abroad, and passed Step 1 of the United States Medical Licensing Examination.

4.5.1. After these students successfully complete a year of clinical training sponsored by an LCME-accredited United States medical school and pass USMLE Step 2 components, they become eligible for an ACGME-accredited residency as an international medical graduate.

4.5.2. The Fifth Pathway program is not supported by the American Medical Association after December 2009.

4.6. Applicants who have passed United States Medical Licensing Examination (USMLE) Steps 1 and 2—Clinical Knowledge (CK) and Clinical Skills (CS), or have a full, unrestricted license to practice medicine issued by a United States State licensing jurisdiction.

4.6.1. Selectees cannot begin MSM residency programs prior to passage of the Step 2 Clinical Skills (CS) examination.

4.6.2. This expectation must be met by the time of the MSM-GME Incoming Resident orientation.

4.7. Each resident in our programs must be a United States citizen, a lawful permanent resident, a refugee, an asylee, or must possess the appropriate documentation to allow the resident to legally train at Morehouse School of Medicine.

V. SCREENING AND SELECTION CRITERIA:

5.1. Available MSM resident positions are dependent upon the following criteria:

- The current number of residency program positions authorized by the Accreditation Council for Graduate Medical Education (ACGME)
- The space available in the post graduate year
- Funding and faculty resources available to support the education of residents according to the “educational requirements” of the specialty program

5.2. In order for any applicant to be eligible for appointment to a MSM residency program, the following requirements shall be met along with the eligibility criteria stated in paragraph IV above:

5.2.1. All MSM residency programs shall participate in the National Resident Matching Program (NRMP) for PGY-1 level resident positions. All parties participating in the match shall contractually be subject to the rules of the NRMP. This includes MSM, its residency programs, and applicants. Match violations will not be tolerated.
5.2.2. All applicants to MSM residency programs shall do so through the Electronic Residency Application Service (ERAS). This service shall be used to screen needed information on all applicants. All applicants shall request that three (3) letters of professional or academic references current as of at least 18 months, be sent to the residency program administration.

5.2.3. Any program requests for an official adjustment to the program’s “authorized” resident complement shall be evaluated and approved by the GMEC through the Designated Institutional Official (DIO) prior to submission to the ACGME Residency Review Committee (RRC).

5.2.4. Programs may establish additional selection criteria (e.g.: determine specific minimum scores for the USMLE). Specific criteria must be published for applicants to review as part of the required program-level policy on Eligibility and Selection.

5.2.5. Residency program directors and their Residency Advisory Committees shall have program standards to review MSM residency program applications in order to ensure equal access to the program. Eligible resident applicants shall be selected and appointed only according to ACGME, NRMP, and MSM’s requirements and policies.

5.2.6. Applicants from United States or Canadian accredited medical schools shall request that an original copy of a letter of recommendation or verification from the dean of the medical school be sent to the program administration.

5.2.7. Selectees from an LCME- or AOA-accredited United States medical school shall provide proof of graduation or pending “on-time” graduation. They shall request that official transcripts, diplomas, or “on-time” letters be sent to the program.

5.2.8. Selectees shall provide official proof of passing both USMLE Step 1 and USMLE Step 2 (CK and CS) before they are eligible to begin their appointment in MSM Residency Programs.

5.2.9. Residents are considered transfer residents under several conditions including moving from one program to another within the same or different sponsoring institution and when entering a PGY-2 program requiring a preliminary year even if the resident was simultaneously accepted into the preliminary PGY-1 program and the PGY-2 program as part of the match (e.g.: accepted to both programs right out of medical school). Before accepting a transfer resident, the program director of the “receiving program” must obtain written or electronic verification of previous educational experiences and a summative competency-based performance evaluation from the current program director.

5.2.10. The term “transfer resident” and the responsibilities of the two program directors noted above do not apply to a resident who has successfully completed a residency and then is accepted into a subsequent residency or fellowship program. However, MSM Residency Programs shall identify all residents who would begin the residency program and would have to continue beyond the “Initial Residency Period.”

*The Initial Residency Period is the length of time required to complete a general residency program (e.g.: Internal Medicine—3 years; Psychiatry—4 years).

5.2.11. The State of Georgia and MSM consider any time spent in a residency program as time that must be declared by the applicant when applying for a Temporary Resident Postgraduate Training Permit. This time is applicable whether the applicant completed the period of residency or not. A letter of explanation/verification is required by the applicant and the past residency program director.
5.2.12. Applicants who have not graduated from a United States or Canadian accredited medical school shall request certification of completion (by seal) by an official of the medical school. If the medical school is not in the United States, such official letters shall be in English and/or have a certified or notarized English translation of the content.

5.2.13. A current (stamped indefinite) certificate from the Educational Commission on Foreign Medical School Graduates (ECFMG) must also be submitted with ERAS documents. Initial ECFMG Certificates should not be pending when applicants are reporting to a residency program. Failure to obtain an ECFMG Certificate by the start date of the resident appointment will void both NRMP and MSM resident agreements.

5.2.14. Program directors must ensure that IMG candidates are eligible for J1-Visa sponsorship before ranking these candidates in NRMP.

5.2.15. All selectees shall complete an MSM Non-Faculty Employment Application. The Human Resources Department is available for assistance.

5.2.16. Upon selection, all academic and employment documents referenced within this section and other documents requested by the residency program must be presented to the program administrator in their original form.

5.2.16.1. As a part of credentials authentication, documents shall be screened for authenticity and must be void of alterations.

5.2.16.2. Program administrators shall screen for signatures, seals, notarization, and other official stamps as being original.

5.3. An Applicant invited to interview for a resident position must be informed, in writing or by electronic means, of the terms, conditions, and benefits of appointment to the ACGME-accredited program, either in effect at the time of the interview or that will be in effect at the time of his or her eventual appointment. Information that is provided must include: financial support; vacations; parental, sick, and other leaves of absence; and professional liability, hospitalization, health, disability, and other insurance accessible to residents/fellows and their eligible dependents.

5.3.1. Personal interviews of applicants shall be conducted by at least two (2) faculty members assigned to the program. These interviews should be documented for the residency program files and be retained for the period determined by MSM management policies. These interviews also become a permanent part of a selected applicant's file.

5.3.1.1. If telephone interviews are performed, the same standards and documentation criteria must be used to record the interview.

5.3.1.2. In MSM programs, the applicant's credentials and the faculty interview summary are formally presented to the Residency Program Advisory Committee (RAC) or equivalent.

5.3.2. A faculty consensus is formed on the selections for entry into the NRMP Rank Order Listing or for departmental selection for those positions not placed in the match (i.e.: PGY-2). Final disposition for applicant selection and ranking is done by the residency program director and/or department chairperson.
VI. NON-IMMIGRANT APPLICANTS TO RESIDENCY PROGRAMS:

6.1. MSM supports the AAMC recommendation that the J-1 visa is the more appropriate visa for non-immigrant International Medical School Graduates (IMGs) seeking resident positions in MSM-sponsored programs (Reference: AAMC Legislative and Regulatory Update, October 15, 1993).

6.2. All IMGs shall provide a current (stamped indefinite) certificate of proof of meeting the Educational Commission for Foreign Medical Graduates (ECFMG) requirements for clinical proficiency.

6.3. The Exchange Visitor Program is administered by the United States Department of State. The ECFMG is the sponsoring institution for Alien Physicians in GME programs under the Exchange Visitor Program.

6.3.1. Applicants may be considered for selection by the residency program based on their academic qualifications and eligibility for sponsorship by the ECFMG.

6.3.2. The MSM-GME office is the school liaison for processing applications for ECFMG sponsorship of non-immigrants for J-1 status.

6.4. Applicants seeking residency positions that have other non-immigrant status such as Transitional Employment Authorization Documents, Asylum status, etc., may need to seek legal counsel to effect entry into a residency program. This review will be coordinated through the MSM-GME office along with the MSM-International Programs office for final determination.

6.5. Visa Categories for International-Born or -Educated Physicians Applying to United States Graduate Medical Education Programs

6.5.1. Residency programs that employ individuals on visas will be responsible for an annual fee for each visa, effective each July 1.

6.5.2. Consular Processing of Physician Visas

6.5.2.1. United States Embassies/Consulates require face-to-face interviews for all initial visa stamps and in some instances for the renewal of the same visa stamp.

6.5.2.2. It can take several months for a person to receive an appointment at the Embassy/Consulate to apply for the visa stamp.

6.5.2.3. Embassy/Consulate security checks take about one (1) month.

6.5.2.4. If an applicant is selected for a security check in Washington, DC, then the process could take up to five (5) months.

6.5.2.5. After this process is started, no one can interfere.

6.5.3. The J-1 Exchange Visitor Visa

6.5.3.1. Sponsored by the Educational Commission for Foreign Medical Graduates (ECFMG), this is the most common type of visa category used by institutions offering graduate medical education training (residency or fellowships) to international medical graduates (IMGs).

6.5.3.2. IMGs who seek to obtain this type of visa must first apply to the ECFMG for certification.
6.5.3.3. ECFMG offers the USMLE exams and is the sponsoring organization providing assurance to residency programs that the candidates meet defined qualifications equivalent of a United States medical degree. See [www.ecfmg.org](http://www.ecfmg.org).

6.5.3.4. IMGs applying to Residency Programs requiring the J-1 Visa must contact the specific residency program and the Office of Graduate Medical Education where they have been accepted in a program to coordinate the J-1 visa sponsorship with the ECFMG. ECFMG will issue the visa document (DS-2019) after the institution submits the individual’s application to ECFMG.

6.5.3.5. An ECFMG Certificate is not required if the physician is a graduate of a Canadian or United States Medical School. Canadian Medical School graduates must have passed the equivalent Canadian medical licensing exam.

6.5.3.6. An ECFMG Certificate is not required for physicians who are graduates of LCME-Accredited schools in Puerto Rico.

6.5.3.7. A visa is required if the physician is not a United States citizen or permanent resident of the United States.

6.5.4. Summary of J-1 Visa for IMGs

6.5.4.1. SEVIS Fee must be paid by accepted applicant prior to the United States Embassy interview in home country.

6.5.4.2. Applicant is responsible for the annual application process and the corresponding fee.

6.5.4.3. J2 Dependents must enter with their own DS-2019.

6.5.4.4. The visa is easy to coordinate or obtain for both the individual and institution.

6.5.4.5. The visa provides possible tax advantages (for a limited period of time).

6.5.4.6. The visa is recognized and accepted by most institutions for IMG residency training.

6.5.4.7. The applicant’s spouse may seek work permission while in the United States (must process USCIS Form I-765 after in the United States).

6.5.4.8. The applicant must receive J-1 visa status while in his or her home country; it is strongly recommended that status change does not occur in the United States.

6.5.4.9. The visa has a mandatory two-year foreign residency requirement (Section 212[e]) for all IMGs attending graduate medical education programs in the United States at the completion of training.

6.5.4.10. Obtaining a waiver of the foreign residency requirement is both troublesome and costly.

6.5.4.11. The visa may be extended only for Board Certification; during this time, J visitor cannot work.

6.5.4.12. The DS-2019 (J-1 application) is renewed yearly with a seven (7)-year limit or length of residency program, whichever comes first.
6.5.4.13. The J-1 Exchange Visitor may enter the United States 30 days prior to the start of the J-1 visa and cannot be paid prior to the start date. The J1 visitor must NOT enter the United States 30 days AFTER the start date listed on form DS-2019.

6.5.4.14. After the J-1 period ends, the exchange visitor has 30 days to exit the United States and cannot work during this "grace period."

6.5.4.15. Under this visa status, moonlighting is not permitted.

6.5.4.16. It is very difficult to process J-1 applications to non-accredited Residency/Fellowship Programs. The ECFMG uses the ACGME’s Green Book for reference of accredited programs and their program duration.

6.5.4.17. The J2 visa status is acceptable for Graduate Medical Education training at Morehouse School of Medicine (MSM) but can create problems since the J2 depends on the J1 Primary Holder. The J2 must have a valid EAD card and must also maintain the EAD card.

6.5.5. The H1B Professional in a Specialty Occupation—for IMGs Seeking Graduate Medical Training in Residency or Fellowships

6.5.5.1. The H1B visa must be sponsored by the institution where the individual will attend their residency training program. It is a non-immigrant visa requiring the institution to make attestations to the Department of Labor about the position and salary. There are different regulations and restrictions on the institution filing an H1B as compared to the J1 visa. Note that the H1B applicant must have sufficient time remaining on the H1B visa to complete his or her training program. H1B visa terms max out after a period of six (6) years. The H1B visa is typically issued in three (3)-year increments.

6.5.5.2. Morehouse School of Medicine supports the H1B visa in very limited circumstances.

6.5.5.3. The applicant file must be reviewed by the Graduate Medical Education Office, the respective Residency Program, and the Office International Program Services.

6.5.5.4. An applicant holding an H1B visa for research or other non-clinical employment is NOT eligible for an H1B visa at Morehouse School of Medicine.

6.5.5.5. Filing fees as well as all regulatory fees will be at the expense of the hiring department.

6.5.5.6. Morehouse School of Medicine’s Office of International Program Services requires the use of its dedicated resource for outside counsel on matters of immigration, and all filings will be through that resource.

6.5.5.7. An H1B submitted by the institution to the United States Department of Homeland Security requires additional documentation to be approved for clinical work, including but not limited to, the following:

- ECFMG Certification (not required for Canadians or those educated in the United States)
- PASS on the USMLE Exams, including USMLE Step 3 (If the applicant has NOT received Step 3 results by the Rank Order Deadline, they will not be considered for an H1B visa).
Must have a Georgia medical license or training permit in process and obtain a letter from GCMB before the application is reviewed by the United States Department of Homeland Security

- Copy of home country medical registration and/or licensure (optional)
- Copy of Medical Degree, translated to English
- Filing fees to the United States Department of Homeland Security
- Curriculum Vitae
- Other related immigration documents (passport copy, I-94, J1 Waiver document, etc.)
- Institutional documents required by the institution
- Attestation that the Department will pay the cost of reasonable transportation back to the physician’s home country or last country of residence if the Department, for any reason, dismisses the physician on H during the duration of the dates listed on the H Approval Notice and the beneficiary requests to be returned home.
- In order to be considered for an H1B visa, the applicant must provide documentation of Clinical Experience in the United States or recent (within the past 12 months) clinical experience in another country.

6.6. MSM H1B Visa Requirements

6.6.1. H-1B Visa Procedure

At the discretion of the individual training programs, the H-1B visa may be considered for candidates who have passed the USMLE Step 3 exam and who provide documentation that meets one or more of the following criteria:

- Applicant currently holds a valid H-1B visa at this university or another institution (provide copy of Form I-797, Notice of Action).
- Applicant is the spouse/registered domestic partner of a United States citizen, permanent resident (“green card” holder), or individual holding an H-1 or O-1 visa (provide copy of marriage certificate or H-4 document).
- Applicant/applicant’s spouse has a permanent resident petition pending with a likely chance of success (provide copy of proof of petition).
- Applicant is not eligible for or would face a hardship on a J-1 visa due to unique immigration circumstances (e.g.: applicant already obtained a J-1 waiver; applicant who has to return home periodically to care for ill parent faces higher risk of being denied re-entry on J-1 visa) (provide letter explaining reason for hardship).
- Applicant’s spouse/registered domestic partner is employed by the university in a faculty or other continuing position (provide letter identifying spouse’s position).
- Applicant is a graduate of a medical school in the United States, Canada, or Puerto Rico accredited by the Liaison Committee on Medical Education (LCME) (provide copy of medical school diploma).
- The department has offered or is strongly considering the applicant for a faculty or research position after applicant completes the training program (provide letter identifying intentions of department after applicant finishes training program).
6.6.2. Advantages of the H1B

- The H1B does not carry the two-year home residency requirement at the completion of the residency program.
- The institution may be able to retain high-skilled/qualified international-training physician for faculty and/or staff.
- The H1B dates can be processed with a maximum of three (3) years; it is renewable for an additional three (3) years.
- It is a valuable recruiting tool to attract higher levels of talent.

6.6.3. Disadvantages of the H1B

- Institutional policy restricts the use of H1B for IMGs (AAMC influence).
- Department must pay $500 anti-fraud fee for new H1B resident or fellow.
- If the applicant is in the United States in another status while the H1B application is pending at USCIS, the applicant must not travel outside of the United States.
- The H visa is limited to six (6) years; the applicant may not have enough time to complete the GME program.
- There is a possibility the H1B will not be received by July 1. If the applicant is in the Match, there might not be enough time to process the H visa. USCIS is currently taking up to three (3) months to review an application, which may take up to one (1) month to prepare.
- Premium Processing is available for a cost which is currently $1,225. USCIS will process the Premium Process application within 15 days. The applicant can pay immigration fees, with the exception of the $500 anti-fraud fee.
- A spouse on the H-4 dependent visa cannot work while in the United States.
- See section on Security Requirements.
- The H physician may enter the United States 10 days prior to the start date on the H Notice and cannot begin employment until the H1B start date. After the H period ends or the person is terminated, the non-immigrant has up to 10 days to leave the United States. No employment is allowed during this 10-day “grace period.”
- The Department incurs financial responsibility if the H physician is dismissed for any reason during the period of time listed on the H approval form and must pay costs of transportation for the physician to return to his or her country of last permanent residence or home country.

6.6.4. If a residency/fellowship is considering an applicant who is requesting H1B visa status from MSM, the program must complete the following H1B Visa Information Form BEFORE forwarding the applicant’s package to the International Office for review.
INFORMATION MUST BE COMPLETED FOR H1B VISA CANDIDATE

Today’s Date: ____________________________________________
Name (First/Last): _________________________________________
E-Mail: ___________________________________________________
Residency Program (applying for) ___________________________________
PGY level: ________________________________________________
Current Visa: ______________________________________________
Expires: _________________________________________________
Current Visa Sponsor: _______________________________________
Current Visa Category: Clinical____ Research____
Current H # (if applicable): ______________________ Date of initial H: ______________________

Important: Forward copy of current visa approval form, EAD, or Alien Reg. Card to Residency Program Office.

Dates of Anticipated New H Visa (from XX/XX/XX to XX/XX/XX): __________________________

Have you been on any other type of visa in the U.S. within the past 5 years? If so, describe fully:
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

Country of Birth: __________________________________________
Country of Citizenship: _____________________________________
Date of Birth: ______________________________________________
Social Security Number: ______________________________________
Date of Last Entry to U.S.: ____________________________________

I-94 #: _____________________________________________________

Medical School Name and Location ______________________________________________________
Date of Medical School Graduation: ______________________________
Has applicant passed USMLE Step 3? _____________________________
    If pending, give date of USMLE Step 3: _______________________
ECFMG #: _________________________________________________
Is applicant eligible for Mass. Limited License? ___________________
Residency Coordinator Name: __________________________________
Date of Match: ______________________________________________

Residency Program Comments:
____________________________________________________________________________________
____________________________________________________________________________________

Date Reviewed by International Office: _____________________________
International Office Comments: ______________________________________
____________________________________________________________________________________

Date Reviewed by GME Applicant Committee: __________________________
Comments and Final Decision: ________________________________________
____________________________________________________________________________________
VII. RESIDENT APPOINTMENTS:

7.1. Prior to appointment to the program, residents must be provided with information that describes the program’s current accreditation status, educational objectives, and structure.

7.2. Morehouse School of Medicine Resident appointments shall be for a maximum of 12 months from July to June, year to year.

7.2.1. At MSM, a “Resident Appointment” is defined as a non-faculty position granted to an individual based on his or her academic credentials and the meeting of other eligibility criteria as stated in MSM and residency program policies and standards.

7.2.2. This position is also that of a “physician in training.”

7.3. Resident appointments are managed by the Graduate Medical Education Office on behalf of the Senior Vice President for Academic Affairs and are processed by the Human Resources Department (HRD).

7.4. Residents may enter the residency program at other times during a given Post Graduate Year (PGY) but must complete all requirements according to the structure of the program. This usually means completing the PGY-1 year from the date the Resident started. There are no provisions for “shared” or “part-time” positions in MSM Residency programs.

7.5. A selected applicant must be formally offered a position in the residency program. A written agreement shall be entered into between the applicant and Morehouse School of Medicine (MSM).

7.5.1. This agreement signed by the residency program director and department chairperson shall constitute a recommendation for an academic non-faculty appointment to the Dean.

7.5.2. Approval of the selection shall be by the Director of Graduate Medical Education as the Dean’s designated approval authority.

7.6. Residents shall not perform any clinical duties until they:

7.6.1. Are processed through the MSM Human Resources Department and officially become a part of the MSM personnel system; and

7.6.2. Have obtained a Georgia Temporary Resident Postgraduate Training Permit or possess a permanent physician’s license.

7.7. References to support this policy including the Resident Appointment Agreement are available in the GME Office and website at

http://www.msm.edu/Education/GME/index.php
Resident Leave Policy

I. PURPOSE:
The purpose of this policy is to ensure that the quality of Graduate Medical Education programs at Morehouse School of Medicine (MSM) meets the standards outlined in the Graduate Medical Education Directory: “Essentials of Accredited Residencies in Graduate Medical Education” (AMA-current edition). MSM residents will be afforded the opportunity to provide for personal and/or family welfare through this defined leave policy.

II. SCOPE:
All MSM administrators, faculty, staff, residents, and administrators at participating training affiliates shall understand and support these and all other policies and procedures that govern both Graduate Medical Education programs and resident appointments at MSM.

III. POLICY:
3.1. MSM will provide residents with the opportunity to take personal and family leave as needed during a Post-Graduate Year (PGY).

3.2. Leave accounting is the responsibility of the Residency Program Director in coordination with the Office of Graduate Medical Education (GME) and Human Resources Department.

3.3. Federal law, Accreditation Council for Graduate Medical Education (ACGME) “program requirements,” and medical specialty board requirements shall apply as applicable.

IV. COMPENSATED LEAVE TYPES:

4.1. Resident Vacation Leave: Residents are allotted 15 days compensated Vacation Leave per academic year (from July 1 through June 30).

4.1.1. Vacation Leave may not be carried forward from year-to-year (accrued).

4.1.2. Vacation leave shall not be subject to an accumulated “pay out” upon the completion of the program, transfer from the program, or upon a resident’s involuntary termination from the program.

4.2. Sick Leave: Compensated Sick Leave is 15 days per year. This time can be taken for illness for the resident or for the care of an “immediate” family member.

4.2.1. Sick leave is not accrued from year to year.

4.2.2. Available sick leave, 15 days maximum, and/or available vacation leave, 15 days maximum, may be used to provide paid leave in situations requiring time off for the purpose of caring for oneself or an immediate family member due to serious health conditions.
4.3. **Administrative Leave**: granted at the discretion of the Program Director, may not exceed ten (10) days per twelve-month period. Residents should be advised that some Medical Boards count educational leave as time away from training and may require an extension of their training dates.

4.4. **Holiday Leave**: time off for a holiday is based on a resident’s rotation assignment. When rotating on a clinic or service that closes due to a holiday, the resident may take that time off as paid holiday leave with approval of the Program Director.

4.5. **Family and Medical Leave**: MSM provides job-protected family and medical leave to eligible residents for up to 12 workweeks of unpaid leave during a 12-month period based on the following qualifying events:

- For incapacity due to pregnancy, prenatal medical care or child birth;
- To care for the employee’s child after birth, or placement for adoption or foster care;
- To care for the employee’s spouse, son, daughter, or parent, who has a serious health condition; or
- For a serious health condition that makes the employee unable to perform the employee’s job.

4.5.1. Eligible residents who care for covered service members may also be eligible for up to 26 workweeks of unpaid leave in a single 12-month period.

4.5.2. Residents are eligible for FMLA leave if they have worked for MSM for at least one year, have worked 1,250 hours over the previous 12 months, and have a qualifying event as outlined above. Direct all questions about FMLA leave to the Human Resources Department.

V. **SHORT TERM DISABILITY**:

5.1. Short-term disability (STD) is an MSM employee paid benefit offered to regular full-time employees and part-time employees who are eligible for benefits. The benefits are administered by an insurance carrier, which provides income continuation to employees who are unable to work for up to twenty-six (26) weeks due to a non-work related illness or injury that prevents the performance of normal duties of their position.

5.2. Eligible employees must enroll for the STD program within thirty (30) days of employment. If the employee does not enroll within thirty (30) days of eligibility and would like coverage at a later date, the employee must provide evidence of insurability to gain coverage subject to approval by the insurance carrier.

5.3. There is a required fourteen (14) day benefit elimination period during which an employee must use any available accrued sick and/or vacation leave. If an employee continues to be determined disabled after the benefit elimination period, the insurance carrier will pay sixty percent (60%) of his or her weekly salary until a decision is made that the employee is no longer disabled, or the employee’s claim transitions to Long-Term Disability. The maximum benefit period for STD is twenty-six (26) weeks. The benefit period could be shorter as determined by medical documentation submitted. For additional information, refer to MSM’s Short Term Disability Policy (HR 6.01).
VI. **LEAVE OF ABSENCE WITHOUT PAY:**

6.1. Leave required beyond available compensated sick and/or vacation leave will be uncompensated Leave without Pay (LWOP). Requests for LWOP shall be submitted in writing to the Residency Program Director and reviewed by the Human Resources Department for disposition and approval no less than 30 days in advance of the start of any planned leave. The request shall identify the reason for the leave and the duration. LWOP, when approved, shall not exceed six (6) months in duration.

6.2. MSM's Human Resources Department shall advise both the resident and the Residency Program Director on applicable policies and procedures. All applicable categories of compensated leave must be exhausted prior to a resident being granted LWOP. Residents shall consult with the HR Manager for Leave Management prior to taking LWOP.

VII. **OTHER LEAVE TYPES:**

All other leave types (e.g., military, bereavement, jury duty, etc.) are explained in detail in MSM's Policy Manual which is available on the Human Resources Department Intranet webpage.

VIII. **RETURN TO DUTY:**

8.1. For leave due to parental or serious health conditions of the resident or a family member, a physician's written "Release to Return to Duty" or equivalent is required with the date the resident is expected to return to resume his or her residency. This information is submitted to the Human Resources Department (HRD).

8.2. When applicable, the Residency Program Director will record in writing the adjusted date required for completion of the PGY or the program because of Extended Resident Leave. One copy is placed in the resident’s educational file and a copy is submitted to the Office of Graduate Medical Education (GME) to process the appropriate Personnel Action.

IX. **PROGRAM LEAVE LIMITATIONS:**

9.1. Leave away from the residency program includes the total of all leave categories taken within an academic year. This includes uncompensated Federal Family and Medical Leave or other Leave without Pay (LWOP).

9.2. All leave is subject to the requirements of the individual medical specialty boards and the ACGME-RRC regarding the completion of the program. It is the responsibility of each Residency Program Director to determine the effect of absence from training for any reason on the individual's educational program and, if necessary, to establish make-up requirements that meet the Board requirements for the specialty. Always review the current certification application eligibility requirements at the specialty board website.

X. **PROGRAM-LEVEL LEAVE PROCESSES: MONITORING AND TRACKING:**

10.1. All residency programs should have written guidelines for resident leave processes including how to request leave. Guidelines must be consistently applicable to all residents in the program.

10.2. Program Managers are responsible for entering and tracking resident leave in New Innovations and the Kronos systems.
Resident Promotion Policy

I. PURPOSE:

The purpose of this policy is to ensure that the quality of Graduate Medical Education programs at Morehouse School of Medicine (MSM) meets the standards outlined in the Graduate Medical Education Directory: “Essentials of Accredited Residencies in Graduate Medical Education” (AMA-current edition). A resident will be prepared to undertake independent medical practice upon the successful completion of a residency program and shall have completed requirements to obtain a physician’s license and prepare for certification by a specialty board.

II. SCOPE:

All MSM administrators, faculty, staff, residents, and accredited participating affiliates shall understand and support this policy and all other policies and procedures that govern both Graduate Medical Education programs and resident appointments at MSM.

III. POLICY:

3.1. Residency education prepares physicians for independent practice in a medical specialty. A resident is expected to progressively increase his or her level of proficiency in order to advance within a residency program.

3.2. MSM’s focus is on the resident’s acquisition and development of pertinent skills and behaviors with the intent of providing a competent practicing physician to the community.

3.3. Appointments are made on a yearly basis with the expectation of continuation within the one-year appointment and of reappointment yearly throughout the duration of the residency period.

IV. RESIDENCY PROGRAM PROMOTION:

4.1. Program Responsibilities

4.1.1. The resident will receive periodic, scheduled, written evaluations of his or her performance, progress, and competence in the program specialty as outlined in the MSM Evaluation Policy.

4.1.2. Residents must be familiar with ACGME-RRC and MSM educational requirements to successfully complete the residency program.

4.1.2.1. This should begin on the first day of matriculation.
4.1.2.2. At a minimum, residents must be given the following information by the residency program and/or the GME office:

- A copy of the MSM Graduate Medical Education (GME) General Information Policy
- A Residency Program Handbook (or equivalent) outlining at a minimum:
  - The residency program goals, objectives, and expectations
  - The ACGME Specialty Program Requirements
  - The six general competencies designed within the curriculum of the program
  - Clinical rotations and/or other education modules with specific goals, objectives, and expected outcomes
  - Schedules of assignments to support rotations
  - The educational supervisory hierarchy within the program, rotations, and education affiliates
  - The residency program evaluation system

4.2. Promotion Requirements

4.2.1. In order for a resident to complete an MSM residency education program, he or she must successfully meet the following standards in addition to any program-specific requirements:

4.2.1.1. The resident must exhibit clinical and academic performance and competence consistent with the curricular standards and the level of training undergone.

4.2.1.2. The resident must satisfactorily complete all assigned rotations, as supported by evaluation documentation, in each Post Graduate Year (PGY).

4.2.1.3. The Program Director must certify that the resident has fulfilled all criteria, including the program-specific criteria, to move to the next level in the program.

4.2.1.4. The resident must demonstrate professionalism, including the possession of a positive attitude and behavior, along with moral and ethical qualities that can be objectively measured in an academic and/or clinical environment.

4.2.1.5. The resident must achieve a satisfactory score on the in-service examinations along with other program-specific criteria required in order to advance. ACGME-RRC Program Requirements provide the outline of standards for advancement.
4.2.2. Upon a resident’s successful completion of the criteria listed above, the Residency Program Director will certify the completion by placing the semi-annual evaluations and the promotion documentation into the resident’s portfolio indicating that the resident has successfully met the specialty requirements for promotion to the next educational level. If this is a graduating resident, the Program Director should place the Final Summative Assessment in the resident’s portfolio.

4.3. Process and Timeline for Promotional Decisions

4.3.1. Normal promotion decisions are made no later than the fourth month of the appointment. Reappointment agreements are prepared based on the residency Clinical Competency Committee and Program Director’s recommendation for promotion.

4.3.2. When a resident will not be promoted to the next level of training, the program will provide the resident with a written notice of intent no later than four months prior to the end of the resident’s current appointment agreement. If the primary reason for non-promotion occurs within the last four months of the appointment agreement period, the program will give as much written notice as circumstances reasonably allow.

4.3.3. If a resident’s appointment agreement is not going to be renewed, the residency program must notify the resident in writing no later than four months prior to the end of the resident’s current contract. If the decision for non-renewal is made during the last four months of the contract period, the residency program must give the resident as much written notice as possible prior to the end of the appointment agreement expiration.

4.3.4. For more information concerning adverse events, refer to the Adverse Academic Decisions and Due Process Policy.
Sleep Deprivation and Fatigue Policy

I. PURPOSE:

The purpose of this policy is to ensure that the quality of Graduate Medical Education programs at Morehouse School of Medicine (MSM) meets the standards outlined in the Graduate Medical Education Directory: “Essentials of Accredited Residencies in Graduate Medical Education” (AMA-current edition). Resident education and patient care management can be greatly inhibited by resident sleepiness and fatigue.

II. SCOPE:

This policy is in direct response to requirements of the Accreditation Council on Graduate Medical Education (ACGME) pertaining to residents’ fatigue and is designed to ensure the safety of patients as well as to protect the residents’ learning environment. This policy is in addition to any policy established by MSM and its affiliate institutions regarding sleep deprivation and fatigue.

III. DEFINITION OF FATIGUE:

3.1. Fatigue is a feeling of weariness, tiredness, or lack of energy. Fatigue can impair a physician’s judgment, attention, and reaction time which can lead to medical errors, thus compromising patient safety.

3.2. There are many signs and symptoms that would provide insight to one’s impairment based on sleepiness. Clinical signs include:

- Moodiness
- Depression
- Irritability
- Apathy
- Impoverished speech
- Flattened affect
- Impaired memory
- Confusion
- Difficulty focusing on tasks
- Sedentary nodding off during conferences or while driving
- Repeatedly checking work and medical errors
IV. POLICY:
MSM Faculty and residents must be educated to recognize the signs of fatigue and sleep deprivation and must adopt and apply the following programs and procedures to prevent and counteract potential associated negative effects on patient care and learning. These programs and procedures are designed to:

- Raise faculty and residents’ awareness of the negative effects of sleep deprivation and fatigue on their ability to provide safe and effective patient care.
- Provide faculty and residents with tools for recognizing when they are at risk.
- Identify strategies for faculty and residents to use that will minimize the effects of fatigue (in addition to getting more sleep).
- Help identify and manage impaired residents.

V. INDIVIDUAL RESPONSIBILITY:

5.1. Resident’s Responsibilities in Identifying and Counteracting Fatigue

5.1.1. The resident will be educated on the hazards of sleep deprivation and fatigue in the workplace and in their personal lives (motor vehicle accidents).

5.1.2. The resident is expected to adopt habits that will provide him or her with adequate sleep in order to perform the daily activities required by the program.

5.1.3. Duty Hours should be strictly adhered to. In the event that the resident is too sleepy to drive home at the end of a work period, he or she should be encouraged to use another form of transportation (taxicab) or take a nap prior to leaving the training site.

5.2. Faculty Responsibilities in Identifying and Counteracting Fatigue

5.2.1. Faculty will be educated on the hazards of sleep deprivation and fatigue in the workplace and in the provision of care to patients.

5.2.2. Faculty members will be able to determine if residents are sleep deprived and will make the appropriate recommendations to the resident that will correct this problem.

5.2.3. The faculty will learn to accept the limitations on the role of the resident under the Duty Hour mandates and will not penalize the resident as being lazy or disinterested when the resident leaves a work assignment “on time.”

VI. ACGME REQUIREMENTS ON SLEEP AND FATIGUE:

6.1. “Faculty and residents must be educated to recognize the signs of fatigue, and adopt and apply policies to prevent and counteract its potential negative effects.” (Accreditation Council for Graduate Medical Education [ACGME] Common Program Requirements VI.A.3)
6.2. “Providing residents with a sound didactic and clinical education must be carefully planned and balanced with concerns for patient safety and resident well-being. Each program must ensure that the learning objectives of the program are not compromised by excessive reliance on residents to fulfill service obligations. Didactic and clinical education must have priority in the allotment of residents' time and energy. Duty hour assignments must recognize that faculty and residents collectively have responsibility for the safety and welfare of patients.” (ACGME Common Program Requirements VI)

6.3. “Counseling services: The Sponsoring institution should facilitate residents’ access to appropriate and confidential counseling, medical, and psychological support services.” (ACGME Institutional Requirements III.D.1.I)

6.4. Resources available for Program Directors include a bibliography of articles on the effect of sleep loss on performance that is available on the ACGME website:
   a) http://www.acgme.org/acWebsite/dutyHours/dh_sleepdeppbib2.pdf as well as the LIFE Curriculum

   This site includes video segments, expert commentaries, discussion questions, suggested role play exercises, and resources that may be used for self-study, embedded in classroom sessions, or as one or more workshops.

6.5. The ACGME instituted a work hour mandate for residents which became effective in 2003. This was stimulated by the death of a patient in a teaching hospital in New York in 1984. New York became the first state to legislate Resident Duty Hours after submission of the report by the Bell Commission, which investigated the event. The Duty Hour mandate has required many programs to increase the “in-house” time spent by faculty as an approach to decrease the total number of hours a resident will be on continuous duty.

VII. MSM IMPLEMENTATION:

7.1. This policy uses the LIFE Curriculum as the source for recommendations and guidance on the management of sleepiness and fatigue in residents. The LIFE Curriculum was created to educate faculty and residents about the effects by fatigue and other common impairments on performance.

7.2. The policy is designed to:
   a) Identify strategies to assist in the prevention of these conditions;
   b) Provide an early warning system for impairments and ways to effectively manage them;
   c) Access appropriate referral resources;
   d) Identify an impaired resident.

7.3. The Sleep Deprivation and Fatigue Policy is appropriate for all residency programs in that it:
   a) Has a faculty component and a resident component;
   b) Addresses policies to prevent and counteract the negative effects on patient care and learning;
c) Seeks the expertise of existing faculty to present materials;
d) Uses modules for role play, case studies that address the adverse effects of inadequate supervision and fatigue.

7.4. The GME office shall sponsor a session during orientation where incoming residents will receive an introduction to Duty Hours, sleepiness and fatigue, and other impairments. New residents will continue the discussion on sleepiness and fatigue in their residency specialty program. Each program will revisit the topic periodically throughout the year through role play, videos, and other discussions (many of these materials are available through the LIFE Curriculum).

7.5. Faculty preceptors will receive a separate orientation to the LIFE Curriculum modules through a faculty development session conducted by each individual program.

7.5.1. The GME office will periodically survey each program to determine if the core faculty has received the training and over what period of time.

7.5.2. The LIFE Curriculum will suffice for this educational session, however programs are encouraged, where appropriate, to adapt the modules or create new modules that are specific to their specialty.

7.6. It is encouraged that each program revisit the sleepiness and fatigue curriculum at least twice during the academic year in addition to preparation for the session that new residents receive during orientation.

VIII. COUNSELING:
In the event that a resident is reported as one who appears to be persistently sleepy or fatigued during service, the Program Director and faculty member mentor to the resident will counsel the resident individually to determine if there are some medical, physical, or psychosocial factors affecting the resident’s performance. An appropriate referral will be made based on the finding during that interview.

IX. EVALUATION:
The effectiveness of this policy will be measured by:

a) The number of residents who report that they have received the training (ACGME Resident survey);
b) The number of residents who comply with the Duty Hour requirements;
c) The assessment by faculty and others of the number of incidents by which a resident can be identified as fatigued during work hours and the number of medical errors attributed to resident’s fatigue
Supervision of Residents Policy

I. PURPOSE:

The purpose of this policy is to ensure that the quality of Graduate Medical Education (GME) programs at Morehouse School of Medicine (MSM) meets the standards outlined in the Graduate Medical Education Directory: “Essentials of Accredited Residencies in Graduate Medical Education” (AMA-current edition) and the specialty program goals and objectives. The resident physician is expected to progressively increase his or her level of proficiency with the provision of predetermined levels of supervision.

II. SCOPE:

All Morehouse School of Medicine (MSM) administrators, faculty, staff, residents and accredited affiliates, shall understand and support this policy and all other policies and procedures that govern both GME programs and resident appointments at MSM.

III. POLICY:

3.1. Supervision in the setting of graduate medical education has the following goals:

3.1.1. Ensuring the provision of safe and effective care to the individual patient

3.1.2. Ensuring each resident’s development of the skills, knowledge, and attitudes required to enter the unsupervised practice of medicine

3.1.3. Establishing a foundation for continued professional growth

3.2. In the clinical learning environment, each patient must have an identifiable, appropriately-credentialed, and privileged Attending physician (or licensed independent practitioner) who is ultimately responsible for that patient’s care. This information should be available to residents, faculty members, and patients.

3.3. Residents and faculty members should inform patients of their respective roles in each patient’s care.

3.4. All residents working in clinical settings must be supervised by a licensed physician. The supervising physician must hold a regular faculty or adjunct faculty appointment from the Morehouse School of Medicine. For clinical rotations occurring outside of Georgia the supervising physician must be approved by the residency Program Director.

3.5. The program must demonstrate that the appropriate level of supervision is in place for all residents who care for patients.

3.5.1. The privilege of progressive authority and responsibility, conditional independence, and a supervisory role in patient care delegated to each resident must be assigned by the Program Director and faculty members.

3.5.2. The program director must evaluate each resident’s abilities based on specific criteria. When available, evaluation should be guided by specific national standards-based criteria.
3.5.3. Faculty supervision assignments should be of sufficient duration to assess the knowledge and skills of each resident and delegate him or her the appropriate level of patient care authority and responsibility. Faculty members functioning as supervising physicians should delegate portions of care to residents based on the needs of the patient and the skills of the residents.

3.5.4. Senior residents or fellows should serve in a supervisory role of junior residents in recognition of their progress toward independence, based on the needs of each patient and the skills of the individual resident or fellow.

3.5.5. Programs must set guidelines for circumstances and events in which residents must communicate with appropriate supervising faculty members, such as the transfer of a patient to an intensive care unit, or end-of-life decisions.

3.5.6. Each resident must know the limits of his or her scope of authority, and the circumstances under which he or she is permitted to act with conditional independence. In particular, PGY-1 residents should be supervised either directly or indirectly with direct supervision immediately available.

IV. LEVELS OF SUPERVISION:

4.1. To ensure appropriate resident supervision and oversight, graded authority, and responsibility, the program must use the following classifications of supervision:

4.1.1. Direct Supervision: the supervising physician is physically present with the resident and patient.

4.1.2. Indirect Supervision with direct supervision immediately available: the supervising physician is physically within the hospital or other site of patient care, and is immediately available to provide direct supervision.

4.1.3. Indirect Supervision 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.

4.1.4. Oversight: the supervising physician is available to provide review of procedures and encounters with feedback provided after care is delivered.

4.2. Each program must specify in writing the type and level of supervision required for each level of the program. Levels of supervision must be consistent with Joint Commission regulations for supervision of trainees, “graduated job responsibilities/ job descriptions”. The required type and level of supervision for residents performing invasive procedures must be clearly delineated.

4.3. Joint Commission Standards for GME Supervision:

4.3.1. “Written descriptions of the roles, responsibilities, and patient care activities of the participants of graduate education programs are provided to the organized medical staff and hospital staff.

4.3.2. The descriptions include identification of mechanisms by which the supervisor(s) and graduate education program director make decisions about each participant’s progressive involvement and independence in specific patient care activities.
4.3.3. Organized medical staff rules and regulations and policies delineate participants in professional education programs who may write patient care orders, the circumstances under which they may do so (without prohibiting licensed independent practitioners from writing orders), and what entries, if any, must be countersigned by a supervising licensed independent practitioner”.

V. SUPERVISION OF PROCEDURAL COMPETENCY:

5.1. Residents shall obtain competence in their field to be able to treat and manage patients in a qualified manner.

5.2. This competence shall be evaluated and documented as to success and qualifications. The following protocol is used for administration of certifying residents’ procedural competency.

5.2.1. Residents must be instructed and evaluated in procedural techniques by a licensed independent practitioner (LIP) who is certified as competent to independently perform that procedure or who has been credentialed by the Medical Staff Office to perform that procedure.

5.2.2. The Attending or Program Director is responsible for assessing procedural competency based on direct observation and/or identifying the number of procedures which must be completed successfully to grant proficiency.

5.2.3. The Program Director for each training program will be responsible for maintaining an updated list of residents who have been certified as competent to perform procedures independent of direct supervision. This list must be available to Nursing in order to assist them in developing a physician resource listing.

5.2.4. The Program Director must also develop a method for surveillance of continued competency after it is initially granted.

5.2.5. The ability to obtain and document informed consent is an essential component of procedural competency. The supervising LIP must also supervise and attest to the trainee’s competence in obtaining and documenting informed consent.

5.2.6. Until a resident trainee is judged competent in obtaining informed consent, he or she may only obtain informed consent while supervised by an individual with credentials in that procedure.

VI. GME PROGRAM SUPERVISION PROCEDURES AND PROCESSES

6.1. Each program will maintain current call schedules with accurate information enabling residents, at all times, to obtain timely access and support from a supervising faculty member.

6.2. Verification of required levels of supervision for invasive procedures will be reviewed as part of the Annual Program Review process. Programs must advise the Associate Dean for GME, in writing, of proposed changes in previously approved levels of supervision for invasive procedures.

6.3. The GMEC Committee must approve requests for significant changes in levels of supervision.
6.4. The Program Director will ensure that all program policies relating to supervision are distributed to residents and faculty who supervise residents. A copy of the program policy on supervision must be included in the official Program Manual and provided to each resident upon matriculation into the program.

6.5. The GME Office provides a Program Supervision Policy Template and Example for programs to utilize.

VII. **CLINICAL RESPONSIBILITIES:**

The clinical responsibilities for each resident must be based on PGY-level, patient safety, resident education, severity and complexity of patient illness/condition and available support services.
USMLE Step 3 Requirement Policy

I. PURPOSE:
The purpose of this policy is to ensure that the quality of Graduate Medical Education (GME) programs at Morehouse School of Medicine (MSM) meets the standards outlined in the Graduate Medical Education Directory: “Essentials of Accredited Residencies in Graduate Medical Education” (AMA-current edition) and the specialty program goals and objectives. A resident who will be prepared to undertake independent medical practice shall have completed requirements to obtain a physician’s license.

II. SCOPE:
All Morehouse School of Medicine (MSM) administrators, faculty, staff, residents, and accredited affiliates shall understand and support this policy and all other policies and procedures that govern both GME programs and resident appointments at MSM.

III. POLICY:
3.1. Residents must pass USMLE Step 3 by their 20th month of residency.
   3.1.1. Residents must present the official results of their USMLE Step 3 examination to the residency Program Director before the last working day of the resident’s 20th month which is, in a normal appointment cycle, February.
   3.1.2. Residents who have not passed Step 3 by the end of the 20th month will not receive a reappointment letter to a residency program at the regular time.

3.2. Residents who pass USMLE Step 3 between the 21st and 24th month, will receive a reappointment letter to a residency program at the time of receipt of the results, if this is the sole reason for not receiving an appointment letter.

3.3. A resident who passes USMLE Step 3 beyond the outer parameters of this policy (e.g.: passes in the 25th month) shall not be waived to continue in the residency program. However, that resident may reapply to the program subject to review by the Associate Dean for Graduate Medical Education in consultation with the Program Director and the Director of Graduate Medical Education.

3.4. Residents who transfer to MSM at the PGY-1 or PGY-2 level are subject to this policy.
   3.4.1. MSM residents who change status after beginning training in a PGY-1 preliminary position in internal medicine or surgery to a categorical position in another MSM program are recognized as a transfer resident.
   3.4.2. This policy applies even if the resident remains in internal medicine or surgery (preliminary to categorical).

3.5. MSM Residency programs shall not select transfer residents above the PGY-2 level for an MSM appointment if they have not passed USMLE Step 3.
3.6. Residents shall be briefed on this policy in the annual GME Orientation.

3.6.1. Residents who have not passed USMLE Step 3, but are still within the time limits, must sign a Letter of Understanding that they acknowledge the policy.

3.6.2. A copy of the Letter of Understanding is co-signed by the GME Director and shall be placed in the resident's educational file as well as in the Office of Graduate Medical Education file.

3.7. Individual waivers to this policy may be considered by the Associate Dean for Graduate Medical Education under the following circumstances:

- Extended illness or personal leave
- Personal hardship or extenuating circumstances.
Appendix A
American Psychiatric Association:
The Principles of Medical Ethics with Annotations Especially Applicable to Psychiatry
The Principles of Medical Ethics

2013 Edition

American Psychiatric Association
1000 Wilson Boulevard #1825
Arlington, VA 22209
THE PRINCIPLES OF MEDICAL ETHICS

With Annotations Especially
Applicable to Psychiatry
2013 Edition

In 1973, the American Psychiatric Association (APA) published the first edition of The Principles of Medical Ethics with Annotations Especially Applicable to Psychiatry. Subsequently, revisions were published as the APA Board of Trustees and the APA Assembly approved additional annotations. In July of 1980, the American Medical Association (AMA) approved a new version of the Principles of Medical Ethics (the first revision since 1957), and the APA Ethics Committee\(^1\) incorporated many of its annotations into the new Principles, which resulted in the 1981 edition and subsequent revisions. This version includes changes to the Principles approved by the AMA in 2001.

Foreword

ALL PHYSICIANS should practice in accordance with the medical code of ethics set forth in the Principles of Medical Ethics of the American Medical Association. An up-to-date expression and elaboration of these statements is found in the Opinions and Reports of the Council on Ethical and Judicial Affairs of the American Medical Association.\(^2\) Psychiatrists are strongly advised to be familiar with these documents.\(^3\)

However, these general guidelines have sometimes been difficult to interpret for psychiatry, so further annotations to the basic principles are offered in this document. While psychiatrists have the same goals as all physicians, there are special ethical problems in psychiatric practice that differ in coloring and degree from ethical problems in other branches of medical practice, even

\(^1\)The committee included Herbert Klemmer, M.D., Chairperson, Miltiades Zaphiropoulos, M.D., Ewald Busse, M.D., John R. Saunders, M.D., and Robert McDevitt, M.D. J. Brand Brickman, M.D., William P. Camp, M.D., and Robert A. Moore, M.D., served as consultants to the APA Ethics Committee.


\(^3\)Chapter 7, Section 1 of the Bylaws of the American Psychiatric Association (May 2003 edition) states, “All members of the Association shall be bound by the ethical code of the medical profession, specifically defined in the Principles of Medical Ethics of the American Medical Association and in the Association’s Principles of Medical Ethics With Annotations Especially Applicable to Psychiatry.” In interpreting the Bylaws, it is the opinion of the APA Board of Trustees that inactive status in no way removes a physician member from responsibility to abide by the Principles of Medical Ethics.
though the basic principles are the same. The annotations are not designed as absolutes and will be revised from time to time so as to be applicable to current practices and problems.

Following are the AMA Principles of Medical Ethics, printed in their entirety, and then each principle printed separately along with an annotation especially applicable to psychiatry.

Principles of Medical Ethics
American Medical Association

Preamble

The medical profession has long subscribed to a body of ethical statements developed primarily for the benefit of the patient. As a member of this profession, a physician must recognize responsibility to patients first and foremost, as well as to society, to other health professionals, and to self. The following Principles adopted by the American Medical Association are not laws, but standards of conduct which define the essentials of honorable behavior for the physician.

Section 1
A physician shall be dedicated to providing competent medical care, with compassion and respect for human dignity and rights.

Section 2
A physician shall uphold the standards of professionalism, be honest in all professional interactions, and strive to report physicians deficient in character or competence, or engaging in fraud or deception, to appropriate entities.

Section 3
A physician shall respect the law and also recognize a responsibility to seek changes in those requirements which are contrary to the best interests of the patient.

Section 4
A physician shall respect the rights of patients, colleagues, and other health professionals, and shall safeguard patient confidences and privacy within the constraints of the law.

Section 5
A physician shall continue to study, apply, and advance scientific knowledge, maintain a commitment to medical education, make relevant information available to patients, colleagues, and the public, obtain consultation, and use the talents of other health professionals when indicated.
Section 6
A physician shall, in the provision of appropriate patient care, except in emergencies, be free to choose whom to serve, with whom to associate, and the environment in which to provide medical care.

Section 7
A physician shall recognize a responsibility to participate in activities contributing to the improvement of the community and the betterment of public health.

Section 8
A physician shall, while caring for a patient, regard responsibility to the patient as paramount.

Section 9
A physician shall support access to medical care for all people.

Principles with Annotations

Following are each of the AMA Principles of Medical Ethics printed separately along with annotations especially applicable to psychiatry.

Preamble
The medical profession has long subscribed to a body of ethical statements developed primarily for the benefit of the patient. As a member of this profession, a physician must recognize responsibility to patients first and foremost, as well as to society, to other health professionals, and to self. The following Principles adopted by the American Medical Association are not laws, but standards of conduct which define the essentials of honorable behavior for the physician.⁴

Section 1
A physician shall be dedicated to providing competent medical care with compassion and respect for human dignity and rights.

1. A psychiatrist shall not gratify his or her own needs by exploiting the patient. The psychiatrist shall be ever vigilant about the impact that his or her conduct has upon the boundaries of the doctor–patient relationship, and thus upon the well-being of the patient. These requirements become particularly important because of the essentially private, highly personal, and sometimes intensely emotional nature of the relationship established with the psychiatrist.

2. A psychiatrist should not be a party to any type of policy that excludes, segregates, or demeans the dignity of any patient because of ethnic origin, race, sex, creed, age, socioeconomic status, or sexual orientation.

⁴Statements in italics are taken directly from the American Medical Association's Principles of Medical Ethics.
3. In accord with the requirements of law and accepted medical practice, it is ethical for a physician to submit his or her work to peer review and to the ultimate authority of the medical staff executive body and the hospital administration and its governing body. In case of dispute, the ethical psychiatrist has the following steps available:

   a. Seek appeal from the medical staff decision to a joint conference committee, including members of the medical staff executive committee and the executive committee of the governing board. At this appeal, the ethical psychiatrist could request that outside opinions be considered.

   b. Appeal to the governing body itself.

   c. Appeal to state agencies regulating licensure of hospitals if, in the particular state, they concern themselves with matters of professional competency and quality of care.

   d. Attempt to educate colleagues through development of research projects and data and presentations at professional meetings and in professional journals.

   e. Seek redress in local courts, perhaps through an enjoining injunction against the governing body.

   f. Public education as carried out by an ethical psychiatrist would not utilize appeals based solely upon emotion, but would be presented in a professional way and without any potential exploitation of patients through testimonials.

4. A psychiatrist should not be a participant in a legally authorized execution.

Section 2

A physician shall uphold the standards of professionalism, be honest in all professional interactions and strive to report physicians deficient in character or competence, or engaging in fraud or deception to appropriate entities.

1. The requirement that the physician conduct himself/herself with propriety in his or her profession and in all the actions of his or her life is especially important in the case of the psychiatrist because the patient tends to model his or her behavior after that of his or her psychiatrist by identification. Further, the necessary intensity of the treatment relationship may tend to activate sexual and other needs and fantasies on the part of both patient and psychiatrist, while weakening the objectivity necessary for control. Additionally, the inherent inequality in the doctor-patient relationship may lead to exploitation of the patient. Sexual activity with a current or former patient is unethical.
2. The psychiatrist should diligently guard against exploiting information furnished by the patient and should not use the unique position of power afforded him/her by the psychotherapeutic situation to influence the patient in any way not directly relevant to the treatment goals.

3. A psychiatrist who regularly practices outside his or her area of professional competence should be considered unethical. Determination of professional competence should be made by peer review boards or other appropriate bodies.

4. Special consideration should be given to those psychiatrists who, because of mental illness, jeopardize the welfare of their patients and their own reputations and practices. It is ethical, even encouraged, for another psychiatrist to intercede in such situations.

5. Psychiatric services, like all medical services, are dispensed in the context of a contractual arrangement between the patient and the physician. The provisions of the contractual arrangement, which are binding on the physician as well as on the patient, should be explicitly established.

6. It is ethical for the psychiatrist to make a charge for a missed appointment when this falls within the terms of the specific contractual agreement with the patient. Charging for a missed appointment or for one not canceled 24 hours in advance need not, in itself, be considered unethical if a patient is fully advised that the physician will make such a charge. The practice, however, should be resorted to infrequently and always with the utmost consideration for the patient and his or her circumstances.

7. An arrangement in which a psychiatrist provides supervision or administration to other physicians or nonmedical persons for a percentage of their fees or gross income is not acceptable; this would constitute fee splitting. In a team of practitioners, or a multidisciplinary team, it is ethical for the psychiatrist to receive income for administration, research, education, or consultation. This should be based on a mutually agreed-upon and set fee or salary, open to renegotiation when a change in the time demand occurs. (See also Section 5, Annotations 2, 3, and 4.)

Section 3
A physician shall respect the law and also recognize a responsibility to seek changes in those requirements which are contrary to the best interests of the patient.

1. It would seem self-evident that a psychiatrist who is a law-breaker might be ethically unsuited to practice his or her profession. When such illegal activities bear directly upon his or her practice, this would obviously be the case. However, in other instances, illegal activities such as those concerning the right to protest social injustices might not bear on either the image of the psychiatrist or the ability of the specific psychiatrist to treat his or her patient ethically and well. While no committee or board could offer prior assurance that any illegal activity would not be considered unethical, it is conceivable that an individual could violate a law without being guilty
of professionally unethical behavior. Physicians lose no right of citizenship on entry into the profession of medicine.

2. Where not specifically prohibited by local laws governing medical practice, the practice of acupuncture by a psychiatrist is not unethical per se. The psychiatrist should have professional competence in the use of acupuncture. Or, if he or she is supervising the use of acupuncture by nonmedical individuals, he or she should provide proper medical supervision. (See also Section 5, Annotations 3 and 4.)

Section 4
A physician shall respect the rights of patients, colleagues, and other health professionals, and shall safeguard patient confidences and privacy within the constraints of the law.

1. Psychiatric records, including even the identification of a person as a patient, must be protected with extreme care. Confidentiality is essential to psychiatric treatment. This is based in part on the special nature of psychiatric therapy as well as on the traditional ethical relationship between physician and patient. Growing concern regarding the civil rights of patients and the possible adverse effects of computerization, duplication equipment, and data banks makes the dissemination of confidential information an increasing hazard. Because of the sensitive and private nature of the information with which the psychiatrist deals, he or she must be circumspect in the information that he or she chooses to disclose to others about a patient. The welfare of the patient must be a continuing consideration.

2. A psychiatrist may release confidential information only with the authorization of the patient or under proper legal compulsion. The continuing duty of the psychiatrist to protect the patient includes fully apprising him/her of the connotations of waiving the privilege of privacy. This may become an issue when the patient is being investigated by a government agency, is applying for a position, or is involved in legal action. The same principles apply to the release of information concerning treatment to medical departments of government agencies, business organizations, labor unions, and insurance companies. Information gained in confidence about patients seen in student health services should not be released without the students’ explicit permission.

3. Clinical and other materials used in teaching and writing must be adequately disguised in order to preserve the anonymity of the individuals involved.

4. The ethical responsibility of maintaining confidentiality holds equally for the consultations in which the patient may not have been present and in which the consultee was not a physician. In such instances, the physician consultant should alert the consultee to his or her duty of confidentiality.

5. Ethically, the psychiatrist may disclose only that information which is relevant to a given situation. He or she should avoid offering speculation as fact. Sensitive information such as an individual’s sexual orientation or fantasy material is usually unnecessary.
6. Psychiatrists are often asked to examine individuals for security purposes, to determine suitability for various jobs, and to determine legal competence. The psychiatrist must fully describe the nature and purpose and lack of confidentiality of the examination to the examinee at the beginning of the examination.

7. Careful judgment must be exercised by the psychiatrist in order to include, when appropriate, the parents or guardian in the treatment of a minor. At the same time, the psychiatrist must assure the minor proper confidentiality.

8. When, in the clinical judgment of the treating psychiatrist, the risk of danger is deemed to be significant, the psychiatrist may reveal confidential information disclosed by the patient.”

9. When the psychiatrist is ordered by the court to reveal the confidences entrusted to him/her by patients, he or she may comply or he/she may ethically hold the right to dissent within the framework of the law. When the psychiatrist is in doubt, the right of the patient to confidentiality and, by extension, to unimpaired treatment should be given priority. The psychiatrist should reserve the right to raise the question of adequate need for disclosure. In the event that the necessity for legal disclosure is demonstrated by the court, the psychiatrist may request the right to disclosure of only that information which is relevant to the legal question at hand.

10. With regard for the person’s dignity and privacy and with truly informed consent, it is ethical to present a patient to a scientific gathering if the confidentiality of the presentation is understood and accepted by the audience.

11. It is ethical to present a patient or former patient to a public gathering or to the news media only if the patient is fully informed of enduring loss of confidentiality, is competent, and consents in writing without coercion.

12. When involved in funded research, the ethical psychiatrist will advise human subjects of the funding source, retain his or her freedom to reveal data and results, and follow all appropriate and current guidelines relative to human subject protection.

13. Ethical considerations in medical practice preclude the psychiatric evaluation of any person charged with criminal acts prior to access to, or availability of, legal counsel. The only exception is the rendering of care to the person for the sole purpose of medical treatment.

14. Sexual involvement between a faculty member or supervisor and a trainee or student, in those situations in which an abuse of power can occur, often takes advantage of inequalities in the working relationship and may be unethical because:

   a. Any treatment of a patient being supervised may be deleteriously affected.
   b. It may damage the trust relationship between teacher and student.
   c. Teachers are important professional role models for their trainees and affect their trainees’ future professional behavior.
Section 5
A physician shall continue to study, apply, and advance scientific knowledge, maintain a commitment to medical education, make relevant information available to patients, colleagues, and the public, obtain consultation, and use the talents of other health professionals when indicated.

1. Psychiatrists are responsible for their own continuing education and should be mindful of the fact that theirs must be a lifetime of learning.

2. In the practice of his or her specialty, the psychiatrist consults, associates, collaborates, or integrates his or her work with that of many professionals, including psychologists, psychometrists, social workers, alcoholism counselors, marriage counselors, public health nurses, and the like. Furthermore, the nature of modern psychiatric practice extends his or her contacts to such people as teachers, juvenile and adult probation officers, attorneys, welfare workers, agency volunteers, and neighborhood aides. In referring patients for treatment, counseling, or rehabilitation to any of these practitioners, the psychiatrist should ensure that the allied professional or paraprofessional with whom he or she is dealing is a recognized member of his or her own discipline and is competent to carry out the therapeutic task required. The psychiatrist should have the same attitude toward members of the medical profession to whom he or she refers patients. Whenever he or she has reason to doubt the training, skill, or ethical qualifications of the allied professional, the psychiatrist should not refer cases to him/her.

3. When the psychiatrist assumes a collaborative or supervisory role with another mental health worker, he or she must expend sufficient time to assure that proper care is given. It is contrary to the interests of the patient and to patient care if the psychiatrist allows himself/herself to be used as a figurehead.

4. In relationships between psychiatrists and practicing licensed psychologists, the physician should not delegate to the psychologist or, in fact, to any nonmedical person any matter requiring the exercise of professional medical judgment.

5. The psychiatrist should agree to the request of a patient for consultation or to such a request from the family of an incompetent or minor patient. The psychiatrist may suggest possible consultants, but the patient or family should be given free choice of the consultant. If the psychiatrist disapproves of the professional qualifications of the consultant or if there is a difference of opinion that the primary therapist cannot resolve, he or she may, after suitable notice, withdraw from the case. If this disagreement occurs within an institution or agency framework, the differences should be resolved by the mediation or arbitration of higher professional authority within the institution or agency.

Section 6
A physician shall, in the provision of appropriate patient care, except in emergencies, be free to choose whom to serve, with whom to associate, and the environment in which to provide medical care.
1. Physicians generally agree that the doctor-patient relationship is such a vital factor in effective treatment of the patient that preservation of optimal conditions for development of a sound working relationship between a doctor and his or her patient should take precedence over all other considerations. Professional courtesy may lead to poor psychiatric care for physicians and their families because of embarrassment over the lack of a complete give-and-take contract.

2. An ethical psychiatrist may refuse to provide psychiatric treatment to a person who, in the psychiatrist’s opinion, cannot be diagnosed as having a mental illness amenable to psychiatric treatment.

Section 7
A physician shall recognize a responsibility to participate in activities contributing to the improvement of the community and the betterment of public health.

1. Psychiatrists should foster the cooperation of those legitimately concerned with the medical, psychological, social, and legal aspects of mental health and illness. Psychiatrists are encouraged to serve society by advising and consulting with the executive, legislative, and judiciary branches of the government. A psychiatrist should clarify whether he/she speaks as an individual or as a representative of an organization. Furthermore, psychiatrists should avoid cloaking their public statements with the authority of the profession (e.g., “Psychiatrists know that”).

2. Psychiatrists may interpret and share with the public their expertise in the various psychosocial issues that may affect mental health and illness. Psychiatrists should always be mindful of their separate roles as dedicated citizens and as experts in psychological medicine.

3. On occasion psychiatrists are asked for an opinion about an individual who is in the light of public attention or who has disclosed information about himself/herself through public media. In such circumstances, a psychiatrist may share with the public his or her expertise about psychiatric issues in general. However, it is unethical for a psychiatrist to offer a professional opinion unless he or she has conducted an examination and has been granted proper authorization for such a statement.

4. The psychiatrist may permit his or her certification to be used for the involuntary treatment of any person only following his or her personal examination of that person. To do so, he or she must find that the person, because of mental illness, cannot form a judgment as to what is in his/her own best interests and that, without such treatment, substantial impairment is likely to occur to the person or others.

5. Psychiatrists shall not participate in torture.
Section 8
A physician shall, while caring for a patient, regard responsibility to the patient as paramount.

1. Psychiatrists’ relationships with companies, organizations, the community, or larger society can affect their interactions with patients.

2. When the psychiatrist’s outside relationships conflict with the clinical needs of the patient, the psychiatrist must always consider the impact of such relationships and strive to resolve conflicts in a manner that the psychiatrist believes is likely to be beneficial to the patient.

3. When significant relationships exist that may conflict with patients’ clinical needs, it is especially important to inform the patient or decision maker about these relationships and potential conflicts with clinical needs.

4. In informing a patient of treatment options, the psychiatrist should assist the patient in identifying relevant options that promote an informed treatment decision, including those that are not available from the psychiatrist or from the organization with which the psychiatrist is affiliated.

Section 9
A physician shall support access to medical care for all people.
PROCEDURES FOR HANDLING COMPLAINTS
OF UNETHICAL CONDUCT

INTRODUCTION

The medical profession has long subscribed to a body of ethical statements developed primarily for the benefit of the patient. As a member of this profession, a physician must recognize responsibility not only to patients but also to society, the profession, other health professionals, and to self. The Principles of Medical Ethics with Annotations Especially Applicable to Psychiatry (hereafter referred to as the “Principles”), adopted from the American Medical Association, are not laws but standards of conduct that define the essentials of honorable behavior for the physician.

Complaints charging members of the American Psychiatric Association (APA) with unethical behavior or practices shall be investigated and resolved in accordance with procedures approved by the APA Assembly and the APA Board of Trustees. These procedures are congruent with the minimum requirements under the Health Care Quality Improvement Act. A District Branch (DB) of the APA may adopt additional requirements to comply with any additional or more stringent requirements of state law. A District Branch should notify the APA if additional requirements are adopted.

Ethics cases are confidential. The allegations, the names of the parties and other information are made available only to persons directly participating in the proceedings. Information regarding an ethics case is made public in limited circumstance as set forth in these procedures and only after a final determination has been reached when required by law or necessary to protect the public.

PART I: INITIAL PROCEDURES

A. The Complaint

1. An ethics complaint can be filed by a patient or guardian, a family member of a patient, an APA member or other individual with personal knowledge of the alleged unethical conduct.

2. The individual submitting the complaint is the “Complainant” and the APA member charged with ethics violations is the “Accused Member.”

3. Complaints charging an APA member with unethical behavior shall be:
   a. In writing;
   b. Signed by the Complainant and
c. Addressed to the DB of the Accused Member. If addressed to the APA, the complaint shall be referred by the APA to the Accused Member’s DB.

B. **Proceeding on Extrinsic Evidence:**

1. A complaint may be based on extrinsic evidence, including any documents attached to the complaint.

2. A DB may initiate an ethical proceeding without a Complaint based upon extrinsic evidence which it receives or otherwise becomes aware that a member has potentially acted unethically in violation of the *Principles*. In such proceeding, there is no Complainant.

3. Extrinsic evidence includes formal judicial or administrative reports, sworn deposition or trial testimony, medical or hospital records, and similar reliable documents.

C. **Review for Jurisdiction**

1. Once a complaint is received, the DB shall review the complaint to determine if the DB has jurisdiction over the matter. This review shall take place before the Accused Member is notified that a complaint was filed.

2. This review will consider:

   a. Is the Accused Member a member of the APA and the DB? Only complaints against APA members can be investigated. If the Accused Member is not a member, the DB shall notify the Complainant that it cannot pursue the complaint because the Accused Member is not a member of the APA and no further action can be taken.

   b. Is the Accused Member a member of the DB? If not, the complaint shall be forwarded to the APA Office of Ethics.

   c. Does the complaint allege unethical conduct that took place over ten (10) years ago? A complaint alleging unethical conduct must be received within ten (10) years of the alleged conduct. In the case of a minor patient, the ten (10) year limit will not begin until the patient reaches the age of 18. If the alleged conduct took place outside of the ten year limit, the DB shall notify the Complainant in writing that no further action can be taken.

3. If the complaint meets these jurisdictional standards, the DB shall evaluate the complaint as set forth in Part II below to determine whether it alleges conduct that violates the *Principles*. 

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4. The DB’s determination that a complaint does not meet these jurisdictional standards is final and there is no review by the Chair of the APA Ethics Committee.

D. **Notice:** Any "Notice" required in these procedures should be sent by a delivery system that requires a verifying of receipt, such as certified or overnight mail.

**PART II: REVIEW OF ALLEGATIONS**

The DB Ethics Committee (DBEC) shall review the complaint to determine whether it alleges a recognized ethics violation of the *Principles*.

A. **Preliminary Determinations**

1. The DBEC shall determine whether the complaint alleges on its face an ethics violation(s) as set forth in the *Principles*.

2. This is not a determination on the merits of the complaint. Rather, it is a determination of whether a recognized ethics violation is alleged assuming the facts in the complaint are true. This review is limited to reviewing the allegations in the complaint and a determination of whether those allegations assert a recognized ethics violation as set forth in the *Principles*.

3. If the complaint alleges conduct that does not violate the *Principles*, the DBEC shall notify the Complainant in writing (with a copy to the APA Ethics Office) that no further action will be taken and also inform the Complainant that he/she may request within 30 days a review of this decision by the Chair of the APA Ethics Committee as set forth in Part II.C.1.

4. Before initiating this below Review phase, a signed Confidentiality Agreement shall be obtained from the Complainant (including any attorney representing the Complainant) by which the Complainant agrees that all information and documents concerning the ethical procedures and all communications from the APA and DB, including their ethics committees and Hearing Panels, are confidential and shall be used solely in connection with the ethical proceedings and not for other purposes or legal proceedings.

B. **Review of Allegations**

1. This phase is the period during which the DBEC begins to look at the
merits of the case. The purpose of this process is to assess all information provided by the Complainant and then evaluate whether there is a basis for the allegation of unethical conduct. The DBEC can choose whether or not to contact and advise the Accused Member of the ethics complaint during this stage.

2. The DB ethics chair shall appoint a member(s) to review the allegations in the complaint. The individual(s) shall submit a written or oral report to the DBEC.

3. To help ensure fairness, it is desirable that the DBEC arrange for those who do the review and those who serve on the hearing panel to be separate teams. Sometimes what surfaces during this review is not always relevant to or admissible at the hearing, and thus this separation of functions minimizes the chances that the hearing panel will have been influenced by an earlier phase of the case.

4. The review is accomplished by reviewing the allegations and any related materials provided to them by the Complainant. During the review phase, the reviewer(s) may seek additional information from the Complainant. The additional information can be obtained by written request, phone conference or in person interview.

5. During this Review of Allegations phase, the DBEC may, but is not required to, notify the Accused Member of the complaint and invite additional information from him or her. The additional information can be obtained by written request, phone conference or in person interview.

6. If the DBEC finds the complaint does state a potential ethics violation, it shall notify the Accused Member and invite additional information from him or her before proceeding with a formal investigation of the member pursuant to Part III.

7. If the DBEC finds the complaint does not state a potential ethics violation under the ethical standards established by the Principles and thus there is no basis to proceed, it shall notify the Complainant in writing of the conclusion. This Notice shall also inform the Complainant that he/she has 30 days to request a review of this decision by the Chair of the APA Ethics Committee as set forth in Part II.C.1.

8. If the DBEC determines there is a basis to proceed, it must notify the APA Secretary as well as the Complainant and the Accused Member and proceed to the exchange of information phase.
9. DBECs should postpone adjudication of ethics complaints until all other pending actions such as civil, criminal or licensing board proceedings have been resolved.

C. **Review by the Chair of the APA Ethics Committee**

1. If the DBEC determines the complaint does not allege an ethics violation of the *Principles*, the Complainant may request a review of a DB’s decision by the Chair of the APA Ethics Committee. The request for a review must be sent to the DB and the Chair of the APA Ethics Committee within 30 days of the date of the Notice by the DB not to proceed.

2. If the Chair of the APA Ethics Committee determines that the complaint identifies a potential violation, he/she will request that the DB proceed with processing the complaint, and will provide the DB with a written explanation for this decision.

3. If the Chair of the APA Ethics Committee determines that the complaint does not warrant further action, then he/she will notify the Complainant and DB of this decision and that the case is closed.

**PART III: EXCHANGE OF INFORMATION**

A. **Notice to Accused Member**

1. If the DBEC decides to proceed, the DBEC must notify the Accused Member of the ethics complaint and that the DBEC will proceed to determine whether the Accused Member violated the *Principles*. The Notice should include:

   a. A copy of the complaint;
   b. All documents that were attached to the complaint or obtained during the initial review phase; and
   c. Copies of the Principles and Procedures for Handling Complaints of Unethical Conduct;
   d. The ethical principle(s) the Accused Member is accused of violating.

2. The DBEC should also notify the Accused Member of his or her due process rights. These include the right:

   a. To request a hearing;
   b. To be represented by an attorney or other person of the Accused Member’s choice (hereafter referred to as “Counsel”);
   c. To have a record made of the proceedings (but not the Ethics Committee’s subsequent deliberations, which will not have been preserved), copies of which
may be obtained by the Accused Member upon payment of any reasonable charges;
d. To call, examine, and cross-examine witnesses;
e. To present evidence determined to be relevant by the hearing panel, regardless of its admissibility in a court of law;
f. To submit a written statement or make an oral statement at the close of the hearing;
g. To receive a written decision; and
h. To appeal any adverse decision to the APA Ethics Committee.

3. When applicable, the DBEC shall obtain and provide the Accused Member with valid written authorization(s) from the patient(s) involved to provide relevant medical records and other information about the patient, and, if applicable, psychotherapy notes.

B. **Accused Member’s Response**

1. The Accused Member shall provide a written response to the complaint, including copies of all documents and a list of all witnesses he or she intends to present at the hearing. The Accused Member is not limited at the hearing to the evidence and witnesses identified in his or her response.

2. The DBEC may also consider additional information prior to any scheduled hearing. On the basis of information in the Accused Member's response, or other information that surfaces during the Exchange of Information phase but prior to the hearing, the DBEC may decide to dismiss the case. A decision by the DBEC to dismiss in this phase requires review by the APA Ethics Committee as set forth in Part VI.

3. The name of any member who resigns from the APA after an ethics complaint against him/her is received and before it is resolved shall be reported in *Psychiatric News* and in the district branch newsletter or other usual means of communication with its membership.

C. **Appointment of Hearing Panel**

The DBEC shall appoint a panel of no less than three members to hear the complaint. All members should be ethics committee members when possible, and at least one must be. One member of the panel shall be selected to chair the Hearing Panel (Hearing Panel Chair) and shall be a voting member of the panel. The Accused Member may request those with whom he/she has a conflict of interest be excused, and reasonable requests should be honored.
D. **Notice of Hearing**

1. No less than 30 days before the scheduled hearing, the DBEC shall provide a Notice to the Complainant and the Accused Member. The Notice should supply the following information:
   
   a. The place, date and time of the hearing;
   
   b. The names of the Hearing Panel Chair and the other panel members who will hear the case; and
   
   c. A list of witnesses expected to testify.

2. Any reasonable requests by the parties for alternative hearing dates should be honored.

E. **Education Option**

1. At any time before a final determination of whether the Accused Member violated the ethical standards established by the *Principles*, and with the agreement of the Accused Member, the complaint may be resolved in accordance with the Educational Option rather than determine whether the Accused Member violated the *Principles*. In deciding whether to use this approach, the DBEC shall consider such factors as the nature and seriousness of the alleged misconduct and any prior findings or allegations of unethical conduct.

2. If the DBEC decides to attempt to resolve the complaint by using the Educational Option as described in paragraph 1 above, it shall proceed only after:
   
   a. Accused Member has been informed (1) that he/she is entitled to proceed under enforcement procedures, and (2) that the DBEC reserves the right to proceed on the complaint to determine whether the Accused Member violated the *Principles* if, in its sole discretion, it determines that the Accused Member has not satisfactorily cooperated.

   b. Accused Member agrees to proceed under the Educational Option;

   c. There are appropriate education opportunities available and the DBEC has the resources to monitor compliance;

   d. The Accused Member will have the opportunity to respond to the suggestion to use the Education Option. The DBEC shall determine the procedures to be used to obtain the responses, including written submissions and/or meeting with the parties separately or together. However, in determining the procedure it will use, the DBEC shall seek to provide a format that will facilitate the Accused Member's understanding of the ethical issues raised by the complaint, including the reasons for or sources of the Complainant's concern, and to permit the DB to assess the Accused Member's understanding of these matters.
3. The DBEC shall identify a specific educational program including courses, reading and/or consultation for the Accused Member to complete within a specified period and shall notify the Accused Member and the APA Ethics Committee of the required program. The DBEC will monitor the Accused Member’s compliance with any such educational requirements. The Accused Member’s failure to complete the specified educational program may result in the proceedings being reopened to determine whether the Accused Member violated the *Principles*. It is preferable, but not required, that the subsequent proceeding be conducted by DBEC members other than those who participated in the process previously.

4. The DBEC shall retain records of complaints considered pursuant to this Part and of any education thereafter required of an Accused Member. The DB may consider such information in connection with a decision as to how to handle any later complaints involving the Accused Member.

5. Once the DBEC decides to resolve the complaint by using the Educational Option, it shall notify both the Complainant and Accused Member.

6. Upon completion of an Education Option requirements, the proceeding shall be terminated.

PART IV: THE HEARING

A. Basic Requirements

1. While the spirit of this process is a collegial one based on mutual respect among professional colleagues -- and not a court of law -- procedural safeguards are an integral aspect in order to preserve the rights of the Accused Member and provide fairness and respect for both the Accused Member and the Complainant.

2. If deemed useful and not likely to prejudice the panel, the Hearing Panel Chair may allow the individual(s) who did the review of allegations under Part II to present oral or written documentary and testimony evidence, subject to cross examination by the Accused Member or his or her counsel, for the panel’s consideration. This reviewer(s) of the allegations should not participate any further in the hearing or be part of the panel’s deliberations or voting.

3. Counsel’s participation is subject to the continuing direction and control of the Hearing Panel Chair. The Hearing Panel Chair shall exercise his or her discretion so as to prevent the intimidation or harassment of the Complainant and/or other witnesses given the peer review nature of the proceedings. Panel members may ask questions of the Accused Member.

4. The Accused Member’s voluntary waiver of a hearing shall not prevent the Hearing Panel from meeting with, and hearing the evidence of, the
Complainant and other witnesses, and reaching a decision in the case. The Accused Member may choose not to be present at the hearing and to present his/her defense through other witnesses and/or Counsel.

5. The Complainant must be present in person at the hearing to testify regarding his/her allegations unless excused by the Hearing Panel Chair, and this should occur only when, in the judgment of the Hearing Panel Chair, participation would be harmful to him/her or extrinsic evidence serves as the Complainant. Complainants may bring a support person to the hearing if approved by the Hearing Panel Chair. Complainants generally do not remain in the hearing once they have presented their testimony and evidence and been cross examined. The Hearing Panel Chair may have them wait outside during the remainder of the hearing in the event further information from the Complainant becomes needed.

B. The Hearing

1. The hearing may consist of:

   a An oral opening statement by the Complainant, and the Accused Member or his/her Counsel;

   b Testimony by the Complainant and any witnesses, and any written or oral cross examination by Accused Member or his/her Counsel;

   c Testimony by the Accused Member;

   d Questions by the Hearing Panel members; and

   e Presentation of any evidence determined to be relevant by the Hearing Panel Chair, regardless of its admissibility in a court of law.

2. The Accused Member or his Counsel shall be permitted to make an oral closing statement and/or submit a written statement at the close of the hearing or within a reasonable time thereafter.

PART V: DISTRICT BRANCH DECISION

After the hearing, the Hearing Panel shall meet and reach a decision based on the information presented at the hearing, including the testimony from the parties and any other witnesses, the documents submitted and any other evidence provided as part of the hearing. The decision shall consist of (A) a determination of whether the Accused Member violated the ethical standards established by the Principles, and (B) if so, then what sanction, if any, is appropriate.
A. **Determination**

1. After the conclusion of the hearing, the panel shall issue a written determination that sets forth the Hearing Panel’s findings, recommendations, and reasoning.

2. In making its decision, the Hearing Panel should consider:
   
   a. The nature and seriousness of the alleged conduct;
   
   b. Whether or not there is a reasonable belief that an ethics violation occurred.
   
   c. The credibility of the Accused Member, Complainant and the other witnesses;
   
   d. Any documents submitted that the panel finds credible; and

3. The DB executive council (or the DB’s governing body) must review the panel’s determination. The DB executive council can accept or modify the panel’s findings. In all cases, the DB shall seek to reach a decision as expeditiously possible.

4. Before notifying the Complainant and Accused Member, all determinations must be forwarded to the APA Ethics Committee for review pursuant to the procedures set forth in Part VI.

5. Unless the DBEC proceeds under the Education Option, there are two basic findings:

   a. The Accused Member did not act unethically; or
   
   b. The Accused Member acted unethically.

6. **No Ethical Violation**

   a. If the Hearing Panel decides after a hearing that no ethical violation occurred, it shall prepare a written explanation that sets forth the reasons for the determination. This determination shall be submitted to the DB executive council and the APA Ethics Committee for review as set forth in Part VI.

   b. If approved by the DB executive council and the APA Ethics Committee as set forth in Part VI, the DBEC shall notify the Complainant and Accused Member in writing of the determination.

   c. There is no appeal from this determination.
7. Ethical Violation

a. If the panel decides after a hearing that Accused Member acted unethically, it shall prepare a written explanation that sets forth the reasons for the determination. It shall then proceed to determine the appropriate sanction. This determination shall be submitted to the DB executive committee and the APA Ethics Committee for review as set forth in Part VI.

b. If approved by both the DB executive committee and APA Ethics Committee, only the Accused Member shall be notified in writing of the determination setting forth the reasons for the determination and the sanction. This Notice should be copied to the APA Ethics Office. This Notice shall also inform the Accused Member of his or her right to appeal the determination to the APA Ethics Committee within 30 days. The appeal right applies to all adverse findings.

c. The Complainant is not notified of the determination until all appeals have been concluded or the time for the Accused Member to appeal has expired.

B. Sanctions

If the panel finds that an ethical violation has occurred, it must determine the appropriate sanction. This determination may include consideration of any mitigating or aggravating circumstances such as illness or prior findings of unethical conduct that are relevant to the current violation. The three (3) sanctions in increasing order of severity are: (1) Reprimand; (2) Suspension; and (3) Expulsion.

1. Reprimand

a. A reprimand is an official admonishment by the APA. The reprimand shall identify the conduct considered unethical and the basis of the determination.

b. The reprimand is confidential and is not published to the general membership of the DB or the APA, or to the general public.

c. Additional conditions may be included with the reprimand as set forth Part V.C.)

2. Suspension

a. Suspension is a serious sanction that will be made public. An Accused Member may be suspended for a period not to exceed five (5) years.
b. A suspended member shall pay dues and is eligible for APA benefits, except that such a member will lose his/her rights to hold office, vote, nominate candidates, propose referenda or amendments to the Bylaws, and serve on any APA committee or component, including the APA Board of Trustees and the APA Assembly. If the suspended member is a Fellow, Life Fellow, Distinguished Fellow or Distinguished Life Fellow, the Fellowship will be suspended for the same period of time.

c. Each DBEC shall decide which, if any, DB privileges and benefits shall be denied the Accused Member during the period of suspension.

d. Additional conditions may be included with the suspension as set forth in Part V.C.

e. The name of any member who is suspended for an ethics violation, along with an explanation of the nature of the violation, shall be reported by the APA Office of Ethics:

   i. In Psychiatric News;

   ii. To the DB to be included in the DB newsletter or other usual means of communication with its membership;

   iii. To the medical licensing authority in all states in which the member is licensed:

   iv. To the National Practitioner Data Bank.

f. The DB should also consult applicable state law to assure that it adheres to any requirements.

3. Expulsion

   a. Expulsion is the most serious sanction. As a result, all determinations to expel an Accused Member must be affirmed by the APA Board of Trustees.

   b. Once a decision to expel a member has been approved by the DB executive council and the APA Ethics Committee, and the appeal process under Part VII has been exhausted or expired the APA Ethics Committee Chair (or his/her designee) shall present the matter and the documentary record to the APA Board of Trustees at the Board's next meeting. The APA Board of Trustees may:

   i. Affirm the sanction;

   ii. Impose a lesser sanction;
iii. Remand to the APA Ethics Committee or DBEC for further action or consideration in which case these procedures shall apply to those actions; or

iv. Request further information from the DBEC before voting on the decision to expel.

c. A decision to affirm an expulsion must be by a vote of two-thirds (2/3) of those Trustees present and voting. A decision to impose a lesser sanction shall be by a majority vote.

d. If the APA Board of Trustees affirms expulsion, the APA Secretary shall notify the DBEC, and the DBEC shall in turn notify the Complainant and Accused Member of the decision and that it is final. The Accused Member shall also be provided copies of the DBEC and/or panel recommendation(s) and reasoning.

e. The name of any member who is expelled from the APA for an ethics violation, along with an explanation of the nature of the violation, shall be reported by the APA Office of Ethics:

i. In *Psychiatric News*:

ii. To the DB to be included in the DB newsletter (APA Office of Ethics will provide DBEC with language) or other usual means of communication with its membership;

iii. To the medical licensing authority in all states in which the member is licensed:

iv. To the National Practitioner Data Bank.

f. The DB should also consult applicable state law to assure that it adheres to any state requirements.

C. Additional Conditions

Concurrent with the imposition of the sanctions of reprimand and suspension, additional conditions can be imposed. These conditions are designed to reinforce and facilitate ethical behavior.

1. Supervision

   a. The DBEC may impose supervisory requirements on a suspended member. When such conditions are imposed, the following procedures shall apply:
i. If the DBEC imposes conditions, it shall ensure that the DB monitors compliance;

ii. If a member fails to satisfy the conditions, the DBEC may decide to recommend a new sanction; and

iii. If the DBEC determines that a member should be expelled for noncompliance with conditions, the APA Board of Trustees shall review the expulsion in accordance with the provisions set forth in Part VII. E. of these procedures.

b. In determining whether to require supervision, the Hearing Panel and/or the DBEC should consider the available resources to conduct and monitor such supervision.

2. Education Requirement

a. The DBEC may impose an Education Requirement as part of the sanctions of reprimand or suspension.

b. If the DBEC decides to impose an Education Requirement, the DBEC shall identify a specific educational program including courses, reading and/or consultation for the Accused Member to complete within a specified period and shall notify the Accused Member and the APA Ethics Committee of the required program. The DB will monitor the Accused Member’s compliance with any such educational requirements. The Accused Member’s failure to complete the specified educational requirement(s) may result in the proceedings being reopened (e.g., to determine if a greater sanction is indicated).

3. Personal Treatment

a. As part of any sanction, personal treatment may be recommended, but not required, and any such recommendation shall be carried out in accordance with the ethical requirements governing confidentiality as set forth in the Principles. In appropriate cases, the DBEC may also refer the psychiatrist in question to a program responsible for considering impaired or physically ill physicians.

PART VI: REVIEW BY THE APA ETHICS COMMITTEE

A. APA Ethics Committee Review

1. After the DBEC decision is confirmed by its DB executive council (or the
DB's governing body), the decision and any pertinent information concerning the procedures followed or relating to the action taken shall be forwarded to the APA Ethics Committee for review. This review applies to all decisions, including those where the DBEC finds that an ethics violation has not occurred.

2. The APA Ethics Committee will appoint a panel composed of at least three (3) voting members of the APA Ethics Committee to undertake these review functions on behalf of the full APA Ethics Committee. The review shall assure that:

   a. The complaint received a comprehensive and fair review;

   b. That the review was in accordance with the applicable procedures; and

   c. The sanction imposed was appropriate.

3. If the APA Ethics subcommittee concludes that these requirements were not satisfied, it shall so advise the DBEC, and the DBEC shall remedy the deficiencies and shall make further reports to the APA Ethics Committee until such time as the APA Ethics Committee is satisfied that these requirements have been met.

4. If the APA Ethics subcommittee concludes that the sanction should be reconsidered by the DBEC, it shall provide a statement of reasons explaining the basis for its opinion, and the DBEC shall reconsider the sanction. After reconsideration, the decision of the DBEC shall be final with the exception that Expulsions must also be approved by the APA Board of Trustees.

5. The Complainant and Accused Member shall not be notified of any decision until this review is completed.

B. **Notification of Decision**

1. After the APA Ethics Committee or subcommittee completes the review process, the following Notices will be sent:

   a. If the determination is that no ethics violation has occurred, the DB shall provide written Notice to the Complainant and Accused Member of the decision.

   b. If the determination is that an ethical violation did occur, the DBEC shall provide written Notice to the Accused Member of the decision and the sanction. The Accused Member shall be provided: (1) copies of the DBEC and/or panel recommendation(s), (2) the DBEC decision, and (3)
notice of his/her right to Appeal the decision within 30 days of receipt of the letter. The Complainant shall not be notified until all appeals or the time for all appeals has expired.

c. If the decision is to expel the member, the DBEC shall not provide Notice until the APA Board of Trustees has approved the expulsion pursuant to Part V.B.4. Once approved by the Board, the DBEC shall provide written Notice to the Complainant and Accused Member, with a copy to APA, that Expulsion has been approved by the Board of Trustees and that the decision is final.

PART VII: APPEALS

A. Appeal Panel

1. All appeals shall be considered and decided by a panel of three (3) members of the APA Ethics Committee who have not been involved in a review of the case pursuant to Part VI.

2. The Chair of the APA Ethics Committee may appoint a replacement if there are not three members of the Committee who have not been involved in the case who are able to serve.

B. Grounds for Appeal

All appeals shall be based on one (1) or more of the following grounds:

1. That there have been significant procedural irregularities or deficiencies in the case;

2. That The Principles of Medical Ethics with Annotations Especially Applicable to Psychiatry has been improperly applied;

3. That the findings of or sanction imposed by the DB are not supported by substantial evidence;

4. That substantial new evidence has called into question the findings and conclusions of the district branch.

C. Accused Member’s Request For Appeal

1. The Accused Member’s request for an appeal must be received within 30 days of the date the Accused Member is notified of the district branch decision. Upon receipt of the Accused Member’s request for an appeal, the APA Ethics Committee shall request and the DB shall provide to the APA Ethics Committee a copy of the DB file, including the recording of the hearing. The APA Ethics Committee shall make a copy the DB file available to the Accused Member upon request and compliance with any conditions set by the APA Ethics Committee.
2. In appeals heard by an APA Ethics Committee appeals panel, the panel will review and decide the appeal solely on the basis of the DB’s documentary record of its actions and decision and any written appeal statements filed by the Accused Member and the district branch. The Accused Member’s statement will be provided to the DB, which may file a written response. Any DB response will be forwarded to the Accused Member, who will have the opportunity to respond in writing prior to the Ethics Committee’s consideration of the appeal. Filing deadlines and other procedures governing the appeal shall be established by the APA Ethics Committee.

D. Decision by APA Ethics Committee Appeal Panel

1. After reviewing all documents, the APA Ethics Committee appeals panel may take any of the following actions:

   a. Affirm the decision, including the sanction imposed by the district branch;

   b. Affirm the decision, but alter the sanction imposed by the district branch;

   c. Reverse the decision of the district branch and terminate the case; or

   d. Remand the case to the district branch with specific instructions as to what further information or action is necessary. Remands will be employed only in rare cases, such as when new information has been presented on appeal or when there is an indication that important information is available and has not been considered. After the district branch or panel has completed remand proceedings, the case shall be handled in accordance with procedures in Part VI and VII.

2. After the APA Ethics Committee appeals panel reaches a decision, if the decision is anything other than to expel a member or remand, the Chair of the APA Ethics Committee shall provide Notice to the DB of the decision. The DB shall then provide Notice to the Accused Member and the Complainant of the decision and that it is final.

3. If the decision is to expel the member, the decision would be forwarded to the APA Board of Trustees as outlined in Part V.B.4.
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