MCLAREN-OAKLAND
2012-2013

HOUSESTAFF TRAINING MANUAL

Note: Relevant sections of this manual shall also apply to residents in Podiatric Medicine and Surgery enrolled in programs approved by the Council on Podiatric Medical Education of the American Podiatric Medical Association.

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INTRODUCTION

This Manual, which you have acknowledged receipt of by your contract signature, contains residency program requirements, as well as McLaren-Oakland's procedures and protocols. **It is your responsibility to follow this manual!**

The training you will receive at McLaren-Oakland will prepare you for your medical practice in your office, hospital, or for further postgraduate training.

McLaren-Oakland
Mission Statement

McLaren-Oakland provides primary and specialty health care services guided by the principles of osteopathic medicine. We aspire to enhance the quality of life and health status of the people we serve.

GRADUATE MEDICAL EDUCATION MISSION STATEMENT

McLaren-Oakland, in pursuit of its Mission, has supported Graduate Medical Education programs since 1955. McLaren-Oakland continues this tradition by sponsoring osteopathic internship and residency training programs in multiple disciplines in an effort to better meet the needs of the communities that it serves. McLaren-Oakland's commitment is to provide the education, financial and human resources necessary to achieve its Mission.

The purpose of these programs is to:

A. Train osteopathic physicians who can ultimately serve this or other communities with high quality, high value, clinical services, based upon clinical competence and social responsibility;

B. Provide high quality, community focused teaching programs reflective of our mission and values;

C. Foster the continual medical education activities of its attending medical staff through the productive interaction of the staff and the teaching program;

D. Allow house staff to participate in the mission for caring for the poor through a variety of programs designed to provide opportunities to care for the underserved communities;

E. Enhance the stature of the institution; and

F. Provide an educational environment capable of supporting medical student education.

The McLaren-Oakland Mission is served by:

A. The recruitment of house staff who has demonstrated appropriate competence and skills to carry out their training programs in a manner that is consistent with the values of McLaren-Oakland.

B. The recruitment and retention of high quality physicians and teachers willing to serve as faculty to support the Mission of the programs.

C. Program structures that enhance attending/house staff interactions and provide venues conducive to the enhancement of learning for both house staff and attending staff. The program will be identified as successful when the following outcomes have been achieved:

1. When graduating physicians can enter the community with the skills and knowledge base necessary to practice high quality osteopathic medicine, and to be successful in achieving their personal goals. This is measured by:
   a). Performance on certifying board exams;
   b). Candidates achieving post-graduate training positions that they desire; and/or
   c). Candidates achieving career placement positions that they desire.

2. House staff report a high level of satisfaction with all aspects of the program:
   a). Ongoing resident survey tools measure this.

b). Attending physicians preferentially seek admission for their patients to McLaren-Oakland to have access to, and communication with, our house staff.

i. This is measured by staff satisfaction surveys and episodic focus groups, as necessary. Also, by following up with physicians who stop or decrease their admissions to McLaren-Oakland.

3. All programs consistently and routinely fulfill all requirements of the American Osteopathic Association, and achieve ongoing approval without conditions or probations on a routine basis.

4. Patients consistently identify interactions with the house staff as a positive part of their care at McLaren-Oakland, as determined by patient satisfaction surveys.

5. Successful performance of medical students on medical school end-of-rotation exams, and by positive student and medical school feedback.

6. Evidence of departmental academic achievement, including:
   a). University affiliations
   b). Participation at regional or national societies
   c). Publication
   d). Presentation
   e). Each resident participates in a scholarly activity during his/her course of training.

McLaren-Oakland
Principles of Behavior

McLaren-Oakland strives to accomplish its Mission to improve the health care of the community. To be successful, every member of the organization must understand that the people we serve view our daily actions as representing McLaren-Oakland. Our commitment to the Mission is accomplished through our relationships, specifically as individuals, as an organization and as citizens of the community.

As *INDIVIDUALS*, we will:

- Respect and accept all people's inherent dignity in the provision of quality health care services and in our daily conduct towards others
- Inform, enable and empower the poor to access our care and services with dignity and confidence
- Demonstrate compassion, empathy and respect
- Promote participatory decision-making at the point of service
- Provide clear and realistic expectations with constructive and honest feedback
- Provide each other with opportunities to reach our fullest potential

As an *ORGANIZATION*, we will:

- Provide safeguards against unauthorized release of confidential information
- Create an environment of trust in the workplace
- Practice compassion through customer focused care
- Demonstrate an attitude of hospitality
- Encourage and support creativity and risk taking in developing innovative solutions to new and traditional challenges
- Respect patients and their families as equal partners in treatment
- Be committed to the continuous quality improvement process as a means to improve quality, productivity and efficiency
- Value diversity as a trademark of an enriched and successful organization

As citizens of our *COMMUNITY*, we will:

- Create an environment of trust in all of our interactions and provisions of services
- Share our resources in partnership with other providers, as well as advocate for the needs of the disadvantaged in the public domain
- Demonstrate a spirit of openness and receptiveness
- Demonstrate our values by the integrity of the relationships among ourselves and the community we serve
- Recognize health care as a right by providing access of needed health services for all
- Be an advocate for unbiased and ethical outcomes internally as well as within the community
- Provide organizational leadership and presence in the endeavor to improve the health status of the community

ADMINISTRATION

Clarence Sevillian	President and CEO
Fred Korte	Chief Financial Officer
Steven Calkin, D.O.	Vice President of Medical Affairs
Jo Ann Mitchell, D.O.	Director of Medical Education
Tressa Gardner, D.O.	Traditional Internship Program Director Director of Emergency Medical Services
Pat Crean	Medical Education Manager
Aubin Whitmer	Medical Education Coordinator
Laura Paul	Medical Education Assistant
Deborah Dalton	Medical Education Assistant
Sheela John	Library Specialist

OGME 1 Year Description

History:
In 2006, the AOA Board of Trustees and House of Delegates supported a COPT resolution for restructuring the osteopathic internship. This new restructuring does not eliminate the requirement: however, the restructuring offers three separate options as choices of OGME training

OGME 1 Options:
OPTION 1 - OGME 1R programs grant residency credit for the first postdoctoral year of training, e.g. anesthesiology family practice, internal medicine, obstetrics and gynecology, pediatrics, and surgery.

OPTION 2 - OGME 1P programs require a preliminary year of training. Programs will not grant residency credit but indicate completion of a designated preliminary year curricular rotations, as prerequisites for entry into the 1 year of residency in the 2nd post doctoral year of training e.g. radiology, ophthalmology.

OPTION 3 - OGME 1T represents a traditional rotating internship. This track if for those who are undecided about on future plans or are interested in programs that are not linked to a residency or are associated with ACGME programs e.g. dermatology, occupational/preventative medicine, physical medicine, rehabilitation and proctology.

General Remarks:

1. ROTATIONS: Rotations for the OGME 1 year are based on the AOA Basic Standards associated with the specific residency programs. There may be additional requirements as determined by the Director of Medical Education, the Program Director and the needs of the institution.
   See Appendix 2

OGME YEAR 1, 2, 3 and above

2. McLaren-Oakland WORK HOUR POLICY: It is the responsibility of the resident to work within the McLaren-Oakland Duty Hours Policy (see policy #107a). The resident is not to exceed and average of 80 hours per week, averaged for each month (4 weeks).

3. DIDACTICS: It is required that house staff attend morning lecture, noon lecture and rotation specific lectures/conference depending upon the rotation. Morning Report and Noon Lectures shall be attended by: general Internal medicine, and subspecialty medicine. (in-house rotations). The only exception to this is ICU ROTATION. If the subspecialty medicine rotation is OUT OF HOUSE it is expected that the resident attend morning report at the very least. ******

   Surgery, Anesthesiology, Radiology, Orthopedics, and ER should refer to the specific sections in this handbook for further information regarding required conferences.

   In addition to regular daily lectures, there will be several mandatory conferences throughout the year.
   a. Neonatal Resuscitation and Fetal Monitoring
   b. Code Review
   c. Orthopedic Casting Clinic
   d. Soft Tissue Course
   e. Tumor Board –

4. VACATION/CONFERENCE/HOLIDAY/SICK DAYS: The house staff are allowed 20 (TOTAL) days for sick, travel, vacation, holiday, Guatemala or conference time. Per CMS (Medicare) guidelines, McLaren-Oakland may not claim (get paid!!) the house staff unless time off is considered "VACATION". You MUST submit a "Request for Time Off" form to Medical Education signed/approved by the service, resident and attending. REQUEST for TIME OFF must be submitted at least 6 weeks in advance, unless of course it is an EMERGENT situation. Every effort should be made to distribute vacation time throughout the year. It is NOT recommended that more than 5 days be taken the month of JUNE. Beware that unused days do not roll over to the next academic year.

5. ROTATION OBJECTIVES: The house staff is encouraged to read the House staff Manual as it relates to specific rotations. Objectives vary from rotation to rotation. House staff is encouraged to discuss the "expectations and objectives" with the attending during the first week of rotation. Senior Residents are also available to discuss the expectations of the rotation including the curriculum, reading assignments, and required lectures.

6. ROTATION EVALUATIONS: The house staff is evaluated by the attending physician at the end of the rotation. The attending is required to review the evaluation with the house staff. The house staff is encouraged to initiate conversation mid way thru the rotation with the attending and/or the senior resident regarding their progress. By discussing progress the house staff has ample time to improve in areas that the attending physician or the senior resident perceives as an issue.

7. ATTENDING EVALUATIONS: The house staff has the opportunity to review the rotation, the attending and the residents on the rotation. It is kept confidential so the house staff is encouraged to answer honestly, yet in a constructive manner.

8. CALL SCHEDULE: The IM/ER senior resident is responsible for making up the OGME 1 floor and ICU call schedules.
   a) All call related schedule requests must be emailed to Dr. Botnick, IM/ER Chief Resident by six weeks in advance of the schedule. Dr. Botnick's email is elisha.botnick@gmail.com. Dr. Botnick will present the final schedule by email to the first year class and GME on the 15th of the previous month. After the 15th the schedule is final.
   b) Changes to the final call schedule may only be approved by Dr. Botnick and should only be requested in the case of an emergency. The GME office will not take schedule changes unless they come from Dr. Botnick.
   c) All vacation requests during a call month must be approved by Dr. Botnick six weeks in advance to requesting time off from the service.

9. PAGERS: Pagers should be worn 24/7, unless on vacation. When paged, please direct the caller to the appropriate person. '

10. STEP 3 BOARD EXAM: Residents must take Step 3 of the Boards by January of their first year. It is the responsibility of the resident to pay for the exam. In addition, any resident who does not provide documentation of passing Part III by the end of the OGME 1 year will also be responsible to pay for the renewal of their educational license. Once the resident passes Step 3, McLaren-Oakland will pay for the Full State and DEA licenses.

RESIDENCY TRAINING PROGRAM DESCRIPTION

The McLaren-Oakland Residency Training Programs Descriptions specific to McLaren-Oakland and approved by the AOA and the Council on Podiatric Medical Education are attached.

The program description is periodically updated by the Office of Medical Education, your Program Director, and approved by the McLaren-Oakland Medical Education Committee, the AOA specialty college, AOA Council on Postdoctoral Training (COPT) and the Council on Podiatric Medical Education.

A copy of the Residency Training Program Description with any approved changes during your program is available in the Office of Medical Education at your request, or at www.mclaren.org.

RESIDENCY BENEFITS

McLaren-Oakland is pleased to offer the following benefits to its interns/residents. The brief description following each benefit is only a summary. All questions concerning the interpretation of benefit eligibility and amounts should be directed to the Human Resources Department and will be resolved in accordance with language contained in master insurance company contracts and/or Human Resources Policy. Unless otherwise stated, all benefits are provided by the Hospital at no cost to the employee.

SALARY FOR 2012-2013

OGME 1	$44,000	
OGME 2	$45,500	*There is a $5,000 per year bonus*
OGME 3	$47,000	*available to Internal Medicine and Family*
OGME 4	$48,000	*Practice Residents during years OGME 2*
OGME 5	$49,000	*and OGME 3.*
OGME 6	$50,000	
OGME 7	$51,000	

Medical-Dental-Vision-Life insurance-Long Term Disability

McLaren-Oakland offers medical coverage through McLaren Health Advantage. Medical coverage includes prescription drug coverage with reduced co-pays when employees use the hospital pharmacy. Medical and dental coverage is available for single, 2-person, family coverage. Vision coverage is through EyeMed Vision Care. EyeMed covers a complete eye exam, as well as frames and lenses or contact lenses (co-pays apply) once every 24 months. Dental coverage is provided through Delta Dental. Cleanings and exams are covered at 100%, and all other services at 50%. There is an annual maximum benefit of $1000 and a lifetime maximum benefit of $1,250 for orthodontic services.

Interns/Residents/Fellows are covered for life insurance in the amount of 1½ times their annual salary, rounded to the next highest $1,000 with a maximum of $150,000. Employees may purchase additional life insurance on themselves and family members at group rates. Life insurance includes coverage for accidental death and dismemberment. Residents are eligible for long-term disability insurance. LTD benefits are 60% (up to $3,000 monthly) of base hourly rate when on a non-occupational medical leave.

This summary of benefits is not intended to provide detailed information about benefits offered by McLaren-Oakland. Additional details about any of the listed benefits are available in the Human Resources Department. Where information on this summary differs from the information contained in benefit plan master documents, or other McLaren-Oakland policies, the master documents and McLaren-Oakland policies shall prevail. This benefit summary does not constitute a contract nor should it be construed to be a contract. These benefits are subject to change or revision without notice. For further information, please review plan documents in the Human Resources Department.

OTHER INSURANCE

Workers' compensation is provided by the hospital at no cost to you.

REIMBURSEMENT OF EDUCATIONAL EXPENSES

Interns/Residents/Fellows may be reimbursed for expenses to attend meetings that have educational value closely related to their specialty field of training, or to purchase textbooks, journal subscriptions, and/or computer hardware/software, with the approval of the Residency Program Director and the Director of Medical Education. Maximum amounts for reimbursement are $1,000 for OGME-1, $1,500 for OGME-2 & 3, and $1,800 for OGME-4 and above.

Reimbursement includes the following:

- Hotel room charges (single rate)
- Per diem up to $40 a day for meals and other incidentals
- Use of personal car at current IRS rate (51 cents per mile as of 1/1/11)
- Tolls and parking charges
- Public transportation at coach fare rates
- Taxi fare to and from public transportation depot

All applications for reimbursement (other than per diem) must include receipts.
***See Policy 125.**

VACATION

Residents receive twenty days of paid vacation per contract year.

ADDITIONAL BENEFITS

BCLS and **ACLS** certification are provided at the hospital.

Dining Room Privileges – Meals are provided, while on duty at McLaren-Oakland. Per meal/per day maximums will apply. This policy is subject to change.

Hospital Discount – Courtesy discounts are given for both inpatient and outpatient medical services.

Parking Privileges – Free parking is provided.

Social Security – You and the Hospital contribute an equal amount toward your benefit each pay period.

Memberships – Dues are paid for membership in the AOA and appropriate osteopathic specialty colleges.

Licensing Fees – Fees are paid for State of Michigan Physician and Controlled Substance licenses, as well as DEA licensing. Fingerprinting fees are paid by the resident.

Clothing Allowance – White coats are provided and laundered at your request.

Employee Fitness Center – The Fitness Center features the latest innovations in fitness facilities, including walking track, aerobics area, sauna, stair master, and circuit weight training may be utilized for $15/month.

Employee Discounts – Recreational activities, entertainment events, and other items are available at reduced prices to McLaren-Oakland employees.

MEDICAL EDUCATION DEPARTMENTAL POLICIES

In addition to the Medical Education Department's policies and procedures, house staff is subject to the McLaren-Oakland and McLaren-Oakland Medical Staff bylaws, policies and procedures. An example is the McLaren-Oakland *Corporate Compliance Policy* and the Surgery Department's *Supervising Physician Policy*. Copies of these documents may be requested from Human Resources Department or Medical Staff Services Office.

GENERAL POLICIES

Policy 101	AOA Approval
Policy 102	Eligibility of House staff
Policy 103	Selection Process of House staff
Policy 104	Statement of Professionalism
Policy 105	Appeal/Grievance Process for Probation, Disciplinary Action & Termination
Policy 106	Corrective Action or Performance Improvement Plan (Academic or Behavioral)
Policy 107a:	Duty Hours
Policy 107b:	Moonlighting
Policy 108:	Work Hours Audit Protocol
Policy 19:	Review of Size and Scope of Programs
Policy 110:	Intern/resident Evaluation
Policy 111:	Substance Abuse Policy for Interns/residents
Policy 112a:	Impaired House staff
Policy 112b:	Sexual Harassment
Policy 112c:	Disruptive Physician
Policy 113:	Certification of House Officers
Policy 114:	House staff Physician Supervision
Policy 115:	McLaren-Oakland Teaching Staff Appointment for Clinical Instructor
Policy 116:	Verbal/Telephone Orders
Policy 117:	House staff Involvement with Medical Staff Committees
Policy 118:	House staff Contracts
Policy 119:	Medical Education Department Annual Report
Policy 120:	Visiting House staff Application
Policy 121:	Observers in Medical Education
Policy 122:	Non-Medical Student, Non-House Officer Observers
Policy 123:	COBRA Anti-Dumping Legislation
Policy 124:	Transfer of Emergency Patients to another Facility
Policy 125:	Travel and Reimbursement
Policy 126:	Sickness and Injury
Policy 127:	Family Leave
Policy 128:	Dress Code
Policy 129:	Admission Procedure
Policy 130:	Deaths
Policy 131:	Criteria for Death
Policy 132:	Lectures
Policy 133:	Procedures
Policy 134:	H & P and PAT Assignment Protocol
Policy 135:	Procedure for Correction of Errors and Omissions in the Medical Record
Policy 136:	Care of Patients
Policy 137:	Information Management
Policy 138:	Research Requirements
Policy 139:	Phlebotomy, Physician-Required Intervention
Policy 140a:	Intern, Resident & Fellowship Physician Job Description
Policy 140b:	Chief Intern/OGME 1 Resident Description of Duties
Policy 140c:	Chief Resident Description of Duties
Policy 141:	Social Networking
Policy 142:	Trainee Activity Logs

AOA APPROVAL

Policy 101:
The American Osteopathic Association Council on Postdoctoral Training's inspection packages must be completed and submitted to the Director of Medical Education's office thirty (30) days prior to scheduled site reviews.

Purpose:
This policy ensures the timely development of site review packages and for the preparation of house staff and faculty for the review.

Policy 102: ELIGIBILITY OF HOUSESTAFF

Define eligibility of house staff.

Purpose:
The documentation of eligibility of residents and residents programs will rest with the Director of Medical Education and the Program Director of each program and the program specific departmental educational committee members in full compliance with the AOA and CPME requirements (Basic Documents for Postdoctoral Training) and Statewide Campus System of Michigan State University College of Osteopathic Medicine.

Acceptance to McLaren-Oakland is not influenced by race, color, sex, religion, creed, national origin, age or handicap. Only graduates of an American Osteopathic Association accredited college of osteopathic medicine are considered.

Procedure:

A. The applicant is a graduate from an osteopathic medical college whose programs are accredited by the American Osteopathic Association.
B. The applicant must provide:
   1. A completed application form
   2. A Dean's letter
   3. Three or more physician reference letters
   4. Medical school transcripts
   5. Scores from National Osteopathic Board of Medical Examiners
   6. For residency application, a reference from the Director of Medical Education at the hospital where the applicant completed any training.
   7. CV
C. The applicant must appear for a personal interview or phone interview if post-match scramble.
D. Applicants who are in advanced standing and cannot complete their residency training in a time frame that will result in 100% reimbursement on direct medical education benefits will not be routinely accepted without special approval by the MCLAREN-OAKLAND Medical Education Committee. Candidates seeking OGME1 specialty programs (family practice, Internal medicine, ENT/plastic surgery or OB/GYN) in addition to interview with the DME (and/or designee) will interview with the respective Program Director and/or other departmental program trainers.
E. If there is a question regarding the eligibility of an applicant, the final decision will rest with the Medical Education Committee.
F. All applicants are reviewed by the Department of Medical Education and must comply with the United States Federal Government Department of Health and Human Services, Department of Immigration and Naturalization, Visa and Cobra 85 Regulations and Guidelines. Further, they must be eligible for a State of Michigan Limited License. Residents must successfully complete all three (3) parts of NBOME and become fully licensed in the State of Michigan before advancing to the OGME3 year.
G. Monthly, completed applications (including interview results) are presented to the Medical Education Committee by the Director of Medical Education for ranking of the candidates. Candidates are ranked as follows: preferred candidate, alternate or non-preferred. Intern and resident selection is conducted following AOA Resident Registration Program (match program) and Residency Training Requirements (respectively).

Policy 103: SELECTION PROCESS OF HOUSESTAFF and Medical Students

Define selection process of house staff.

Purpose:
The selection o interns, residents, and medical students, if applicable, in all programs will depend upon the compliance with the eligibility requirements (Policy 101) and final confirmation of applications by the Director of Medical Education, the Program Director of each program, and the program specific educational faculty members in full compliance, as per Policy 101, and the Medical Education Committee.

1. The Director of Medical Education is responsible for the validation of eligibility requirements for resident and medical student applicants.
2. The Program Director of each program will be responsible for the validation of eligibility requirements for resident and medical student applicants.
3. The Medical Education Committee will be responsible for the final selection of resident applicants for the AOA's National Resident Matching Program and all resident applicants.

Policy 104: Statement of Professionalism

Preamble

The goal of the McLaren-Oakland's Department of Medical Education is to create individual professionals; physicians who can access and examine critically, a reliable and extensive fund of knowledge and apply it consistently to maximize the clinical benefit of patients. McLaren-Oakland students, interns, residents and fellows, hereinafter referred to as "trainees", are expected to demonstrate academic professionalism and honesty, and to maintain the highest standards of integrity according to a code of honor that embodies a spirit of mutual trust and intellectual honesty. The McLaren-Oakland Human Resources Personnel Policies, Procedures and Practices Manual establishes that trainees training at McLaren-Oakland have certain rights and responsibilities, and affirmed that they are a party to the social trust shared by all in the McLaren-Oakland community.

The Department of Medical Education recognizes that a code of professional behavior cannot encompass all potential issues of conduct that may arise, and that judgments regarding professional behavior are subjective thereby making it impossible to specify all behaviors deemed to be unprofessional. Trainees are expected to hold themselves and their peers to professional standards of behavior throughout their course of study. Included among these standards are five fundamental values of academic integrity including honesty, trust, fairness, respect and personal accountability. Trainees shall also be bound by the precepts of professional behavior contained within the AOA code of ethics and the institutions where they complete medical rotations.

Professionalism

Principles of professionalism are not rules that specify behaviors, but guidelines that provide direction in identifying appropriate conduct. These principles include the safety and welfare of patients, competence in knowledge and skills, responsibility for consequences of actions, professional communication, confidentiality, and lifelong learning for maintenance of professional skills and judgments. Professionalism and professional ethics are terms that signify certain scholastic, interpersonal and behavioral expectations. Among the characteristics included in this context are the knowledge, competence, demeanor, attitude, appearance, mannerisms, integrity and morals displayed by the trainee to faculty, peers, patients and colleagues in other health care professions. Trainees are expected to conduct themselves at all times in a professional manner and to exhibit characteristics of a professional trainee.

Trainees Rights and Responsibilities

Each individual trainee is responsible for their behavior and is expected to maintain standards of academic honesty. Trainees share the responsibility with faculty for creating an environment that supports academic honesty and principles of professionalism. Proper relationship between faculty and trainee are fundamental to the hospital's function and this should be built on mutual respect and understanding together with shared dedication to the education process. It is a fundamental belief that each trainee is worthy of trust and that each trainee has the right to live in an academic environment that is free of injustice caused by dishonesty. While trainees have an obligation to assist their fellow trainees in meeting the common goals of their education, trainees have an equal obligation to maintain the highest standards of personal integrity.

Policy 105: APPEAL/GRIEVANCE PROCESS FOR PROBATION, DISCIPLINARY ACTION & TERMINATION

The Medical Education Department follows the Resident Appeal/Grievance Process whenever an Intern or Resident is notified of an action that could result in dismissal from the program, suspension, repeating a clinical rotation, probation or to resolve any dispute or complaint regarding the interpretation or application of the provisions contained in the Intern/Resident Manual. Should any of these events occur, the house officer has the right to request a hearing before an appeals/grievance committee as described below.

In the case of termination from an internship or residency program based upon academic performance, the intern or resident shall be entitled, upon request, to a hearing before a quorum of the Medical Education Committee members pursuant to the "Hearing and Review Procedure for Program Termination for Interns and Residents" (see below).

Any probationary or disciplinary determination made by the Medical Education Department based upon non-academic performance shall not be subject to a hearing and review procedure. The decision of the Medical Education Department will be final. The Hearing and Review Procedure shall not apply to any disciplinary action up to and including termination that results specifically from patient abuse, sexual harassment, racial harassment, age discrimination, any other unlawful discrimination, or any non-academic performance matters.

Purpose:
To ensure that the house staff have an appropriate mechanism for resolving grievances and to ensure that the process is consistent, orderly and timely.

Procedure:
Section 1
PROCEDURE FOR OGME 1 RESIDENT

A. In the event an OGME 1 is to be terminated based upon the recommendation of the Internship Program Director based upon academic performance, the intern shall follow the procedures outlined herein.

PROCEDURE FOR RESIDENTS (OGME 2-above)

B. When any resident receives notice of a recommendation by a Program Director that he/she be terminated from the training program based upon academic performance, he/she shall, upon request, be entitled to a hearing before the Medical Education Committee of McLaren-Oakland. The resident shall follow the procedures outlined herein.

Section 2

A. Upon receipt of the recommendation of the Program Director or upon receipt of recommendation by the Director of Medical Education the affected resident shall, if he/she desires, request a hearing before the Medical Education Committee within five (5) days of the receipt of such recommendation.

B. The request for a hearing before the Medical Education Committee shall be in writing and served upon the Director of Medical Education who shall, in turn, notify the Chair of this committee.

Section 3

A. The Medical Education Committee shall not act upon the recommendation of the Program Director until the time within which the affected resident may request hearing shall have elapsed.

Section 4

A. In the event the affected resident shall have requested a hearing before the Medical Education Committee, the Chair of the Medical Education Committee and the Director of Medical Education shall, within ten (10) calendar days, arrange for such hearing before the Medical Education Committee and shall notify the affected resident, in writing, of the time and place of such hearing at least five (5) days before said hearing.

B. The notice of hearing shall state the recommendation to be acted upon by the Medical Education Committee and the basis for such recommendation.

Section 5

A. At such hearing, the affected resident shall be entitled to be represented by an attorney or other of his/her choice and shall have the right to produce whatever relevant testimony, oral or otherwise, as he/she sees fit. In the event the resident wishes to be represented by an attorney, he/she is to notify the Chair of the Medical Education Committee within three (3) days before said hearing.

B. In the case of a resident who has requested a hearing, a representative of the Department shall be present at said hearing.

C. The Director of Medical Education shall be present at said hearing.

Section 6

A. The Chair of the Medical Education Committee shall preside at such hearing and shall determine the order of procedure and shall assure that all participants in the hearing have a reasonable opportunity to present relevant oral and documentary evidence. The hearing need not be conducted strictly according to rules of law relating to the examination of witnesses or presentation of evidence.

Section 7

A. Upon completion of the hearing, The Medical Education Committee shall, within ten (10) days, consider the matter before them and render its decision. The Medical Education Committee shall cause a copy of their official action to be served upon the affected resident in writing, by registered mail, return receipt requested.

Section 8

A. Nothing contained herein shall operate to diminish or otherwise affect the necessity to summarily suspend a resident if deemed required. In the event a resident is summarily suspended, the Director of Medical Education shall be notified immediately, verbally and in writing. The Director of Medical Education shall document the suspension.

B. Nothing contained herein shall diminish the ability of a Department to call a special ad hoc meeting to resolve issues in special circumstances.

C. The failure of the affected resident to request any of the hearings provided for within the time limits provided shall operate as a waiver of his/her right to such hearing.

Policy 106: CORRECTIVE ACTION/Performance Improvement Plan (PIP) – Academic or Behavioral

Define Corrective House Office action for violation of professional responsibilities/standards.

Purpose:
This was prepared to incorporate McLaren-Oakland's Principles of Behavior to coincide with the AOA's Basic Standards. Whenever any activity of an resident, whether related to professional responsibilities or otherwise, violates or is reasonably likely to violate applicable rules, regulations or standards of conduct regarding patient safety, the delivery of quality patient care or the carrying out of Hospital operations and procedures, corrective action may be taken against the intern/resident. Corrective action against a resident may be initiated by the Director of Medical Education, a Program Director, any member of the teaching staff, or the Department Chairman of the department sponsoring the relevant program, pursuant to the following procedure:

Procedure:

1. All requests for corrective action shall be made in writing, in the form of a PIP. and submitted to the Director of Medical Education. All such requests must contain reference to the specific conduct or activities that constitute the allegations for corrective action. Upon receipt of such a request, the Director of Medical Education shall notify the resident against whom the corrective action is requested, the Program Director, the Chairman of the Medical Education Committee, and the Chairman of the Department sponsoring the residency program shall provide them with a copy of the written request for a PIP.

2. The Director of Medical Education or the Program Director shall investigate all of the facts and circumstances surrounding the request for corrective action and present the information to the Medical Education Committee or Program's Educational Committee members representing the resident. Following completion of such investigation, the Director of Medical Education or Program Director shall make a written report of his/her recommendation with regard to the action to be taken on the request for corrective action. A copy of such written report shall be provided to the resident involved, the Chairman of the department sponsoring the relevant residency program, the Chairman of the Medical Education Committee and the Director of Medical Education. In the event that the individual requesting the PIP is the Program Director, the request will be presented to the Program's Educational Committee Members. The Program Director will then forward it to the appropriate individuals.

3. Following submission of the written report required by paragraph 2, the Director of Medical Education or the Program Director may take any action he/she deems appropriate with regard to the request for corrective action including, but not limited to, the following:
   a. Rejecting the request for PIP;
   b. Issue an oral warning, a written warning, or a letter of reprimand to the resident;
   c. Place the resident on probation and specify the terms and conditions of that probation, according to the PIP;
   d. Implement a suspension or reduction of all or a portion of the resident's clinical privileges, according to the PIP;
   e. Terminate the resident from the residency program.

4. In the event that the Director of Medical Education and the Program Director elect to implement corrective action as specified in sub-paragraphs (c) through (e) above, the intern/resident shall be entitled to implement the Hearing and Review Procedure except as indicated under number 5, below.

5. The Hearing and Review Procedure shall not apply to any disciplinary action up to and including termination, which results specifically from patient abuse, sexual harassment, racial harassment, age discrimination, any other unlawful discrimination, or any non-academic performance matters.

LOST, STOLEN AND RETURNING COMPANY PROPERTY

PURPOSE
The purpose of this policy is to establish clear understanding and guidelines as it relates to lost, stolen and returning company property, as well as unauthorized or careless use of McLaren-Oakland property.

SCOPE OF APPLICATION
This policy applies to all McLaren-Oakland employees, including residents and all rotating medical students.

POLICY
Upon termination or resignation, it is an obligation to return all property that belongs to McLaren-Oakland. This includes keys, uniforms, identification pass, door access pass, parking pass, lap top computers, beepers, cell phones, scrubs, library books and any other items that were provided during employment or rotations at McLaren-Oakland.

Stealing and/or defacing of McLaren-Oakland property will result in corrective action or PIP in accordance with this policy.

PROCEDURE
These items must be surrendered under termination or resignation.

Any company property which has been provided that has been lost or stolen must be reported to Public Safety immediately. The cost of missing company property, depending upon the circumstances, may be the responsibility of the employee.

Policy 107a: DUTY HOURS

The Director of Medical Education and each Program Director is responsible for establishing guidelines regarding intern/resident duty hours. Respectively these guidelines must be in compliance with AOA Basic Standards and communicated to the house staff. **No exceptions to these guidelines will be permitted.**

Purpose:
To establish uniform guidelines regarding house staff duty hours.

Procedure:

Residents shall not be assigned to work physically on duty in excess of 80 hours per week averaged over a 4-week period, inclusive of in-house night call **and any allowed moonlighting. No exceptions to this policy shall be permitted.** Allowances for **already initiated** clinical care, transfer of care, educational debriefing and formal didactic activities may occur, but shall not exceed **4** additional hours **and must be reported by the resident in writing on the Duty Hour Exception Form (found outside Medical Education) with rationale to the DME/Program Director and reviewed by the Medical Education Committee. These allowances are not permitted for OGME 1 residents**.

1. Residents shall have at least alternate forty-eight (48) hour weekends off or one (1) twenty-four hour period off each week. No call responsibility can be assigned during this time.

2. In hospital call shall not be scheduled more often than every third night or nine (9) calls per 30-31 day month, averaged over any four week period. Home call is NOT subject to this policy, but must satisfy the requirements for time off. Time spent returning to the hospital must be included in the 80 hour limits.

3. After a 20-24 hour duty period trainees shall have a minimum 12 hour period free from duty or call and after completing a duty period of 12-19 hours a minimum of 10 hours off duty or call must be provided. All off duty time MUST be totally free from clinical, on-call and educational activity.

4. Rotations in the Emergency Department are limited to a maximum of 12 hours with no more than 2 additional hours for transfer of care or educational activities and this time must be reported in writing with rationale by the resident to the Program Director/DME and reviewed by the Medical Education Committee for monitoring of the individual residents and the program.

5. The training institution shall provide an on-call room which is clean and comfortable, so as to permit rest during call. A telephone shall be present in the on-call room. Toilet and shower facilities should be present in or convenient to the room. Nourishment shall be available during the on-call hours of the night.

6. The Department of Medical Education will audit work hours in accordance with Policy 108.

7. There is always appropriate supervision and backup established for the on-call intern/resident.

Policy 107b: MOONLIGHTING

MEDICAL EDUCATION POLICY
Moonlighting

I. Purpose

To establish a policy for the Medical Education Department to use for resident moonlighting.

II. Scope

This policy will apply to the McLaren-Oakland's Medical Education Department. All information contained in this policy shall be used as complete criteria for moonlighting.

III. Definitions

House staff or House Officer – refers to all interns, residents and fellows enrolled in a McLaren-Oakland post-graduate training program.

IV. Responsibilities/Requirements

1. **OGME 1 Residents are NOT allowed to moonlight.**

2. Residents are not required to moonlight.

3. With written permission from the Program Director of Section Chair, house staff will be allowed to moonlight.

4. Moonlighting must comply with the established AOA Duty Hours effective July 1, 2011.

5. House staff moonlighting outside of McLaren-Oakland must provide written evidence of liability insurance by the institution where they are moonlighting. McLaren-Oakland will not provide liability insurance for this activity.

6. House staff must have a full and unrestricted license by the State of Michigan before moonlighting is allowed, and house staff must be a United States citizen or must not have a visa that restricts their activities.

7. House staff must remain in good academic standing to be eligible for moonlighting. Eligibility may be reviewed as needed if any problems arise.

8. Moonlighting hours must never interfere with house staff duties.

9. Failure to comply with above procedures will result in immediate and permanent loss of eligibility and may result in further disciplinary action.

Policy 108: INTERN/RESIDENT WORK HOURS AUDIT PROTOCOL

MCLAREN-OAKLAND

Intern/Resident Work Hours Audit Protocol

Effective 7/1/11

In order to monitor the intern/resident work hours and to insure greater compliance with the American Osteopathic Association (AOA) regulations on work hours, McLaren-Oakland has revised the procedure for auditing work hours. Effective July 1, 2011, the following revised protocol will be followed:

1. Prior to commencing training, all residents will complete a Work Hours Attestation form indicating they are aware of and agree to abide by the McLaren-Oakland's Work Hours Policy.

2. Residents currently enrolled in training or rotating into training programs at McLaren-Oakland will be required to sign an attestation at the beginning of their training program.

3. All Programs Directors are responsible for:

a) knowing and understanding the purpose of the McLaren-Oakland 's policies pertaining to resident work hours
b) insuring that all program schedules are designed to comply with the AOA regulations
c) monitoring all working hours of graduate medical education trainees enrolled in or rotating through his/her program to ensure the residents remain compliant with the regulations

4. As a part of the monthly logging process, residents will be required to log their duty hours on New Innovations. Duty hours for each month must be printed and submitted as part of the monthly logs. Any violations will be reported by the resident to Medical Education, **on the Duty Hour Exception Form (found outside Medical Education).**

5. The Department of Medical Education will report any work hour violations to the Medical Education Committee, which is responsible for monitoring and enforcing the AOA's work hour regulations.

Policy 109: REVIEW OF SIZE AND SCOPE OF PROGRAMS

On an annual basis the Director of Medical Education shall review the scope and size of the various residency programs at McLaren-Oakland either sponsored by or affiliated with the institution and make recommendations regarding the continuation, reduction or augmentation of the size and scope of the various programs.

Purpose:
To define a procedure whereby the institution assesses the number of house staff in a training program and defines the scope and size of its programs consistent with the mission and vision for graduate medical education for McLaren-Oakland.

Procedure:

1. Annually - The Director of Medical Education shall:
   a. Review the scope and size of the various programs offered in graduate medical education by McLaren-Oakland.
   b. Present such review with recommendations regarding changes to the Medical Education Committee for input, counsel and endorsement.
   c. All actions regarding reductions in program size or scope of programs offered shall be done in compliance with outstanding contracts and after notifying the AOA and the OPTI. All attempts will be made to avoid termination of programs or program elements while residents are still in the process of training. If a program is terminated during a resident's training, every attempt will be made to reschedule that resident into a suitable program.
   d. Intern/Resident participation in this activity will be accomplished through their participation in the Medical Education Committee.

2. Decisions regarding the reduction, augmentation or change in scope of a graduate medical education program will be communicated to the residents and the medical staff as soon as possible.

Policy 110: INTERN AND RESIDENT EVALUATION AND PROMOTION

This policy is necessary to comply with the AOA's Basic Standards and to ensure quality of resident performance. Each department has developed and must maintain an evaluation system appropriate to the respective subspecialty that determines credentialing for specific procedures and remediation required for advancement.

Purpose:
Timely evaluation and credentialing is a critical responsibility of an academic program. Residents will be evaluated primarily through the utilization of standard electronic forms and will be afforded timely information regarding their progress.

Administration Responsibility
The primary responsibility for such evaluation rests with the Program Directors on an ongoing basis. However, attendings, peers, and chief residents are utilized to provide important performance data. This critical area of intern/resident supervision is an important component of the Annual Evaluation of each.

Procedures:

1. The Program Director will meet with the resident and faculty quarterly or semi-annually (according to the specific program requirements) to evaluate and summarize the progress of each resident.

2. The attending shall complete the form over New Innovations and discuss it with the resident.

3. Evaluations will include, minimally, the core competencies and the following factors for assessment:
   a. Ability - include general medical knowledge, clinical ability, and technical ability
   b. Professionalism - include integrity, initiative and reliability
   c. Attitude - toward attending staff, house staff, nurses and patients
   d. Data/information retrieval and synthesizing skill
   e. Patient management skills adjusted for level of training
   f. Case preparation and presentation skills.
   g. Compliance with hospital policies and ethical principles.

4. This information will be maintained in the intern's/resident's file and readily available to her/him for review.

5. The evaluation records noted shall be maintained on permanent file and shall form the basis for certificates of Program Completion or recommendation for promotion.

6.
7. The intern/resident's evaluation of the rotation and attending will be anonymous. It will be kept in a confidential file in Medical Education. On a quarterly basis, the results of the attendings performance will be tallied and given to the attending.

Policy 111: SUBSTANCE ABUSE POLICY FOR INTERNS AND RESIDENTS

When an intern/resident has been identified as having a substance abuse or dependency problem, Medical Education will work with Human Resources to establish an appropriate plan and to monitor the plan and the resident's performance. The resident, once diagnosed, will be offered treatment. Toward the end of a successful treatment program, a follow-up program will be formulated. The Michigan Health Professional Recovery Program will monitor this program.

McLaren-Oakland is concerned about the well being of every employee reporting to work fit for duty. An employee who reports to work impaired by alcohol or drugs, or who becomes impaired while on hospital premises, will be sent home with the assistance of a relative, taxi service or security staff. Impairment is defined as being affected by alcohol or drugs, or a combination of alcohol and drugs, in any detectable manner.

Any employee who is experiencing problems related to alcohol, drugs or other substances can seek confidential assistance from the Director of Medical Education or Human Resources Department.

Purpose:
The Department of Medical Education is committed to providing a high degree of quality patient care and safety. To that end, the Department supports the Hospital's policy regarding substance abuse and chemical dependency (see following page).

Procedures:

1. Employee Impaired While on Duty
   If there is reasonable cause to believe that any intern/resident is impaired while on duty, he/she will be asked to submit to a medical evaluation, which includes breath, blood or urine testing for the presence of alcohol or drugs. Refusal to submit to such medical evaluation shall subject the intern/resident to corrective action pursuant to the Human Resources Policy. An intern/resident who is determined by the medical evaluation to be impaired, or who refuses the medical evaluation, shall be sent home with the assistance of a taxi service, a relative, or the security staff. The intern/resident shall also be placed on a five-day disciplinary suspension. The intern/resident may elect treatment in lieu of the disciplinary suspension according to the procedures set forth below.

2. Treatment in Lieu of Discipline
   Any intern/resident, who is subject to corrective action for impairment, or for other violation of rules, regulations, policies or procedures of the Hospital and believes that alcohol or drug dependency caused or contributed to such violation, may apply for evaluation and treatment in lieu of discipline. The intern/resident will be placed on suspension for a period of five days, pending determination of eligibility, and provided a list of approved in-patient chemical dependency treatment programs.
   a. Eligibility
      i. In order to be eligible for treatment in lieu of discipline, the employee must: Acknowledge, in writing, responsibility for the violation(s) charged;
      ii. Submit a letter from a therapist or case manager of a program approved by the Hospital, verifying that an evaluation has been performed and describing the treatment program recommended;
      iii. Arrange for submission of progress reports regarding treatment to designated Hospital personnel, at intervals of not more than 30 days; and

iv. Enter into a written agreement with the Hospital, whereby the employee agrees to comply in all respects with the treatment program, including aftercare, and acknowledges that failure to successfully complete the program shall result in release from employment.

b. Medical Leave of Absence and Return to Work
Any intern/resident who is eligible for treatment for chemical dependency in lieu of discipline, and who is accepted into an approved in-patient treatment program, shall be granted a medical leave of absence. The intern/resident must successfully complete the in-patient program or the leave of absence will be discontinued and the employee will be released from employment.

Following official notification of completion of and discharge from the treatment program, the employee shall be eligible to return to work, subject to the employee's then-current license status, if applicable. An intern/resident completing a leave of absence for treatment of chemical dependency shall be returned to work according to the guidelines of the current medical leave of absence policy. Before returning to work, the employee must sign a Chemical Dependency Return to Work Agreement. The content may be individualized to accommodate specific conditions particular to that intern/resident, but should minimally include requirements that the employee:

i. Fulfill all written recommendations of the acute treatment program including aftercare,
ii. Ensure Hospital receipt of aftercare progress reports at least every 30 days,
iii. Permit appropriate Hospital management personnel to discuss treatment progress with the therapist or case manager; and
iv. Provide, upon request at Hospital discretion, blood or urine samples for alcohol or drug screening.

The agreement may provide that the intern/resident be restricted from involvement with narcotic or controlled substance administration for a period of one year. Failure to comply with the terms of the Return to Work Agreement shall be grounds for release from employment.

3. Medical Leave of Absence Without Discipline
Other interns/residents not subject to corrective action shall also be entitled to a medical leave of absence for the purpose of alcohol or drug treatment. The nature of the leave of absence shall be confidential, and shall be communicated to management personnel on a need-to-know basis only. The intern/resident shall be required to arrange for submission of progress reports to designated Hospital personnel regarding treatment at intervals of not more than 30 days.

a. Successful Completion of Program
Following official notification of completion of and discharge from the treatment program, the intern/resident shall be eligible to return to work, subject to the intern's/resident's then-current license status, if applicable. An intern/resident not facing discipline completing a leave of absence for treatment of chemical dependency shall be returned to work according to the guidelines of the medical leave of absence policy. The intern/resident shall not be required to sign a Chemical Dependency Return to Work Agreement, but shall be required to sign a release form permitting appropriate Hospital management personnel to discuss treatment and aftercare progress with the therapist or case manager of the treatment program.

b. Failure to Complete Program

Failure to successfully complete the in-patient program will result in the discontinuance of the leave of absence and the withdrawal of the right to return to work subject to review by management. The intern/resident will be required to sign a Chemical Dependency Return to Work Agreement, as set forth above.

4. Employee Diverting Drugs

If investigation reveals that an intern/resident diverted drugs for the purpose of selling, distributing or otherwise delivering them to others, that intern/resident will be terminated for theft and criminal activity, and the information shall be communicated to the Drug Diversion Unit or other appropriate authority.

If the intern/resident has diverted drugs for personal use due to drug dependency, and has not sold, distributed or otherwise delivered them to others, the diversion shall be reported as required by law, but the intern/resident shall be entitled to treatment in lieu of discipline as set forth above.

5. Employees Requiring Licensure

Any intern/resident in a position requiring Michigan licensure, if their license is revoked or suspended because of alcohol or drug dependency or diversion of drugs for personal use, may be returned to work following the completion of treatment only if their license is reinstated.

Policy 112a: IMPAIRED HOUSESTAFF

If an intern/resident is identified as possibly impaired by a reliable source or is self-referred, he/she may be required at the discretion of the Director of Medical Education or Department Program Director to undergo psychiatric evaluation/drug screening, etc. at the hospital's expense. An open list of counselors/therapists will be made available to ensure confidentiality.

If the intern/resident were diagnosed as impaired, they would be required to undergo therapy in a program approved by the Director of Medical Education and his/her Program Director. Depending upon the severity of the impairment and at the sole discretion of the Director of Medical Education, the Program Director and the Departmental Chairman, the following actions could be entertained:

1. The intern/resident could continue training with modification of his/her service load and supervision as deemed appropriate by his/her Program Director.
2. Intern/resident Suspension
3. Intern/resident Leave of Absence
4. Intern/resident Dismissal

Procedure:
All efforts would be made to provide confidentiality and a supportive environment. Therapy obtained as a condition for the impaired intern's/resident's continuation in the program would be documented in writing as would periodic resident assessment, etc. The Director of Medical Education or Program Director would be responsible for ongoing communication with the resident's or resident's therapist regarding progress (recommendations and appropriate career counseling of the involved intern/resident). An impaired intern/resident undergoing rehabilitative therapy would be reinstated in his/her residency training without stigma or penalties upon successful completion of therapy (i.e., full recovery).

The intern/resident and/or Department Program Director may be subject to reporting the impairment to the Michigan Department of Commerce, Bureau of Occupational and Professional Regulation pursuant to statutory requirements.

Policy 112b: SEXUAL HARASSMENT

The federal Equal Employment Opportunity Commission has declared that sexual harassment constitutes illegal discrimination under Title VII of the Civil Rights Act of 1964. It is and has been the policy of this hospital that sexual harassment of or by employees, patients, medical staff appointees, and others have no place and will not be tolerated in this hospital.

Therefore, the Board restates its policy that sexual harassment will not be tolerated and hereby directs the President/CEO to see that appropriate steps are taken to communicate the Board's intent, as expressed in this policy, to the hospital's employees, patients, and other medical staff. Specifically, the President/CEO shall make sure that patients, employees, and medical staff appointees are aware of the hospital's policy against sexual harassment and that adequate grievance procedures are in effect to facilitate prompt reporting of specific acts of sexual harassment that may occur in the hospital and that prompt action is taken on all complaints that are made.

POLICY 112c: DISRUPTIVE PHYSICIAN

It is the policy of this hospital that all individuals within its facilities be treated courteously, respectfully and with dignity. To that end, the hospital requires all individuals, employees, physicians and other independent practitioners to conduct themselves in a professional and cooperative manner in the hospital.
If a resident or resident fails to conduct him or herself appropriately, the matter shall be addressed in accordance with the appropriate following policy.

1) Documentation of disruptive conduct is critical since it is ordinarily not one incident that justifies disciplinary action, but rather a pattern of conduct. The documentation shall include:
   a) The date and time of the questionable behavior;
   b) If the behavior affected or involved a patient in any way, the name of the patient;
   c) The circumstances which precipitated the situation;
   d) A description of the questionable behavior limited to factual, objective language as much as possible;
   e) The consequences, if any, of the disruptive behavior as it relates to patient care or hospital operations;
   f) Record of any action taken to remedy the situation including date, time, place, action and name(s) of those intervening;
2) The report shall be submitted to the Vice President for Medical Affairs (VPMA).
3) If the single incident warrants a discussion with the offending physician, the VPME shall initiate that and emphasize that such conduct is inappropriate.
4) If it appears that a pattern of disruptive behavior is developing, the DME, VPMA, Program Director and Director of McLaren-Oakland 's Human Resources Department shall meet with the intern/resident to discuss the matter with the intern/resident.
   (a) The initial approach should be collegial and designed to be helpful to the intern/resident.
   (b) Emphasize that if the behavior continues, more formal action will be taken to stop it.
   (c) Meetings shall be documented and include notation that the intern/resident shall state that the physician is required to behave professionally and cooperatively.
5) If such behavior continues, disciplinary action shall be instituted and documentation of the disciplinary action will be kept as part of the intern/resident's permanent file.

Policy 113: CERTIFICATION OF HOUSE OFFICERS

Define Licensure/Certification of House Officers.

Purpose:
McLaren-Oakland employs high caliber, professionally trained personnel to uphold the standard of providing the best possible quality health care. House staff must maintain current licensure from the State of Michigan, current visa (if applicable), current ACLS certification and provide documentation of same to the Department of Medical Education on a regular basis. No house officer will be allowed to work unless they have the appropriate licensure from the State of Michigan.

Procedure:

1. Upon a house officer signing a contract, the Medical Education Department will determine what licensure, certification, etc. is needed to fulfill the terms of the contract and will see that any necessary paperwork is given to the applicant.

2. Each intern/resident, where appropriate, is responsible for providing updated information to the Medical Education Department before the expiration of the license/certification.

3. Copies of all licensure/certification will be given to the Medical Education Department.

4. The Medical Education Department will maintain the copies and input the information into a data base system.

5. The Medical Education Department will generate a computer listing of all house officers having licensure or certification requirements and their current license or certification information. The Department representative will contact the residents regarding the expiring licenses.

6. House officers who do not possess a current license and certifications, will be suspended until such time that the employee provides documentation to the Medical Education Department.

7. Interns/residents failing to comply completely with steps one through six of this policy will jeopardize their current employment/training status with the hospital.

8. Residents must be fully licensed to practice medicine in the State of Michigan before they will be offered an OGME-3 contract.

Policy 114: HOUSESTAFF PHYSICIAN SUPERVISION

As stated in the AOA Basic Standards, the house staff physicians hold unique positions as both students and providers of care. This combination requires an appropriate level of supervision by more senior physicians. In order to accomplish our commitment to graduate medical education and quality medical care, each program must specify in the residency program description for each trainee:

1. Her/His role and responsibilities for each level of training.

2. The organizational supervisory structure provided to ensure the quality and educational value and integrity of the resident curriculum.

3. The appropriate mechanisms and procedures to follow if (a) or (b) is not clear, understood or functioning.

4. A program with graded levels of responsibility that recognizes the ultimate training goal of graduating individuals fully prepared for independent patient management.

Purpose:
To ensure programs clarify for each trainee their roles as students and caregivers.

Procedure:

1. A curriculum shall be provided for each program that clarifies the scope of practice and condition and level of supervision required.

2. Evaluation of trainee competency shall be regularly monitored and documented in writing by faculty and senior attendings.

3. Opportunities for remediating deficiencies or obtaining greater independence shall be an integral aspect of our programs.

4. Departments shall maintain an appropriate system of recording that demonstrates the level of each trainee's progress towards the ultimate goal of independence in patient management.

Policy 115: MCLAREN-OAKLAND STAFF APPOINTMENT FOR CLINICAL INSTRUCTOR

Members of the McLaren-Oakland Medical Staff are encouraged to actively participate in the teaching programs if they meet the "Criteria for Faculty Appointment" (see attached). Any medical staff member who participates in a teaching program will be required to complete "McLaren-Oakland Faculty Application" form (see attached).

Purpose:
To ensure that each teaching staff acknowledges his/her obligations to follow the regulations outlined by the AOA Basic Standards.

Procedure:

1. The support staff will send out the forms each June to teaching staff.

2. The form must be completed and returned to the specific Program Director for review.

3. The Program Director will review the request and contact the physician to determine a schedule as appropriate. The request will then be forwarded to the Director of Medical Education.

4. The Director of Medical Education will forward the application to Michigan State University College of Osteopathic Medicine for approval of a Clinical Faculty Appointment.

5. An annual review of the teaching staff will be conducted by the Program Director.

CRITERIA FOR FACULTY APPOINTMENT
MCLAREN-OAKLAND

1. Board certification/eligibility and a member in good standing for the medical staff. There will be appropriate certification by profession for non-physicians.

2. Current curriculum vitae on file in the Medical Education Office of base hospital.

3. Participate in daily teaching (ambulatory and bedside rounds) and actively participate in documented formal educational activities to include morning report, noon conferences, journal clubs, tumor board and conferences, and/or other educational activities as determined in conjunction with the Medical Education Office.

4. Timely performance of administrative duties such as regular meetings with trainees and completion of evaluations jointly with trainees.

5. Professional conduct in interactions with patients, trainees and peers. Compliance with McLaren-Oakland's Principles and Behavior.

6. Participate in a minimum of three (3) hours of faculty development activities each year.

7. Participate in Faculty Forum (McLaren-Oakland).

8. Faculty membership shall be determined by the Medical Education Committee's "Faculty Appointment Committee" consisting of the Director of Medical Education, the Chair of the Education Committee of the Medical Staff and the Program Director of the Clinical Department of the applicant or Chair if Program Director is unavailable. The decision of the Committee shall be final.

9. Achieve average or better evaluation of teaching activities by trainees on an annual basis.

Policy 116: VERBAL AND TELEPHONE ORDERS

Define house staff responsibility in signing verbal and telephone orders.

Purpose:

All orders for treatment shall be in writing. A verbal order shall be considered to be in writing if dictated to a duly authorized person functioning within his or her sphere of competence and signed by the responsible physician (or appropriate member of the house staff).

Procedure:

All orders dictated over the telephone shall be signed by the appropriately authorized person to whom the orders were dictated with the name of the physician per his or her own name. The responsible physician shall authenticate such orders including documentation in the progress note within 24 hours and failure to do so shall be brought to the attention of the Director of Medical Education or the Program Director for appropriate action.

Policy 117: HOUSESTAFF INVOLVEMENT WITH MEDICAL STAFF COMMITTEES

Participation in committee work dealing with performance improvement activities and medical education activities is an important component of training programs. Therefore, it is appropriate that the Program Directors ensure house staff participation in committees and or functions. Examples include the following:

1. Medical Education Committee
2. Departmental Quality Assurance functions
3. Morbidity and Mortality Reviews
4. Tumor Board
5. Medical Ethics Committee
6. OMM/OPP Committee
7. Hospital Practices Committee

Purpose:

To ensure that the house staff is exposed to appropriate quality assurance and improvement activities and medical education deliberations of the medical staff.

Procedure:

1. On an annual basis, the Director of Medical Education and Program Directors will identify appropriate trainee participation on the Medical Education Committee.

2. Each Program Director will make certain that the residents have appropriate participation in the function of departmental quality assurance and/or morbidity/mortality reviews.

Policy 118: HOUSESTAFF CONTRACTS

The Medical Education Committee will review house staff contracts on an annual basis. Such review may lead to renewal with revisions as required by external agencies and/or be reflective of changes in salary, benefits and other offerings made to the house staff.

Purpose:

To ensure that house staff contracts are maintained as compliant with pertinent regulatory agencies and consistent with the mission of the McLaren-Oakland Medical Education Department. All OGME-2 residents must become fully licensed in the State of Michigan before they will receive an OGME-3 contract. The Program Director will report on the resident's competence and make recommendations for promotion. Funding will not preclude a resident from promotion.

Procedure:

Contracts will be reviewed annually at the Medical Education Committee meeting. Such review is to occur prior to the date of the contract's expiration so that the changes can be implemented.

Policy 119: MEDICAL EDUCATION DEPARTMENT ANNUAL REPORT

Each year the Program Director shall submit to the Director of Medical Education an annual report.

Purpose:

To ensure that the goals and objectives for the education programs are in line with the strategic initiatives of the institution including the mission of the Graduate Medical Education Department and the issues identified by the Medical Staff.

Procedure:

Each August the Program Director shall submit to the Director of Medical Education an annual report. The annual report should include:

1. The goals and objectives for the upcoming year as related to the hospital strategic initiatives and Medical Education Mission Statement.

2. A brief review of the accomplishments of last year's program.

3. Clarification of any outstanding issues other than those issues identified by previous RRC reviews or interim reviews.

4. Recommendations regarding further changes in size and scope of their program in preparation for the recruitment cycle.

Policy 120: VISITING HOUSESTAFF APPLICATION

House staff from a facility with which McLaren-Oakland has no affiliation agreement and who request permission to complete a clinical or observational rotation at McLaren-Oakland must complete a "Request for Affiliation" (see attached).

Purpose:

To ensure that McLaren-Oakland's Director of Medical Education has knowledge of the visiting house staff and to collect appropriate information prior to the visiting house staff rotation.

Procedure:

1. Visiting house staff completes "Visiting Resident Application" and attaches supporting documentation.

2. Intern's/resident's institution department head/director completes Section 2 of the request.

3. Visiting house staff submits application with Section 1 and Section 2 completed (with supporting documentation) four (4) weeks prior to rotation.

4. The Director of Medical Education completes Section 3 after resident's license and proof of liability insurance has been verified.

Policy 121: OBSERVERS IN MEDICAL EDUCATION

Define authorized individuals who provide patient care at McLaren-Oakland.

Purpose:

The Medical Education Department allows contact with patients and their records only to authorized house officers, medical students and other individuals specifically approved by the Department. Only authorized house officers, medical students and specifically approved individuals are allowed on the hospital units or in the clinics.

Procedure:

Authorized house officers are those physicians who have been approved to provide patient care by the Medical Education Department as part of their training program.

1. Medical students are those students from a medical school that has a formal affiliation with McLaren-Oakland.

2. Requests of other individuals associated with a non-affiliated medical school or the profession generally, must be approved by the McLaren-Oakland Department of Medical Affairs.

Policy 122: NON-MEDICAL STUDENT, NON-HOUSE OFFICER OBSERVERS

Only those individuals under McLaren-Oakland house officer contract, on official rotations, or on site with official presence or part of the formal curriculum of a medical school with a relation to McLaren-Oakland are allowed on the hospital wards/clinics. Under no condition is contact with patients or their records to be made by individuals other than those listed above.

Purpose:

This policy is needed in view of the current liability climate, the escalating costs associated with observer arrangements, and the need to better focus our medical education resources as carefully as possible.

Procedure:

Individuals making request for presence on site will be evaluated on the basis of this policy.

Policy 123: COBRA ANTI-DUMPING LEGISLATION

It is the policy of McLaren-Oakland to effect the communication of applicable federal law (COBRA requirements) and Hospital and Department policies regarding the appropriate transfer of patients.

Purpose:

To provide communication of COBRA/EMTALA requirements to all McLaren-Oakland house staff. To communicate policies addressing the appropriate transfer of patients with emergency medical conditions and women in labor.

Procedure:

1. All McLaren-Oakland interns/residents will be notified about the McLaren-Oakland Emergency Center policy entitled: *Transfer from Emergency Center*.
   a. With the annual intern/resident contract, a copy of the McLaren-Oakland Emergency Center Policy titled: *Transfer from Emergency Center* , Policy # 124, will be distributed to each trainee.

2. This transfer policy will also be reviewed with all McLaren-Oakland house staff rotating residents immediately prior to Emergency Center rotations, and include review of the "Emergency Transfer" forms .

Policy 124: TRANSFER OF EMERGENCY PATIENTS TO ANOTHER FACILITY

When patients, and/or family members of patients, request transfer to another facility from the Emergency Department, every attempt will be instituted to accommodate that request. However, there may be conditions or circumstances that supersede the request for transfer of patient to another facility.

Purpose:

To ensure a mechanism for patients and/or patient's families to be allowed the opportunity for transfer to another facility from the Emergency Center, in an appropriate and efficient manner.

Equipment:

1. Inter-Hospital transfer COBRA Form
2. Consent/Release documentation for Leaving the Emergency Department/Hospital Against Medical Advice**,** if applicable
3. Release of Information
4. Medical records, including laboratory and radiology results
5. Addressograph/Computer

Procedure:

1. When a transfer is considered appropriate, it is necessary that the emergency physician or attending physician present in the Emergency Center approves the transfer.

2. Transfer to the receiving facility will not be executed until the emergency physician, or attending physician present in the Emergency Center, has contacted and received acceptance of the patient from a physician at the receiving institution.

3. Patients will not be transferred when: (1) the emergency physician, an attending physician present in the Emergency Center, has requested not to transfer the patient, (2) when it is unsafe to transfer the patient, (3) when the receiving hospital/physician refuses to accept the patient, (4) when the patient is unstable, except for provisions allowed by COBRA, (5) when a competent patient refuses a transfer, (6) the transfer is directed as a result of patient's insurance, or ability to pay for hospital services.

4. Contact EMS transportation. NOTE: Emergency physician will designate type - ALS/BLS.

5. Emergency physician or transferring physician to complete Inter-Hospital Transfer Form.

6. Obtain copies of information physician desires to forward, i.e., Lab reports, Physician/Nursing Notes, X-rays and other ancillary results.

7. Place original copy of Inter-Hospital Transfer Form and additional information in envelope.

8. List and bag patient belongings and give to significant other, if present, after obtaining signature.

9. As applicable, assist patient onto ambulance stretcher or into wheelchair.

10. Give envelope to EMS personnel/patient/significant other to give to the receiving facility.

11. Proceed with discharge; routine or discharge against medical advice.

12. In unusual situations, a registered nurse, resident or specialty resident may be requested to accompany the patient.

<u>OTHER CONSIDERATIONS</u>

1. A patient's right of choice is to be honored if the patient is competent to make an informed, rational decision.

2. A competent patient's wishes supersede those of family members.

3. If a patient is incapable of providing a rational decision, the wishes of the family will apply so long as execution of that decision will not compromise the patient's well being.

4. If a patient's family cannot reach a unanimous agreement, then the wishes of the patient's significant other: (1) guardian; (2) spouse; (3) adult offspring; (4) parent; (5) adult sibling; (6) relative of patient with whom patient resides; (7) grandparents, aunts, uncles, adult nieces/nephews, etc., will take precedence.

5. Transportation of the patient will normally be delegated to an EMS service that will assume responsibility of the patient during transfer. It is, therefore, inappropriate to volunteer or engage the services of hospital employee/agents (nurse, resident, resident) when a patient is leaving against medical advice.

DOCUMENTATION

1. On the Emergency Center Record:
   a. Receiving facility
   b. Method of transport: ALS, BLS
   c. Receiving physician contacted
   d. Treatment rendered
   e. C.O.B.R.A. transfer record completed and by whom
   f. Patient medical records

SCOPE

1. Unstable patients will not be transferred to another facility when transport may compromise their condition, except as allowed by C.O.B.R.A.

2. If the emergency physician does not agree to the transfer due to patient's condition, or patient's inability to make rational decisions, the patient shall not be discharged from the Emergency Department.

3. If the patient refuses the transfer, is stable, and can determine a rational decision, the patient may leave the Emergency Center, providing documentation of refusal of transfer is in the emergency record.

Policy 125: TRAVEL AND REIMBURSEMENT

In accordance with McLaren-Oakland policies regarding travel authorization and reimbursement of expenses, the Department of Medical Education will reimburse residents travel for medical education meetings.

Purpose:

To define the travel reimbursement policy for resident travel.

Procedure:

All hospital travel for which interns/residents anticipate hospital reimbursement from their educational stipend must be made through the Medical Education Manager.
Reimbursement requests must be accompanied by the appropriate documentation for reimbursement.
Appropriate documentation consists of the following:
Airfare – copy of itinerary with amount paid
Mileage – mapquest from McLaren-Oakland to location.
Conference – copy of agenda, brochure or flyer with cost listed.
Questions regarding completion of travel forms should be directed towards the Medical Education Office.

Policy 126: INJURY, SICKNESS, COUNSELING AND SUPPORT SERVICES

Any illness or injury should be reported immediately to the Office of Medical Education. An illness that does not require hospitalization, but is of a serious enough nature to prevent the intern/resident from performing scheduled duties, shall be reported before the next shift begins to the Office of Medical Education either by phone or in person. The Director of Medical Education will then assist in finding an attending physician to care for the illness. In illnesses that require hospitalization, the same procedure shall be enforced. It is the responsibility of the resident to report any illness requiring absence from assigned rotations to the Office of Medical Education. The decision of hospitalization is left entirely to the physician to whom the resident is assigned.

The Director of Medical Education can provide referrals for counseling and support services to assist the intern/resident. Also, McLaren-Oakland has an Employee Assistance Program, which offers interns/residents access to HelpNet providing information, confidential support and resources at no cost. Experienced, trained professionals are available and easy to access, via telephone or online, 24 hours a day, 7 days a week, and 365 days a year. To access these services, call 800-969-6162 to speak with a consultant, or visit HelpNet online at www.helpneteap.com.

Access to the Work Life Web is as follows:

Log onto: www.helpneteap.com

Click on “Work/Life Web”

Type in your user name: mclaren

Type in your password: employee
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The AOA allows each resident or resident to miss only twenty (20) working days during the year (including illness, holiday schedules, conference time or other). Time off exceeding twenty (20) working days must be made up at the end of the academic year. Weekends off are granted only according to the work schedule included in this manual.

Policy 127: FAMILY LEAVE

It is the policy of the Hospital to comply with the Federal Family and Medical Leave Act. This Act provides that an employee, upon request, must be granted up to 12 weeks of leave of absence per year for any of the following reasons:

1. The employee's medical disability
2. Birth of a child (within 1 year after birth)
3. Care of a child (within 1 year after birth)
4. Adoption of a child (within 1 year after placement)
5. Foster care of a child (within 1 year after placement)
6. Serious health condition of spouse, child or parent (Defined as in-patient care or requiring continuing treatment by a physician)

The Hospital Policy of granting leave for the *employee's medical disability* will not be changed. (See Policy No. 681, Medical Leave of Absence) In addition to those provisions for Medical Leave, leave may be granted for the other reasons stated above.

1. <u>EFFECTIVE DATE</u>
   Non-union employees: August 5, 1993 - Union employees: February 5, 1994

2. <u>FULL-TIME AND PART-TIME COVERAGE BY THE LAW</u>
   Full-time employees must have one year of service.

   Part-time employees must have one year of service and must have worked at least 1250 hours during the previous 12-month period. Normally, this will mean those part-time employees who are scheduled to work at least 48 hours per two-week pay period.

3. LENGTH OF LEAVE
   The law provides a maximum leave of 12 weeks during any 12-month period. Vacation and Personal Days may be counted toward the 12 weeks per year.
   a. In calculating the amount of leave the employee has used during the year, count the following:
      1. Medical Leave, Maternity Leave, Family Leave
      2. Personal Leave taken for Family reasons described above
      3. Vacation, Personal Days - All of the above will count toward the 12 week max. **NOTE: Federal law does not permit counting 1, 2 or 3 above that occurred prior to the effective date of the new law.**
   b. The employee has a right to take leave in half-day increments, when medically necessary to care for self or above family.
   c. Leave may be taken intermittently when the employer and employee agree.
   d. In both cases (half-day or intermittent) the taking of such leave results in a total reduction of the 12 weeks only by the amount of leave actually taken.
   e. In the event of spouses both working for McLaren-Oakland, the aggregate number of work weeks of leave is limited to 12 during any 12 month period, except for leaves due to (1) the serious health problem of the employee himself or herself, or (2) a serious health problem of a child or the other spouse. In these cases, each spouse is entitled to the full 12 weeks.

4. PAYMENT WHILE ON LEAVE
   There is no payment to the employee during the leave.

5. CONTINUATION OF BENEFITS

The Hospital will continue the employee's health and dental insurance for the first three full months of Family Leave. The appropriate pro-rating will be made for intermittent leave.

The Hospital's payment of Health and Dental Insurance for an employee on leave will be limited to three months per calendar year, regardless of the reasons for leave.

6. ACCRUAL OF SENIORITY, VACATION, AND SICK DAYS

Employees on Family Leave will continue to accrue seniority, sick days, and pro-rated vacation, as they currently do while on medical leave.

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7. MEDICAL CERTIFICATION

We will require employees to provide medical certification by a doctor of the serious health condition of the employee or family member, stating the following:

a. Date the serious health condition began
b. Probable duration
c. Appropriate medical facts regarding the condition
d. A statement that the eligible employee is needed to care for the family member
e. An estimate of the amount of time needed for such use

Second and third medical opinions may continue to be used in the case of illness of the employee.

8. ADVANCE NOTICE

The law provides that the employee must give 30 days advance notice of foreseeable medical treatment (for self or family member) and shall schedule the treatment so as not to disrupt unduly the employer's operations.

This advance notice is not required if the treatment requires earlier leave.

9. REINSTATEMENT

The new law requires reinstatement to the position held when the leave commenced, or an equivalent position with equivalent benefits and pay.

10. NEW TERMINOLOGY

The Hospital will continue to use the current Medical and Maternity Leaves, and the new Family Leave. Family Leave will be leave for childcare purposes and illness in the family as defined previously.

11. CERTAIN SALARIED EMPLOYEES EXEMPT FROM THE LAW

Department Heads, Administrators and attending physicians may not be covered by this policy. Their leave requirements will be handled in an individual manner.

Policy 128: DRESS CODE

McLaren-Oakland strives to establish and maintain an atmosphere appropriate to the healing arts. We are judged by our personal appearance as well as the service we render and our actions toward patients. The dress policy focus is to avoid extremes and to present employees to patients in professional attire.

All employees are expected to report to work in appropriate clothing. What constitutes proper dress codes for various classifications is determined departmentally. Departmental dress codes may be more stringent, but must adhere to the guidelines given herein as a minimum.

All safety requirements relative to clothing and accessories shall be adhered to. Department Heads and Supervisors are responsible for including specifics of dress codes during orientation and, periodically, in departmental meetings. Adherence to dress codes will be enforced by Supervisors, Department Heads and Administrative Heads.

Departmental dress codes, including color designations, are submitted to and approved by the President/CEO.

GUIDELINES

1. Scrub suits provided by the hospital are to be worn only in the following areas:
   a. Operating Suite
   b. Endoscopy Suite
   c. Ambulatory Surgery Area
   d. Other areas only in specific circumstances approved by the DME or Medical Director. At no time are scrub suits to be worn or carried out of the hospital.
2. If necessary to leave a restricted scrub suit area between cases for duties within the hospital, a clean white knee-length lab coat is to be worn.
3. Masks, headgear and shoe covers must be removed when leaving restricted area.
4. Clean white shoes are to be worn in restricted scrub suit areas. These shoes should remain in the area and should not be worn to or from the hospital. Shoe covers will be worn in restricted areas, changed when soiled, and removed when leaving the restricted area.
5. At conclusion of daily assigned duties in the restricted area, scrub attire is to be removed and replaced by appropriate street attire.
6. A clean white knee-length lab coat is to be worn at all times in non-restricted areas on hospital premises,
   a. Males are to wear dress shirt and neat trousers or slacks (ties optional),
   b. Females are to wear comparable attire; blouses must have jewel neck or collar and sleeves; skirt length must be mid-knee to mid-calf;
   c. No denim shirts or slacks are permitted,
   d. Shoes must have closed toes and heels, heels no higher than 2 inches, hose or socks must be worn,
   e. Jewelry must not be excessive.
7. No soiled portions of attire are acceptable in public or patient care areas at any time.
8. A pictorial identification badge must be worn prominently on white lab coat at all times while on hospital premises.
9. Hair, beards and mustaches shall be clean, trimmed and worn in a neat manner.

Policy 129: ADMISSION PROCEDURE

Patients are admitted and assigned beds by the Admitting Department. Admissions are considered "direct "or through the Emergency Department. Direct admissions are patients who are seen in the private physician's office and then sent to the hospital for admission. The attending physician calls the Admitting Department to reserve an admission date. The patient's diagnosis and other preliminary information are recorded with the Admission Office. The physician may send written orders with the patient, or by other means, i.e., leave them with Admitting, phone orders to the nurse or resident. On the date of admission all necessary forms are completed* and the patient is escorted to his/her room. Patients admitted through the Emergency Department (ED) are taken directly from the ED to their room; assigned by the Admitting Department. The Admitting Department informs the assigned corner of the admission and the patient's room number. The Emergency Room physician will write admitting orders. *NOTE: This includes surgical laboratory work-up done in out-patient.

House staff must see and evaluate all patients admitted to their service between 7 AM and 7 PM, unless you are on night call Monday-Friday, Although your rotation hours are 7 AM to 7 PM, it is not uncommon to be released earlier. You are not expected to return to the hospital to admit patients on your rotation once you have left the hospital. When you are leaving the hospital, you must "sign out" with the resident on call for that evening. If you do not sign out to the house officer, you may be asked to return to the hospital to complete a new admission. The intern and/or resident on call will see admissions to your rotation that evening. When you return to the hospital the next day, you may have history and physical examinations to complete on new patients.

When you are "on call", you will see patients admitted to your service between 7 AM and 7 AM. When you are on Medicine rotations, please come to the hospital at 7 AM to complete this work prior to morning report (7:30 AM). The number of history and physicals house staff is expected to complete is:

Medical students	4 per 24-hour period
Interns	No required number per 24-hour period
Residents	No required number

It is very important that the resident and or resident see all direct admissions. The intern or resident on call completes direct admission history and physicals. If there are any questions regarding a patient's orders, call the attending physician or the on-call resident for that specialty.

ASSIGNMENT OF ADMISSIONS FROM THE EMERGENCY DEPARTMENT

If a patient is admitted through the ED and does not have an attending physician, the ED physician shall assign an attending physician to the patient.

TRANSFER OF PATIENTS FROM ONE LOCATION TO ANOTHER

Patients transferred from their originally assigned area to another must be done through the Admitting Department. Patient transfer is requested through the floor nurse. When patients are transferred from the general medical floor (GMF) to ICU or Intermediate ICU (I-ICU), all orders must be rewritten.

FIRST CONTACT WITH PATIENTS

Greet each patient in a friendly and courteous manner. Tell the patient your name and what you are there to do. When nursing personnel check patient into bed, the resident on call is to be informed of the admission. Sometimes this is overlooked so the intern/OGME 1 must check the "admission box" several times a night for admissions. The intern/OGME 1 resident will call the senior resident and inform him/her of the new admission. Interns/OGME 1s should try to do all admissions on their respective medicine service; however, doing off-service history and physicals

is unavoidable. The intern/OGME 1 has a resident on call with him/her to help with these decisions.

If the intern/OGME 1 does the history and physical, he/she is to examine the patient, record the findings on the history and physical form and write admitting orders as necessary. The intern/OGME 1 should review the history and physical with his/her resident. If there are any questions regarding the patient, contact the attending physician, report the findings and discuss any orders to be written. Each new admission should be seen as soon as possible after admission. For evening admissions the history and physicals may "roll over" until the next day. **If a history and physical is assigned during the day, it must be completed THAT DAY.** Our history and physicals function as an admission note, also. However, if the patient has been admitted through the Emergency Department, for the benefit of house staff and nursing personnel, the Emergency Medicine physicians have been requested to write admitting orders. If there is a resident on a rotation, he/she will write a resident admit note (RAN) with their initial findings. The resident admit note is included in the history and physical.

The interns/OGME 1s and students are responsible for admissions on Medicine and Medical Subspecialty services, Pediatrics and Family Medicine. Admissions to General Surgery and Surgical Subspecialties are taken care of by the respective house staff on that service.

HISTORY

The history should be as complete as possible and include the following: chief complaint, present illness, past medical history, family history, and review of systems. The history should record clear, concise statements pertinent to the patient's complaints and illnesses including onset and duration of each. When the history and physical has been completed, the form must be included in the progress notes, signed and include your doctor number.

PHYSICAL EXAMINATION

A report of the physical examination is the result of a thorough examination of the patient and includes a detailed description of observations and findings. The terms "negative" and "normal" are opinions and not facts and should not be used except when summing up stated facts. A complete physical examination includes a pelvic examination, unless otherwise specified by the attending physician. It is performed only with the patient's permission and always in the presence of a nurse. No vaginal/rectal examination should be made of a minor without consent of her/his parent, guardian, or some other legally responsible member of the patient's family.

An osteopathic structural examination must be performed and documented in the physical record on all patients admitted to the hospital. The structural exam must include evaluations of scapular and pelvic heights, leg lengths, spinal curves and scoliosis, examination of paravertebral musculature for pain, spasm or limitation of movement. Each page of the history and physical, must be timed, dated, signed and include the doctor number. **The history and physical must be completed the day it is assigned.**

PROGRESS NOTE

Progress notes are specific statements by a physician relative to the course of a patient's illness including: examinations, response to treatment, new signs and symptoms, complications, surgical procedures, removal of drains, casts or splints, sutures, abnormal lab and x-ray findings, wound condition, development of infection or any other data pertinent to the course of the illness. The frequent use of general statements such as "condition fair", "general condition good", and "no complaints", are unscientific and valueless. **Progress notes are to be written daily on all patients on your rotation.** If there is a change of service during the stay of the patient, the person leaving the service should be sure that the progress notes are up-to-date and summarize the condition of the patient on the day leaving the service **(off service note).** The person coming

on the service will be responsible to carry on the progress notes from that time. All notes must be signed (not initialed) by the person writing the note and **include their doctor number.**

COMPLETENESS AND ACCURACY

The value of the medical record is in direct proportion to the thoroughness and accuracy with which it is written. It should be remembered that any record might be summoned for legal use, such as in compensation, accident and criminal cases. Prompt and accurate recording of the facts is particularly beneficial in such instances. All entries in the medical record must be complete and accurate. Both the success of handling a patient efficiently and the basis for good teaching and medical research are dependent upon the degree of accuracy with which the records are prepared. Incorrect information is worse than none**.**

CORRECTIONS TO THE MEDICAL RECORD

Erasures and black-out alterations on records are illegal and make the record valueless to the patient or the hospital in case of litigation. If corrections are necessary, a single line should be drawn through the words to be deleted and the new entry should be made. Chart entries are permanent and must be in permanent black ink. Notes are written out longhand. With the integration of computers into the medical field, computer generated notes are also acceptable. There are preprinted forms and orders for certain things, such as ED admitting orders and cardiac catheterization orders. Pencils and carbon copies are prohibited. The original reports, not the carbon copies, of special examinations such as x-ray and pathological examinations, are incorporated into the medical record. Neat, well-kept, complete records may help to advance medical knowledge. The condition of the records is one of the factors determining accreditation by the American Osteopathic Association. Not only is the patient's record a permanent reference file for subsequent admissions and for medical research, it is also a legal document and should be regarded as such. **Notations tinged with frivolity, inappropriate remarks, or implied criticism has no place in these documents. Notes or messages for attending physicians or other members of the house staff should not be written on the permanent record.** These may be written and attached to the outside of the chart, if necessary.

LEGIBILITY

All entries must be legible and signed, not initialed. Doctor numbers must follow all signatures. Treatments and medications should be carefully recorded as ordered, including dosage. Dates and hours should be carefully specified. Entries must be made consecutively, with a minimum amount of space between them. Abbreviations are to be avoided.

CARE OF RECORDS

Records are privileged confidential documents and must be safeguarded as such. Care must be taken that records do not fall into the hands of persons not authorized to review them. Therefore, insurance representatives, attorneys, etc., are required to present written permission of the patient and of the attending physician before reviewing a medical record. Only the attending physician gives information regarding the medical record to the patient. Records should be handled with care and treated with respect, particularly if they are bulky or show signs of wear.

Rules for Patient Records:

1. Must not be removed from the hospital.
2. Must not be taken to the dining rooms, lounges.
3. Must not be kept in desks or file drawers outside of the Medical Record Department.
4. Must not be kept in locked offices.
5. Must not be taken into patients' rooms. Write your orders and notes at the nursing station.

Records are to be removed from the Medical Records Department for the following purposes only:

1. For use by the physicians upon the patient's readmission to the hospital or return to the hospital for outpatient care.
2. For use by the resident or attending staff for reference or study with the Medical Records Librarian's knowledge and permission.
3. For use by other authorized hospital personnel upon request.
4. For use in court upon subpoena.

Attending staff or house staff may requisition a record for use within the hospital for teaching purposes. No record should be taken from the Medical Records Department without the knowledge of some member of the personnel in this department. If a record is required during hours when this department is closed, a request form should be completed and left in the medical records librarian's office.

In case of emergency, the Nursing Director or the Administrator on call may obtain the record. Special permission may be granted by the medical records librarian for use of a record at a scientific meeting outside the hospital, but these records must be properly accounted for at all times. Records properly charged out to specific individuals or divisions must not be moved from one place to another without notifying the Medical Records Department. Careful adherence to these regulations will facilitate the prompt location of records so that they may be made readily available when needed.

REQUIREMENT FOR COMPLETING RECORDS

House staffs, like attending physicians, are required to complete their records in a timely manner. Records that are over two weeks old may subject the house staff to disciplinary action, including possible suspension for a minimum of two (2) weeks without pay. House staff must report to medical records regularly while on in-house services to complete their records and avoid disciplinary action.

OLD CHARTS

When a patient is admitted, review the patient record system, to see if there is an old chart. This is a valuable source of information.

DISCHARGES

When a patient is discharged, the attending physician writes the discharge note and order. Occasionally, a patient may become dissatisfied and wish to leave the hospital without the doctor's permission. The intern/resident should explain the seriousness of such a step to the patient and try to dissuade them. If the patient insists, they must sign the form on the back of the admitting document, "Release from Responsibility for Discharge", stating the fact that they are leaving without the doctor's permission, and releasing the hospital and doctor from all responsibility for any complications which might arise because of this unauthorized departure. The form must be signed in the presence of a doctor or nurse and witnessed.

Policy 130: DEATHS

If death occurs, there are certain requirements to be fulfilled. The resident or resident who pronounces the patient dead promptly notify the attending physician. If more than one doctor was on the case, **courtesy demands that all be notified**. Death certificates from the Health Department are at the front office and the attending physician records the necessary information before they are given to the undertaker.

DEATH IN UNUSUAL CIRCUMSTANCES

If the patient dies while receiving emergency treatment for accident or possible foul play, the Police Department and the County Medical Examiner must be notified. The attending Emergency Room physician will telephone this information to the County Medical Examiner. The exact date and time of death must be recorded.

The following are classified as County Medical Examiner's cases and must be reported:

1. Death due directly or indirectly to any type of accident, no matter how long the patient has been in the hospital.
2. Death from pneumonia complicating a fracture of traumatic origin.
3. Death within 36 hours of admission to the hospital, when the patient has not been under medical care before admission to the hospital.
4. All suicide and deaths due to violence.
5. All poisoning cases, including overdoses.
6. All cases of abortion, self-induced.
7. All deaths that is suspicious for any reason.

Policy 131: CRITERIA FOR DEATH

There are occasions when a member of the house staff (intern/resident) is requested to pronounce a patient dead. Often, this is a frightening, confusing, and challenging experience for the physician. The criteria are to clarify and simplify this procedure with some workable recommendations.

A. Patient not on a ventilator
   1. All of the following should be evident prior to the decision of death,
      (a) No functional cardiac activity
      (b) Absence of spontaneous respirations
      (c) Fixed, dilated, non-reactive pupils

History must be considered because some conditions such as hypothermia, hypoglycemia, drug abuse, etc., may contribute in creating similar findings in the patient. However, for all intents and purposes, most patients with these signs, who have not responded to recommended resuscitation when indicated, may be pronounced dead.

B. Patient on a respirator may be pronounced dead prior to cessation of life support mechanisms:
   1. Evidence of brain death is present prior to pronouncement of death.
   2. The physician must document impressions in the progress notes including time of pronouncement. The attending physician should also document agreement of brain death prior to pronouncement. After the patient is pronounced dead, life support equipment may be terminated and removed.
   3. Other required steps physicians must follow:
      a. Immediate family is to be notified when the decision is made to terminate life support equipment.
      b. If the patient is a Medical Examiner case, the Medical Examiner's office needs to notify when the patient is pronounced dead.

C. Medical Examiner Case
   1. Any death not attributable to natural causes may be considered a Medical Examiner case. These include death by violence, drugs, accident, crib death, suicide, suspicious circumstances, etc.
   2. The Medical Examiner's Office must be notified in each and every case falling into this category. Even when the patient dies many months following the initial injury, it still remains a Medical Examiner's case.
   3. Transplant
      (a) A patient is to be pronounced dead prior to any transplant procedures instituted. If utilized, life support equipment should not be terminated until transplant is complete.
      (b) A Medical Examiner case may not be utilized for a transplant without clearance from the Medical Examiner's office rules and policies take precedence over those of the family, physician, and hospital.
   4. Autopsy
      (a) Medical Examiner cases - the Medical Examiner will determine if and when an autopsy is to be performed on these patients. Family wishes, physician requests, and religious beliefs rarely influence these decisions.
      (b) Nonmedical Examiner cases - the hospital pathologist will determine if and when an autopsy is indicated on these cases following a physician, hospital or family request.
   5. Release of Body
      Medical Examiner cases. Only the Medical Examiner may authorize release of a body in these cases involving a fall, trauma, injury or hospitalized less than twenty-four (24) hours.

Documentation is essential. Record in the progress notes each decision, activity and appropriate communications. There can never be too much Documentation when dealing with the issue of death and its myriad of legal pitfalls. If any questions arise, please contact the Medical Examiner's Office or the hospital Medical Director.

Policy 132: LECTURES

McLaren-Oakland has a formal lecture program. Attendance is **MANDATORY** every day while on in-house services. Interns/OGME 1s on call the previous night still must attend Noon lecture.
Subspecialty residents (neurology, cardiology, pulmonology, etc) are also REQUIRED to attend.
The Critical Care Team is exempt from Morning Report and Noon Lecture.

The lecture series schedule is shown below. It is expected that all interns/residents are present at the noon lecture if they are on a house rotation. Exceptions to this are emergent patient care and assisting in a case in surgery.

Surgery Rotations

Surgical Morning Report	6:30 AM	Monday, Wednesday, Thursday
Surgery Weekly Didactics	10-12 PM	Tuesdays
Trauma Conference	6:30 AM	1st Wednesday of month
Tumor Board	7:00 AM	2nd and 4th Monday of month
Noon Conference	12:00 PM	Monday through Friday

Orthopedics

Orthopedic Morning Report	6:15 AM	Daily

Radiology

Radiology Morning Report	7:15 AM	Monday, Wednesday, Friday
Trauma Conference	6:30 AM	1st Wednesday of month
Noon Conference	12:00 PM	Monday through Friday

Internal Medicine & In-House Medical Subspecialties

Mitchell Conference	**9 a.m. to 1 p.m on Thursdays (time varies**	
Morning Report (Case Report)	7 a.m. on Tuesdays and Thursdays in the Doctor's Dining Room	
OMM Case Report	7:00 a.m. on Wednesdays in the Doctor's Dining Room	
Radiology Review	once/month	
EKG Review	once/month	
Board Review	two times/month	
Morbidity and Mortality	quarterly	
IM/ER Morbidity and Mortality	monthly on Wednesday	
Chest Conference	once/month	
Ethics Conference	every other month on Wednesday at 12 p.m.	
Grand Rounds	every Friday	
Tumor Board	7:00 AM	2nd and 4th Monday of month
Trauma Conference	guest attending quarterly to every other month	
OMM Lectures/Workshop	one to two times/month	
Evidence-Based Medicine Conf.	yearly	
Radiology and Cardiology Conf.	monthly	
Radiology Conference	available daily, anyone may attend in radiology dept.	
Specialty Journal Clubs		

Pediatrics

Medicine Morning Report	Varies – see Intranet for schedule	
Noon Conference	12:00 PM	Monday through Friday

****Exempt from noon conference if rounding with attending**

Emergency Medicine

EM Conference	7:30 AM – 11:30 AM, Wednesdays	
Trauma Conference	6:30 AM	1st Wednesday of month

**Attendance at Morning Report or Noon Lecture is not mandatory while on Emergency Medicine. The attending EM physician may advise you to attend based on activity in the ER.

Family Medicine

Journal Club	8:00 AM	Tuesdays

**May attend additional lectures if in-house.

Anesthesiology, Critical Care Medicine, Other Surgical Subspecialties

Noon Conference	12 Noon	Monday through Friday

There is a Monthly Lecture Schedule. It is available on the McLaren-Oakland Intranet and posted in the Department of Medical Education. Please carefully check times of lectures, as well as locations. If an Intern/OGME 1 fails to attend on a regular basis, they may be required to make up missed lectures before graduating. **Interns/OGME 1s are required to attend 80% of lectures while on in-house services (days) and a minimum of 50% over the year.** Residents are generally required to attend 80% of their specific department's educational meetings. All interns and residents should attend the monthly Tumor Board.

Policy 133: PROCEDURES

House staff are expected to perform or assist in performing all procedures ordered on patients assigned to their service. Residents are expected to be knowledgeable in all phases of osteopathic medicine, through reading and participation in patient care. The intern/resident should be knowledgeable and develop expertise in the following areas. Residents' requirements are further described in their program description. **RESIDENTS OR ATTENDING PHYSICIANS WILL SUPERVISE INTERNS/OGME 1 RESIDENTS.**

MEDICINE
Bone marrow aspirations
Spinal taps
Insertion of nasogastric tube
Insertion of Foley catheter
IV techniques
Phlebotomy
Interpretation of laboratory values
Ventilation via respiratory therapy
EKG interpretation
Basic and advanced cardiopulmonary resuscitationAbdominal paracentesis
Thoracentesis

OBSTETRICS
Labor management
Catheterizations
Circumcision
Amniocentesis
Obstetric analgesia
Review of basic obstetrics
Fetal monitoring
IV therapy
Dilation and curettage
Gynecological-Surgical procedures
Drug therapy in obstetrics

ORTHOPEDICS
Orthopedic surgical techniques
History, physical, and structural examination of orthopedic patients
Osteopathic manipulative therapy
Review of x-rays
Casting
Myelograms
Fracture care
Arthrocentesis

OTOLARYNGOLOGY
Control of simple epistaxis utilizing proper technique
Removal of foreign bodies from ear, nose and throat
Repair of superficial lacerations of head and neck, which D.O. not involve major nerves, vessels or other vital structures
Care of post-operative tracheostomy patient
Other procedures involving otorhinolaryngology patients

SURGERY
Pre and post-operative management of surgical patients
Osteopathic exam of post-op patient

Suturing
D & C's
T & A's
Surgical techniques
Scrubbing techniques
Drain care
Dressings and wound management

PEDIATRICS
Femoral, jugular, and arterial punctures
Resuscitation of newborns, infants and children
Umbilical and saphenous cutdowns
Administration of I.V. fluids
Emergency procedures: seizures, coma, trauma, post-op bleeding, anaphylaxis
Drug therapy - use and abuse
Burn therapy - medical management
Asthma, diagnosis and therapy
Child abuse, diagnosis and management
Venous punctures blood specimens
OMT and physical examination of infants and children
Instruction with baby head intubation
Circumcisions

RESIDENT CLINICAL SERVICE EVALUATIONS
Upon completion of each rotation, the attending physician responsible for the service will complete a form evaluating your progress during his/her tenure including such things as your level of competence, ability to work with staff, motivation, accuracy of your H&P's, and daily progress notes. A review of the resident service logs will constitute part of your service evaluation. Failure to assume and complete your full responsibilities will be referred to the Medical Education Committee for further evaluation (see attached form).
The intern/resident will complete an evaluation of his/her rotation. This evaluation is anonymous. It will be turned in to Medical Education. There is a special file for evaluation of the rotations and attendings. The attendings will receive feedback on a quarterly basis regarding their rotation. This will be in the form of tabulated scores and a compilation of comments.

Policy 134: HISTORY AND PHYSICAL ASSIGNMENT PROTOCOL

History and Physical and Admission Note

It is the responsibility of the "on call" team to see all admissions to Medicine, Medical Subspecialties, Family Medicine and Pediatrics services when they are on call. If house staff from the appropriate service are available, the on-call team may ask the "on-service" house staff to see the patient. Although on-call interns/OGME 1s are responsible for these admissions, they are also responsible for call on surgical patients. This includes surgical subspecialties. These calls are handled by the on-call intern/OGME 1 and discussed with the appropriate resident. Patients are to be evaluated within one (1) hour of admission to the floor. Either the intern or the resident does this evaluation. The intern, medical student or resident will complete the history and physical form. The form must also be discussed with the attending physician and signed by the supervising resident.

The on-call team at night is responsible for evaluating all patients admitted between 7:30 PM and 7:30 AM. The on-call team consists of an intern/OGME 1 and student(s). The patient should be seen in a timely manner. The first year is to evaluate the patient, complete all items of the admission history and physical form. After its completion, this form should be reviewed with the resident's supervising resident.

The first year on call is responsible for a 24-hour period. Each student on call is responsible for a maximum of 4 admissions per 12-hour period. The on-service team will complete the remaining history and physicals the following day. Occasionally, off-service history and physicals will be given to medical students and interns.

House intern/OGME 1 will assign off-service history and physicals for that day. A tally of the history and physical assignments is posted outside the Medical Education Office. The intern/OGME 1 will carry a log of the history and physical assignments. All attempts will be made to assign on-service history and physicals.

In the event that there is no resident on that service, the intern/OGME 1 or student will review the case with the attending physician.

Weekend History & Physical Assignments

1. Medical students who are assigned to provide weekend coverage will check in with the on-call resident by 12 Noon on Saturday and/or Sunday. The medical students will receive a <u>maximum of three</u> history and physicals to complete. It is expected that the approximate hours a student will be at the hospital are from 12 Noon to 10 PM. The student should check out with the resident prior to leaving. Failure for students to complete the weekend history and physical assignments will necessitate a letter be placed in their file. **STUDENTS SHOULD NOT EXPECT TO DO THREE HISTORY AND PHYSICALS AND LEAVE. THIS SHOULD BE CONSIDRED A "SHIFT"**.
2. When there is an excessive number of history and physicals to be done, other interns/OGME 1s will be requested to help. This request may come from the chief intern/OGME 1, a chief resident or the Department of Medical Education.
3. The on-call intern/OGME 1 will keep a log of history and physical assignments in case a dispute arises. This log will be given to one of the chief medical residents or the Medical Education Department.

4. The cut off time for daily history and physical assignments is 5 PM on Monday through Friday.
5. The intern/OGME 1 who is on call for “house/general medicine” is responsible for H&P assignments.

PREADMISSION TESTING
Phone: 248-338-5502

Patients may have surgery scheduled while they are not admitted in the hospital. Prior to their surgery, they must have Preadmission Testing (PAT). Preadmission testing refers to the history and physical and associated ancillary testing that must be completed before surgery. This history and physical is commonly referred to as a PAT. PATs are scheduled on Mondays through Fridays. There are no PATs on weekends or holidays. PATs are done in the Admissions area that is located on the first floor of the West Tower.

The people responsible for the assignment of PATs are the general surgery interns/OGME 1 residents. There are usually two general surgery interns/OGME 1 residents monthly. There is a separate PAT beeper that the intern/OGME 1 resident will carry from Monday through Friday. Interns/OGME 1 residents will rotate this responsibility. **The beeper is #588.**

The intern/OGME 1 resident will call the registration clerk at 338-5305 on Monday through Friday by 7:00 AM. This should be done before the intern/OGME 1 resident goes into surgery. The intern/OGME 1 resident should request the patient’s name and the type of surgery. For example, if there is a student or resident on orthopedics and the patient will have an orthopedic procedure; attempts should make to assign the history and physical accordingly.

The PAT history and physical should be done in a timely manner. Students and residents will be released from rounds, lectures, surgeries or procedures to be sure that this occurs. **The chief** intern/OGME 1 resident **is the back-up for the surgical** intern/OGME 1 resident**.** If there is a significant delay in getting PATs done, Medical Education will be notified. The student or intern/OGME 1 resident is expected to be in the admission area by 1:50 PM.

The house staff that is available for PATs includes students, interns, and residents on general surgery, orthopedics and anesthesia. Other surgical subspecialties may also be asked to do PATs. This includes neurosurgery, urology and ENT. Students on other rotations may be asked to help with PATs in emergent cases. **ALL EFFORTS SHOULD BE MADE TO ASSIGN THE PAT TO THE SPECIALTY THAT WILL PERFORM THE SURGERY/PROCEDURE.**

Policy 135: PROCEDURE FOR CORRECTION OF ERRORS AND OMISSIONS IN THE MEDICAL RECORD

A. AUTHENTICATION
Each and every correction in a medical record shall be dated, timed, and authenticated by the individual making the correction. Initials are acceptable for the purpose of authentication, provided full initials (middle initial included) and identification number are used, and provided the initials and numbers are legibly written so that they clearly identify a particular individual.

B. INDIVIDUALS AUTHORIZED TO MAKE CORRECTIONS
1. Only the individual who made the original entry in a medical record shall be authorized to properly correct that entry.
2. If, for any reason, compliance with (#1 above) is impossible, the matter shall be referred to the hospital's President/CEO or his/her designee.

C. CORRECTION OF ERRORS IN THE MEDICAL RECORD PRIOR TO PATIENT DISCHARGE
1. Correction of One's Own Error. Any individual who discovers an error or omission of his/her own shall immediately upon discovery correct it. Correction of the error shall be as follows:
   a. Draw a single line through the discovered error. (DO NOT scribble over it, erase it, tear the incorrect portion off, "X" it out, or otherwise obliterate the incorrect entry.)
   b. Write the word "ERROR" either in the margin or at the end of the line containing the incorrect entry, followed by the time, date, and proper authentication of the individual making the correction.
   c. Log the correct information in close proximity to the original entry, if possible. Where the correction requires more space than is available near the original entry, record the correct information in a new entry in the medical record or in an addendum to the medical record. In either instance, the correct information must be separately authenticated, timed, and dated. Place a reference to the new entry or addendum in close proximity to the original entry.
   d. State the reason for the correction, along with the correct information, if the reason is relevant to and necessary to subsequent patient care.
2. Discovery and Correction of the Error of Another. Any individual that discovers the error or omission of another shall immediately upon discovery proceed as follows:
   a. Notify the individual who made the original entry. If, for any reason, this is not possible, the matter shall be referred to the President/CEO or his/her designee.
   b. Once notified, the individual who made the original entry shall correct the entry in accordance with (1) (a) - (d) above.
   c. In all cases, the individual who discovered the error shall dictate, type, or handwrite an addendum to the specific portion of the medical record where the error was discovered. This addendum shall set forth the facts as known by the individual discovering the error. The addendum shall be authenticated, timed, and dated.
   d. The individual who discovered the error shall also notify the Director of Medical Records so that correction of the error may be properly supervised.

D. CORRECTION OF ERRORS IN THE MEDICAL RECORD AFTER PATIENT DISCHARGE

1. Correction of errors in the medical record after patient discharge, but prior to completion of the record in final form, shall be made in accordance with the procedures set forth in Section C.
2. Under no circumstances shall any correction be made to any entry in a patient's medical record after the record has been completed in final form, except as may be authorized by the President/CEO or his/her designee.
3. Under no circumstances shall any correction be made to any entry in a patient's medical record where litigation has been threatened or filed with regard to that patient, except as may be authorized by the President/CEO after consulting with the hospital's defense counsel in the case.

E. NOTIFICATION OF ERRORS IN THE MEDICAL RECORD

Upon discovery and correction of an error in the medical record, every physician, nurse, or other individual who may have relied upon the original entry shall be notified of the error. The individual who made the original entry shall be the one responsible for notification. Those individuals so notified, as well as the time and date of notification, shall be indicated in an entry to the medical record. This entry shall be authenticated, timed, and dated.

F. INCIDENT REPORTS

Any individual who corrects an error in the medical record shall prepare an incident report in accordance with hospital policy. The report shall state the original entry, the corrected entry, the reason for the correction, the time and date of the correction, and the individuals notified of the correction.

G. PATIENT REQUEST FOR CHANGE OR AMENDMENT TO THE MEDICAL RECORD

In the event that a patient requests that a change or "correction" be made or his/her medical record, the patient's attending physician shall be notified. The attending physician shall discuss the request with the patient. If, after this discussion, the patient continues to request the change, this change shall be made in an addendum to the medical record. The attending physician or the Director of Medical Records shall thereafter make another entry to the record documenting the fact that the change was made at the request of the patient.

This procedure shall apply to all hospital employees, medical staff appointees and other individuals performing clinical services at McLaren-Oakland.

Policy 136: CARE OF PATIENTS

Purpose:

Compliance with Michigan Complied Laws section 750.411 requirements for reporting by physicians and licensed health facilities of injuries to patients as a result of violence; specifically, imposition of duty of disclosure by a licensed health facility and physicians when an individual presents with a wound or other injury inflicted by violence.

Policy:

McLaren-Oakland and its Professional Staff shall comply with legal reporting requirements related violently inflicted injuries. The requirement applies to any wound or injury inflicted by:

- a knife, a gun, any other deadly weapon; or
- by other means of violence which can include, but is not limited to:
  - beating or other forms of assaulting
  - biting
  - strangling
  - hitting
  - kicking
  - punching or
  - slapping

A physician reporter has no obligation to inform the patient concerning the reporting mandate; however, the physician may advise the patient concerning compliance with this state mandate.

In accordance with the statute, the hospital and Professional Staff suspend information disclosure prohibitions related to the physician-patient privilege (and other provider-patient privileges that exist under separate Michigan law). Therefore, neither physicians nor the hospital shall invoke said privilege to avoid compliance with reporting requirements. Michigan statutes support this suspension of disclosure of confidential medical information policies: (1) The reporting law includes a specific grant of civil and criminal immunity for people who make good faith reports, and (2) the state deems failure to report a criminal misdemeanor.

Procedure:

1. A physician who cares for a patient suffering from a wound or injury inflicted by any violent means shall promptly file a report with the Pontiac Police Department.

2. The physician shall report BOTH by telephone and in writing, and the report must include [see sample reporting format appended to policy], however the report shall not become part of the patient's medical record:
   a. patient name and residence, if known;
   b. patient location;
   c. cause, character, and extent of the injuries; and
   d. perpetrator's name, if known.

Policy 137: INFORMATION MANAGEMENT

Purpose:

To provide guidance to staff for obtaining permission to document a patient on visual or audio recording media, storage of recordings, and requirements for release of recordings.

Policy:

McLaren-Oakland shall protect its patients, within reasonable limits, from invasion of privacy that might occur from the use of patient photography, video recording, audio recording, digital imaging, or other imaging of patient during patient care or other hospital activities.

Definitions:

PATIENT PHOTOGRAPHY: The likeness of a patient recorded through a variety of visual means, including still photography, videotaping, digital imaging, scans, and others, but does not include medical imaging for diagnostic or treatment purposes such as x-rays, CT scan, MRI, fluoroscopy, etc.

HIPAA: The standards for privacy of individually identifiable health information, also known as the final privacy rule from the Health Insurance Portability and Accountability Act of 1996 as it addresses photographs and similar images:

> **Section 160.103** defines health information in a manner that implies inclusion of patient photography:
> "Health information means any information, whether oral or recorded in any form or medium, that:
> (1) is created or received by a health care provider, health plan, public health authority, employer, life insurer, school or university, or healthcare clearinghouse; and
> (2) relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of healthcare to an individual."
> **Section 164.514(b)(2)**, Implementation Specifications: Requirements for De-identification of Protected Health Information, photographic and comparable images are explicitly noted as an item to removed during de-identification in order for records to avoid the protected health information status and fall outside the regulations:
> "A covered entity may determine that health information is not individually identifiable health information only if:
>
> > (2)(I) the following identifiers of the individual or of relatives, employers, or household members of the individual, are removed:
> > (Q) Full face photographic images and any comparable images."

DOCUMENTATION OF PATIENT CARE:
Photographs represent part of the health care record. The hospital shall retain and release these records in accordance with applicable regulations, statutes, and hospital release of protected health care information policies.

TEACHING, EDUCATION AND RESEARCH:

1. Staff shall exercise all reasonable efforts to protect the anonymity of the patient in teaching, education and research patient photography.
2. Teaching, education or research patient photography shall not constitute a part of the patient's medical record.
3. Photography associated with a research study shall conform to the requirement established by the Institutional Review Board, including specific consents for release as necessary.
4. All recorded images or records of patients made pursuant to this policy shall remain the property of McLaren-Oakland and shall be used only in a manner determined by McLaren-Oakland.

PUBLIC RELATIONS AND ADVERTISING:
No patient photography taken in the hospital shall include identifiable images of other patients from whom similar approval to photograph has not been obtained.

MEDIA OR LAW ENFORCEMENT:

In accordance with the *Release of Information to the Media or News Media Contact Policy*, when representatives from the news media or law enforcement agencies ask to photograph a patient, permission may be given if (1) the patient's physician does not feel it would be detrimental to the patient and (2) the patient or his legal representative signs a written authorization form agreeing the photography. Law enforcement may also photograph patients pursuant to a valid search warrant or court order without a patient's consent.

Procedure:

1. The hospital shall include in its general consent for treatment and informed consent forms language addressing the obtaining, ownership, storage, and release of photographic images consistent with HIPAA provisions.

2. The hospital shall include in its *Notice of Privacy Practices* language addressing obtaining, ownership, use, and disclosure of photographic images.

3. Photography for cases involving suspected or actual patient abuse or neglect does not require consent from the patient or patient legal representative. Such photographs may be submitted with required reports to the investigating agency, but they cannot be used for other purposes (such as teaching) without patient or patient legal representative authorization.

4. Still photographs and scanned printouts obtained for medical reasons must be filed with the patient's medical record for safekeeping. Because of their size, videotapes and similar media may be filed separately in the Health Information Management Department or other secure area. Because photographs, video images, etc. may be considered part of the patient medical record, retention shall conform to the minimum period established for retention of a complete medical record.

5. Staff must obtain written authorization from the patient or patient legal representative prior to release of photographs, videotapes, or other media images to outside requestors.

6. Patient photography taken for teaching or educational purposes shall be retained in such a manner that staff can access individual patient media images or recordings with a reasonable amount of effort.

Policy 138: RESEARCH REQUIREMENTS

Purpose:

To ensure uses and disclosures of protected health information in connection with research in the form of medical record and related aggregate data review comply with the HIPAA Privacy Rule.

Definitions:

Individually Identifiable Health Information: a subset of health information, including demographic information collected form an individual, and (1) is created or received by health care providers, health plans, employer, or healthcare clearing house and (2) relates to past, present, or future physical or mental health or condition of an individual, the provision of health care to an individual, or the past, present, or future payment for the provision of health care to an individual; and (I) that identifies the individual; (ii) with respect to which there is a reasonable basis to believe the information can be used to identify the individual.

HIPAA: Health Insurance Portability and Accountability Act, and any subsequent amendments.

Privacy Board: a review body established to act upon requests for a waiver or an alteration of the Authorization requirement promulgated under the Privacy Rule for uses and disclosures of protected health information (PHI) for a particular research study.

Privacy Rule: Department of Health and Human Services regulations entitled *Standards for Privacy of Individually Identifiable Health Information* issued in response to a congressional mandate in the Health Insurance Portability and Accountability Act (HIPAA).

Protected Health Information (PHI): individually identifiable health information that must be protected when it is created, received, maintained, or transmitted by McLaren-Oakland.

Scope:

McLaren-Oakland Main Campus, Community Health Care Center – Oxford, Clarkston, Lake Orion Nursing Center, and Hospital Healthcare managed facilities.

Policy:

Background: The *Privacy Rule* at 45 CFR §§ 160 and 164 establishes a category of health information, defined as protected health information (PHI), that a healthcare facility may only use or disclose to others in certain circumstances and under certain conditions. In general, it requires an individual to provide permission, known as an Authorization before the facility can use or disclose the individual's PHI for research purposes. Under certain circumstances the Rule permits the facility to use or disclose PHI for research without an Authorization by obtaining proper documentation of a waiver or alteration of the Authorization requirement by an Institutional Review Board or a Privacy Board. The Rule also allows for disclosures of PHI as required or allowed by law.

McLaren-Oakland Privacy Board Charge

The Bioethics Committee Chairperson appoints the McLaren-Oakland Privacy Board members and a Chairperson who must be a member of the Bioethics Committee. The Privacy Board operates under this authority and in accordance with its standard operating procedures, the Health Insurance Portability and Accountability Act (HIPAA) and applicable McLaren-Oakland policies and procedures.

The McLaren-Oakland Privacy Board addresses privacy issues in proposed medical research involving medical record and related aggregate data review conducted by physicians or hospital staff who are employed by or otherwise affiliated with McLaren-Oakland. The McLaren-Oakland Privacy Board has authority to approve, require modification to, or prohibit such research activities that involve the use or disclosure of Protected Health Information. The McLaren-Oakland Privacy Board will review and address reports of privacy violations or complaints involving research governed by this policy.

The Privacy Board need not duplicate research project reviews conducted and approved by the hospital's designated Institutional Review Board unless so requested by that Board.

WAIVER OR ALTERATION OF AUTHORIZATION

The Privacy Board shall use the following criteria consistent with the Privacy Rule to evaluate and approve Authorization waiver or alteration:

- The PHI use or disclosure shall involve no more than minimal risk to the privacy of individuals based on at least the presence of (1) an adequate plan presented to the Privacy Board to protect PHI identifiers from improper use and disclosure; (2) an adequate plan to destroy those identifiers at the earliest opportunity, consistent with the research, absent a health or research justification for retaining the identifiers or if retention is otherwise required by law; and (3) adequate written assurance that the PHI will not be reused or disclosed to any other person or entity except (a) as required by law, (b) for authorized oversight of the research study, or (c) for other research for which the use of disclosure of the PHI is permitted by the Privacy Rule.
- The research could not practicably be conducted without the requested waiver or alteration, and
- The research could not practicably be conducted without access to and use of the PHI.

McLaren-Oakland shall limit the use or disclosure of PHI for research that is based on documentation of an approved waiver or alteration of Authorization to the minimum necessary to accomplish the intended purpose of the particular research protocol or project. Documentation supporting the Privacy Board's approval of a waiver or an alteration of Authorization must include a description of the PHI without access to and use of which the Privacy Board has determined the research could not practicably be conducted.

The tasks of the Board are to:

1. Review and approve, reject or defer Applications for Approval of Waiver of Patient Authorization under HIPAA;
2. Review and address reports of privacy violations or complaints involving research governed by this policy.

The McLaren-Oakland Privacy Board will meet as often as is necessary to make timely reviews of non-expedited applications awaiting disposition.

The Privacy Board members shall include:

1. Chair of the Privacy Board (McLaren-Oakland Professional Staff member)

2. Local community member (not affiliated with or related to any person affiliated with the McLaren-Oakland)
3. Privacy Officer (Health Information Management Director)
4. Risk Manager
5. Additional members as deemed beneficial appointed by the chair

Privacy Board Approval Proceedings

The Privacy Board's review and action on requests for approval of a waiver or an alteration of the Privacy Rule's Authorization requirement may be conducted through either the normal review procedures (review by the convened Privacy Board), or in certain cases (described below), through expedited review procedures. The Privacy Board shall maintain a record of its deliberations and shall convey its decisions to the requestor in writing.

REVIEW BY THE CONVENED PRIVACY BOARD

When the convened Privacy Board considers a request for a waiver or an alteration of the Authorization requirement, a majority of the board members must be present at the meeting, including one member not affiliated or related to any person affiliated with McLaren-Oakland. For an approval of a waiver or alteration of the Privacy Rule's Authorization requirement to be effective, a majority of the Privacy Board members present at the convened meeting must approve it. If a member of the Privacy Board has a conflicting interest with respect to the PHI use and disclosure for which a waiver or an alteration approval is being sought, that member shall disclose the nature of the conflict to the Privacy Board and may not participate in the review.

EXPEDITED REVIEW

The Privacy Board may use an expedited review procedure if the research involves no more than minimal risk to the privacy of individuals who are the subject of the PHI for which the use or disclosure is being sought. If the Privacy Board chooses to use expedited review procedure to act on a request, the review and approval may be carried out by the Privacy Board Chair or by one or more Privacy Board members designated by the Chair. Designees shall forward their decisions to the Chair. A member with a conflicting interest shall not participate in an expedited review.

Procedure:

CHART/DATA REVIEW
General information:

The Medical Education Committee shall pre-review all chart/data review project requests as with other research projects and will provide feedback to the requester on the scope and content of the study.

After the pre-review, the requestor will:

1. Obtain a C*hart/Data Review Request Form* from the Medical Education Department.

2. Contact a manager in the appropriate department(s) to obtain approval:

Medical Records - Contact: Supervisor or Director, Health Information Management Department

Non-Invasive Cardiology (EKG, Echo, Stress Test, Holter Data, EEG) – contact Manager, Non-Invasive Cardiology

Invasive Cardiovascular – contact Manager, Cardiovascular Laboratory

Pulmonary (Pulmonary Function Test, etc.) - Contact: Supervisor, Respiratory Care Services

Laboratory (Clinical Lab or Anatomic Pathology) - Contact: Director of Laboratories

Medical Imaging - Contact: Director or Manager, Medical Imaging

3. Complete, sign, and make two copies of the double-sided form. Retain one copy and return the original and a copy to the department housing the records.

4. The contact person for the appropriate department shall review the request to determine if the request is acceptable, reasonable, and if adequate resources are available to fulfill the request. If there are problems, the contact person notes the problems with the study and sends these comments to the requester with a copy to the Medical Education Department. If there are problems, the requester should attempt to work out the problem(s) with the department housing the records and/or their mentor or the Medical Education Department. If and when the department housing the records approves the study, the approval is then forwarded to the Medical Education Department. The department that houses the records keeps one copy of the request for their records.

5. The Medical Education Department reviews the chart/data request form to ensure completeness and forwards it to the Privacy Board. The Privacy Board then shall review the request. If the Board has questions concerning scientific merit, it shall forward a request for evaluation to the Medical Research function of the Medical Education Committee. To ensure that these chart/data reviews are reviewed timely, the requester must turn in any request a minimum of four weeks before data collection needs to begin.

6. If the protocol is found to be acceptable by the Privacy Board, the requester will be notified in writing on the attached *Documentation of Authorization of Waiver or Alteration Determination Form*. If the chart/data review is not approved, the person requesting the chart/data review will receive a written explanation of the basis for disapproval. If the chart/data review is approved by the Privacy Board, and the required signatures are obtained, then the requester may take the form to the department holding the records. The department will release the records to the requestor as indicated on the form. The study may begin when the requested department is able to fulfill the request as delineated in departmental policy and procedure. The department housing the records or data will keep the chart/data review request and copy of the form on file. See *Chart/Data Review Request Form*.

7. The Privacy Board chairperson shall periodically report Privacy Board activities to the Bioethics Committee

CHART/DATA REVIEW REQUEST

(Please Type and fill out both pages)

Requesting Person: _____ Date: _____

Position at McLaren-Oakland:

☐ Attending physician ☐ Resident ☐ Intern ☐ Medical Student ☐ Hospital employee

☐ Other: _____

Department: _____

Phone: (__)_____ Beeper/Answering Service: _____

Other Persons Involved in Review (name, department or address, phone):

_____

NAME DEPARTMENT OR ADDRESS PHONE

_____

NAME DEPARTMENT OR ADDRESS PHONE

_____

NAME DEPARTMENT OR ADDRESS PHONE

_____

NAME DEPARTMENT OR ADDRESS PHONE

Title of Project:

Type of Data Review (check one or more):

☐ Medical Records ☐ Medical Imaging ☐ Lab/Pathology ☐ Cardiology ☐ Pulmonary

☐ Other (specify):_____

Chart Review Summary:

(Describe purpose or problem studied, type of data and number of records to be reviewed, patient population to be studied, methods, data analysis, previous studies or references - continue on reverse side and/or attach additional sheet(s) as necessary):

Expected Number of Charts to be reviewed_____

(fill out other side)

Chart/Data Review Summary (cont):

I agree to maintain patient confidentiality. I will send the McLaren-Oakland Medical Education Department, 50 N. Perry Street, Pontiac, MI 48342, a copy of any papers/ abstracts or other material submitted for publication at least 7 days prior to submission.

_____ _____
Printed name of Requester Date Signature

_____ _____
Printed name co-investigator Date Signature

_____ _____
Printed name co-investigator Date Signature

_____ _____
Printed name co-investigator Date Signature

Reviewed by departmental section head (students, residents, and residents only):
Date: _____ By:_____

Reviewed by Medical Education Committee (Dr. Hatahet):
Date: _____ By: _____

Received and approved in department housing requested records on (if other than Medical Records):
Date: _____ By:_____

Signature of person who rendered care, if requester was not directly involved in the care aspect to be studied:
Date: _____ By:_____
Received in Medical Education Committee on (Date):_____

Action by Privacy Board: ☐ Approved ☐ Rejected ☐ Deferred to:
_____
Privacy Board by it's:

_____ _____
Chairperson or designee Date

MCLAREN-OAKLAND PRIVACY BOARD
DOCUMENTATION OF AUTHORIZATION WAIVER or
ALTERATION DETERMINATION

---

1. Name of Investigator(s):
_____

2. Title of Study:
_____

3. Description of the Protected Health Information (PHI) Determined to be Necessary to Study:
_____
_____
_____

4. Description of Requested Alteration If Applicable:
_____
_____
_____

The McLaren-Oakland Privacy Board has reviewed the request for ☐ waiver ☐ alteration in connection with the above-study under ☐ normal ☐ expedited review procedures. The Board has determined that the following criteria have been met:

- The use or disclosure of PHI involves no more than minimal risk to the privacy of individuals based on at least the presence of:

    1) An adequate plan presented to the Privacy Board to protect PHI identifiers from improper uses and disclosures;

    2) An adequate plan to destroy those identifiers at the earliest opportunity, consistent with the research, absent a health or research justification for retaining the identifiers or if retention is otherwise required by law; and

    3) Adequate written assurances that the PHI will not be reused or disclosed to any other person or entity except:

        a) as required by law;
        b) for authorized oversight of the research study, or
        c) for other research for which the use of a disclosure of the PHI is permitted by the Privacy Rule.

- The research could not practically be conducted without the requested waiver or alteration; and,

- The research could not practicably be conducted without access to and use of the PHI.

Therefore, the Board hereby approves the waiver or alteration.

_____	_____
Date	Chair, McLaren-Oakland Privacy Board or his/her designee:
_____	_____
Date	Member, McLaren-Oakland Privacy Board

PURPOSE:

POLICY:

McLaren-Oakland allows and encourages participation in biomedical and clinical research programs involving human subjects as well as the development of devices or products for human use. All such research conducted at McLaren-Oakland shall be governed by relevant Bioethics Committee policies and review by the hospital's contracted Institutional Review Board (IRB). Currently, this is the Providence Hospital and Medical Center (IRB).

The interdisciplinary Bioethics Committee shall determine the appropriateness of a proposed research study in relation to hospital resources and determine whether the research conforms to community standards for the conduct of research.

All research must abide by Federal regulations governing research involving human subjects (45 CFR Part 46; 21 CFR Parts 50 and 56).

Responsible Authority

The roles and responsibilities of the Bioethics Committee and the IRB are contractually defined in the agreement between McLaren-Oakland and the contracted IRB. A copy of that agreement is attached.

A. Members of the Bioethics Committee include physician representatives from the various medical and surgical specialties, nursing administration, case management/social work, Risk Manager and or legal counsel, and at least one lay community representative. The Bioethics Committee will have the following responsibilities:

1. Conduct further review of approved IRB projects, as appropriate, and may deny a project regardless of IRB review. The Bioethics Committee cannot approve a research study that has been denied by the IRB.

2. Notify the IRB of any research at McLaren-Oakland that requires review.

3. Notify the IRB of all communications to and from the Food and Drug Administration (FDA) and the Office for Human Research Protections (OHRP).

4. Take reasonable measures to ensure that research is conducted in accordance with federal and protocol guidelines.

5. Ensure that internal support services, such as the pharmacy and radiology, are aware of the research and have sufficient resources to support the conduct of each study.

6. Assign a member of the Bioethics Committee as a contact person for the IRB. This person is responsible for all communication between the IRB and McLaren-Oakland. This includes the receipt of monthly reports and verifying that all relevant information is transmitted to appropriate parties and departments within the hospital.

7. Take reasonable actions to require investigators to use the IRB for the review of all patient studies conducted at McLaren-Oakland.

8. Make certain that all data designated "proprietary and confidential" remains proprietary and confidential.

9. Will enforce HIPAA *Privacy Rule* requirements for research studies.

10. Will ensure compliance with federal document filing requirements including the federal-wide assurance (FWA).

B. Per contract, the IRB will have the following responsibilities:

1. Review application for research involving human subjects, per 21 CFR 50 & 56, and 45 CFR 46.

2. Review applications for waiver of informed consent.

3. Review applications for expedited review.

4. Provide McLaren-Oakland on a monthly basis with copies of approved subject information, informed consent forms (ICFs), and applicable minutes for each review.

5. Promptly notify McLaren-Oakland of any new research at the hospital, as well as:

   a. Suspension or termination of IRB approval for research.
   b. Unanticipated problems involving risks to human subjects or others.
   c. Instances of serious or continuing investigator non-compliance with federal regulations or the determinations and requirements of the IRB.

6. Be available for consult in cases of federal agency audits or informal inquiries.

7. Be available if the FDA or OHRP expresses concerns about compliance with federal regulations.

PROCEDURE:

I. Standard Process

A. The Approval Process. In order to complete research at McLaren-Oakland, each investigator must:

1. Complete the *Pre-Application for Research* form (attached) and submit it with a copy of the protocol, and all related materials (including advertising) to the Medical Education Department, MCLAREN-OAKLAND Medical Center, 50 N. Perry Street, Pontiac, Michigan 48342. This form must be completed prior to Medical Education Committee review. The Medical Education Committee administrative assistant will forward the documents to individuals designated below and then review the pre-application prior to forwarding to the Bioethics Committee to verify that:

   a. The form is completed in its entirety.

   b. The principal investigator is on staff at McLaren-Oakland. [A McLaren-Oakland physician must serve as McLaren-Oakland principle investigator for purposes of involvement at McLaren-Oakland; however, the overall principle investigator for a multi-site project originating at another institution may be a non-staff physician but must be identified on the application.]

   c. A copy of the protocol where applicable has been received in the Pharmacy.

   d. A billing address for medical care costs related to the study is provided.

   e. The Risk Manger or legal services has reviewed and accepted the proposed ICF confirming that the attached document contains a description of potential benefits, potential risks and discomforts, an explanation of the study procedures, the subject's right to refuse participation, and the right of the patient to refuse without compromising medical care and treatment.

   f. The Risk Manger or legal services has reviewed and confirmed that the proposed ICF contains the IRB-approved McLaren-Oakland liability clause.

   g. The Risk Manger or legal services has reviewed and confirmed that the proposed ICF conforms to HIPAA guidelines.

2. The Medical Education Committee reviews the proposal for scientific merit and adequacy of informed or waiver of consent. If approved, the Medical Education Committee administrative assistant forwards to the contract IRB. If disapproved, the assistant will remand the study to the requestor and include the recommendations made by the committee; no further action will occur at the committee level until the application with remedies to concerns has been re-submitted.

3. For Medical Education Committee endorsed studies: If approved by the contract IRB, the Medical Education Committee administrative assistant shall forward all related study documents to the Bioethics Committee administrative assistant.

4. After the Bioethics Committee administrative assistant has reviewed the application for completeness, it will be forwarded to the Bioethics Committee with the administrative assistant's affirmation of completeness. If incomplete, the administrative assistant will return the application to the Medical Education Committee administrative assistant to obtain necessary materials. The Bioethics

Committee will review complete application documents and notify the principal investigator of its decision. If approved, the Committee will forward the approved documents to the Medical Education Department and notify the contract IRB.

5. If the application is approved, the Bioethics Committee administrative assistant will inform the principal investigator that the study may begin, or that the study may begin pending the completion of necessary in-hospital activities. Such activities may include the training of staff, contacting all departments that would be affected by the study, or working with the Clinical Pharmacy Coordinator as applicable. Written acknowledgement of the completion of these activities will serve as the final approval of the Bioethics Committee. If the application is denied, the Bioethics Committee administrative assistant will notify the principal investigator.

II. Exceptions to the Approval Process

Emergency use of an investigational drug or biological product, as defined by the FDA, is the use of a drug or biologic product not approved by the FDA on a human subject in a life threatening situation in which no standard acceptable treatment is available, *and* in which there is insufficient time to obtain IRB approval. FDA regulations must be followed for the purpose of this process, unless otherwise indicated. FDA regulation of emergency use is designed to permit only a single emergency use of an investigational drug for the treatment of one patient by one physician within an institution. Formal IRB review and approval is required prior to subsequent use. OHRP permits emergency use of an investigational drug without prior approval, if such use is reported to the IRB and the Bioethics Committee within five working days and the data collected from the patient is not used for research purposes. The Pharmacy will work with staff physicians to obtain medications that are required on an emergency use basis.

A. Qualification for Emergency Use

1. The human subject is in a life-threatening situation, defined by the FDA as a situation where the likelihood of death from disease(s) or condition(s) is high unless progression of the disease or condition is interrupted.

2. There is insufficient time to obtain IRB approval.

B. Emergency Use Process

1. The attending physician (investigator) must notify the Bioethics Committee of the request for emergency use of an investigational drug. The Bioethics Committee administrative assistant will notify the chair of the Bioethics Committee, the VP for Medical Affairs, and the clinical pharmacy coordinator.

2. An *Emergency Investigational Drug Use* form will be initiated by the pharmacist and retained in the Pharmacy.

3. The Pharmacy will verify that the investigational drug has not been used previously on an emergency basis at McLaren-Oakland.

4. The investigator must contact the IRB to determine whether a formal review is possible prior to the administration of the product. Per FDA regulations, a drug can be given on an emergency basis without IRB approval only if the patient is in a life-threatening situation and there is insufficient time for the IRB to convene.

5. If IRB has time to approve the emergency use, the approval will be sought prior to the administration of the product.

6. If IRB approval is not available, authorization for use may be obtained by contacting the chairperson of the Bioethics Committee, or his/her designee. The requesting physician must call the Bioethics Committee administrative assistant at 248.338.5442 or the Medical Staff Office at 248.338.5300 to contact the chairperson or the designee.

7. To document this approval, the authorizing physician must notify the Pharmacy.

8. The investigator must contact the pharmaceutical company's study monitor to discuss the details of the case. If unknown by the investigator, the appropriate information may be obtained from the Pharmacy at 248.338.5479.

9. Drug supply should be shipped directly to the Pharmacy and dispensed from the Pharmacy only on the order of the authorized prescriber for the designated patient. If IRB approval was not obtained, and the manufacturing company will not ship the drug without authorization from IRB, the Bioethics Committee administrative assistant will contact the IRB to obtain a letter documenting IRB awareness of the emergency use.

10. The Pharmacy will receive, dispense, account, and provide information about the investigational agent. Furthermore, the Pharmacy will destroy or return any unused portion of the study medication at the end of the trial.

11. The investigator is responsible for administering informed consent to subjects. ICFs must become part of a patient's permanent record.

12. Exceptions from the informed consent requirement (FDA only) must be certified in writing by the investigator and a physician who is not participating in the research. If there is insufficient time to obtain a second, independent physician opinion, the product may be administered under the condition that a written evaluation of the independent physician is completed within five working days.

13. If the IRB did not give prior approval, the investigator must submit information about the emergency use to the IRB within five working days of the incident. The IRB will acknowledge the emergency usage after review.

14. The principal investigator is responsible for submitting a written request for formal IRB review for any subsequent use of any drug or devise within 30 days. This includes additional use for the same patient.

15. Completed *Emergency Investigational Drug Use* forms will be kept on file in the Pharmacy under the investigator/physician's name. The Bioethics Committee coordinator will report all emergency drug requests to the IRB.

III. Expedited Review

Expedited Review, per FDA and OHRP guidelines, is an abbreviated form of review for research involving no more than minimal risk or minor changes in approved research. The expedited review process is as follows:

1. The principal investigator will submit all required materials to the Bioethics Committee and the IRB.

2. The IRB will determine whether the research qualifies for expedited review under current Federal guidelines. If unqualified, the standard approval process must be followed. If qualified, it will be forwarded for review and will not be presented to the entire IRB board.

3. Upon approval, the IRB will notify the Bioethics Committee administrative assistant, who will alert the Bioethics Committee and the principal investigator that the research may begin.

IV. Patients Admitted to McLaren-Oakland Who Are Participating in Research Studies Not Reviewed by and/or Approved by the Bioethics Committee or the IRB

A. The following scenario should serve as a guideline for the use of investigational products when a study patient enters a second institution.

B. A patient enrolled in a clinical research trial that McLaren-Oakland is not participating in presents to the hospital. The patient's hospitalization is not related to his/her participation in the research study. The following procedures must be followed:

1. The attending physician at McLaren-Oakland will determine if it is appropriate for the subject to continue participating in the trial.

2. The attending physician will notify the primary principal investigator of the subject's admission to the hospital.

3. Prior to the administration of any investigational agent, the attending physician at McLaren-Oakland will obtain all of the following:

   a. Description of treatment procedures.

   b. Warnings of possible adverse reactions.

   c. Descriptions of any emergency procedures.

   d. A copy of the subject's ICF, including addenda.

4. Neither the Bioethics Committee nor the IRB are obligated to review the protocol because McLaren-Oakland is not participating as a research site and is providing only incidental medical care.

5. The Pharmacy and physician should follow the "patient-may-take-own-medication" policy.

6. The principal investigator remains responsible for test drug administration and follow-up.

V. Conduct During Studies

A. Although the IRB is responsible for ongoing review, MCLAREN-OAKLAND is responsible for supervising the conduct of clinical trials performed within the hospital. While conducting clinical trials, investigators must adhere to the following guidelines:

1. The ICF must be signed by the subject and the principal investigator (or a qualified member of his/her staff) and must be attached to the subject's medical record at all times. When a new subject has been consented, the investigator must immediately notify the Bioethics Committee.

   a. For trials that dispense medication through the Pharmacy, a copy of the ICF must be provided prior to the release of study medication. This satisfies the requirement of providing the Bioethics Committee with a copy of the ICF.

   b. For trials that do not use the Pharmacy, a voicemail message indicating the subject's name, trial, and location in the hospital must be left at 248.338.5442. The Bioethics Committee coordinator will review the subject's medical record in order to verify that consent was obtained and placed in the subject's record. The Bioethics Committee administrative assistant will then retain a copy for the Bioethics Committee files.

2. The Bioethics Committee and the IRB must be notified within 24 hours of any serious adverse event (SAE) occurring within the hospital. All other SAEs must be reported within 72 hours of the occurrence. The Bioethics Committee can be reached through the Medical Staff Office at248.338.5442 or 248.338.5300. The Pharmacy Director should also have notification of SAEs at 248.338.5479. The chair of the Bioethics Committee or the Vice President for Medical Affairs will recommend further action.

3. Standardized protocol orders must be used for each subject.

4. The principal investigator will provide written reports on any changes significantly affecting the conduct of the study, and/or increasing the risk to subjects, to the Bioethics Committee and the IRB on a timely basis.

5. The principal investigator will do everything possible to minimize confusion, misinformation, stress, physical discomfort, or other harmful consequences to research subjects during and after research procedures.

B. Post-study review results will be presented to the Bioethics Committee.

1. Auditing.

   a. After each clinical research admission or visit, the study-patient's account will be reviewed for charges related to the research study. Any research-related charges not covered by Medicare or another third party will be removed from the patient's account and transferred to a second account. The second account will be billed to the appropriate parties (e.g., the study sponsor, the investigator, etc.).

2. The Bioethics Committee administrative assistant will verify that the ICF is included in the medical record maintained by the Health Information Management Department. The results of these reviews will be reported to the Bioethics Committee. A chair of the Bioethics Committee will report the results to the Hospital Practices Committee. In addition to the requirements of the approval process, Health Information Management staff shall review the ICFs to determine the following:

   a. That it is located in the subject's chart.

   b. The name of the person who administered the consent is recorded.

   c. The date that the ICF was signed is recorded.

   The principal investigator will be notified of any deficiencies, and must address these deficiencies promptly. When appropriate, the Bioethics Committee may ask the investigator to report the deficiencies to the IRB and/or the sponsor of the study.

3. The Bioethics Committee reserves the right to recommend disciplinary action if an investigator does not comply with the policies and procedures of McLaren-Oakland. Disciplinary action may include revocation of the investigator's rights to conduct research at McLaren-Oakland.

Policy 139: PHLEBOTOMY, PHYSICIAN-REQUIRED INTERVENTION

PURPOSE:

To obtain phlebotomy specimens timely when nursing or laboratory personnel are unable to obtain them.

POLICY:

Nursing and laboratory personnel shall limit the number of unsuccessful phlebotomy attempts per patient draw episode to a maximum of two. Following the maximum of two attempts, the patient will be deemed a physician draw. When nursing or laboratory personnel determine they will be unable to obtain the necessary specimen, they will follow the procedure below:

PROCEDURE:

1. When phlebotomists (or nursing staff on units with phlebotomy delegated to nursing staff) determine they are unable to obtain the requested specimen either due to two failed attempts or when two phlebotomists (or nursing staff on units with phlebotomy delegated to nursing staff) determine that the probability of obtaining the specimen is markedly limited, a phlebotomist (or nursing staff) shall notify the registered nurse responsible for the patient's care (or the charge nurse if that nurse is unavailable).

2. The registered nurse receiving the notification of failed phlebotomy shall contact the intern or resident on the service to obtain the specimen. If the intern or resident on the service is unavailable, the registered nurse shall contact the house officer. The intern or resident notified is responsible for obtaining the specimen within two hours of notification for routine testing (within 30 minutes for 'stat' or one hour for 'now' testing). If the intern or resident is unable to obtain the specimen, the intern or resident must promptly notify the attending physician and obtain further instructions. Once notified the attending physician assumes responsibility for the course of action. The intern or resident shall contemporaneously document this interaction with the attending physician in the medical record. Within these time limits, they shall write an order to either cancel the original order (including reason for cancellation) or provide further direction concerning obtaining the specimen.

Policy 140a: INTERN, RESIDENT AND FELLOWSHIP PHYSICIAN JOB DESCRIPTION AT MCLAREN-OAKLAND

The intern, resident or fellow staff physician must meet the qualifications for intern, resident or fellow eligibility outlined in the American Osteopathic Association's Basic Documents for Postdoctoral Training.

As the position of intern, resident and fellow 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 intern, resident or fellow staff physician is evaluated on a regular basis (see specific program description included with this manual for details). The program maintains a confidential record of the evaluations.

The position of intern, resident and fellow staff physician entails provision of care commensurate with the intern, resident or fellow staff physician's level of advancement 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 of 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, residents and students, and participation in institutional orientation and education programs and other activities involving the clinical staff (see specific program description included with this manual for details);

- participation in institutional committees and councils to which the intern, resident or fellow staff physician is appointed or invited; the Intern/OGME 1 resident class will annually select a Chief Intern/OGME 1 Resident who will represent the class on the Medical Education Committee; all Chief Residents will represent their program on the Medical Education Committee; and

- performance of these duties in accordance with the established practices, procedures and policies of the institution (e.g., Policies 107 a and b- Duty Hours and Moonlighting) and those of its programs; clinical departments and other institutions to which the intern, resident or fellow staff physician is assigned; including, among others, state licensure requirements for physicians in training, where these exist.

- Maintain membership in the American Osteopathic Association (AOA), the Michigan Osteopathic Association (MOA) and the Oakland County Osteopathic Medical Association (OCOMA).

Policy 140b: CHIEF INTERN/OGME1 RESIDENT DESCRIPTION OF DUTIES

Title: Chief Intern/OGME 1 Resident

Duration of Responsibilities: 12 Months

Appointment: Selected by the Intern/OGME 1 Resident class

Qualifications: Intern/OGME1 resident, evidence of leadership, organizational and communication abilities and skills. Professional attitude.

Duties and Responsibilities:

1. Representation: Represents the Intern/OGME 1 Resident class on the Medical Education Committee, and in other intern/resident related activities.

2. A Liaison between the interns/OGME 1s for information and problem solving.

3. Orientation: Participate in planning and presenting orientation for the next resident class during the end of June and the first week in July.

4. Recruitment and Selection: Assist in interviewing candidates for OGME 1 positions and with other recruitment at the request of the Program Director and/or DME.

5. Problem Solving: Deal with problems involving interns/OGME 1s in the program. These problems may involve other interns, residents, attending physicians, medical students, auxiliary staff or administration, etc.

6. Assist in Planning and Organization of Teaching Activities: e.g., Journal Club on a monthly basis, conferences, interesting case presentations, or any other meetings/educational activities that require the presence of residents, e.g. the annual research presentation by residents.

7. Educational Activities: Coordinate teaching and conference participation of the residents and medical students with residents.

8. Regular Meetings with the Program Director, Department, Medical Education Committee, others as assigned by the Program Director and/or DME.

9. Attend and/or assign participation with approval of the Program Director on standing medical staff committee (see addendum for requirements, based on specialty).

10. Other Functions and Duties: As assigned by the Program Director and/or DME.

Policy 140c: CHIEF RESIDENT DESCRIPTION OF DUTIES

Title: Chief Resident

Duration of Responsibilities: 12 Months

Appointment: Nominated by the Department; approved by the Medical Education Committee

Qualifications: Final year (or senior level) of residency, evidence of leadership, organizational, communication abilities and skills, professional attitude. Candidate cannot be "out of house" more than three months during the year.

Duties and Responsibilities:

1. Representation: Represents residents to their Department, the Medical Education Committee, and in other residency related activities.

2. A Liaison between the residents for information and problem solving.

3. Orientation: Participate in planning and presenting orientation for residents and OGME 2 residents during the end of June and the first week in July.

4. Recruitment and Selection: Assist in interviewing candidates for OGME 1 and 2 positions and with other recruitment at the request of the Program Director and/or DME.

5. Scheduling: Annual and monthly rotation schedules; night, weekend and holiday call scheduling to provide appropriate coverage, as well as vacation scheduling.

6. Problem Solving: Deal with problems involving residents in the program. These problems may involve other residents, residents, attending physicians, medical students, auxiliary staff or administration, etc.

7. Annual Evaluation of the Program by Residents: See that the residents complete these evaluations in a timely fashion and provide information feedback.

8. Assist in Planning and Organization of Teaching Activities: e.g., Journal Club on a monthly basis, conferences, interesting case presentations, or any other meetings/educational activities that require the presence of residents, e.g. the annual research presentation by residents.

9. Educational Activities: Coordinate teaching and conference participation of the residents with residents and medical students.

10. Regular Meetings with the Program Director, Department, the Medical Education Committee, others as assigned by the Program Director and/or DME.

11. Attend and/or assign participation with approval of the Program Director on standing medical staff committees (see addendum for requirements, based on specialty).

13. Other Functions and Duties: As assigned by the Program Director and/or DME.

Policy 141: Social Networking

The purpose of this policy is to ensure compliance with McLaren-Oakland and McLaren Health policies when employees are engaged in web activities. Web activities are defined as internet communications including but not limited to social networking sites (e.g. *Facebook, Myspace, YouTube, Twitter*), blogging, bulletin boards and chat rooms.

McLaren-Oakland residents are expected to comply with all McLaren Health privacy and social networking policies, when employees are engaged in web activities. When engaged in web activities and unless specifically required for your job:

- do not share confidential or proprietary information about McLaren Health or McLaren-Oakland, fellow employees, patients, business partners, and subsidiaries,
- maintain patient confidentiality and do not share any protected health information, including patient images,
- do not utilize your McLaren-Oakland email address as your primary means of identification when posting personal views,
- do not utilize McLaren-Oakland or McLaren Health logos, images in your communication without express written consent from the corporation,
- if you identify yourself as a McLaren-Oakland employee, make it clear that you are speaking for yourself and not on behalf of McLaren-Oakland or McLaren Health,
- avoid statements about McLaren-Oakland or McLaren Health or its employees that are defamatory, obscene, threatening or harassing.

Resident conduct in violation of this policy may be subject to corrective action, up to and including termination.

Policy 142: Trainee Activity Logs

PURPOSE:

The American Osteopathic Association (AOA) as the accreditation agency for Osteopathic Graduate Medical Education requires housestaff to maintain activity logs documenting participation in patient care and educational activities. Activity logs provide documentation required to ensure adequate training and educational exposure and are required to maintain accreditation of training programs. In addition, logs provide the trainee with documentation required for future hospital credentialing.

POLICY:

Housestaff will complete a monthly activity log. The log will document the following:

a. Patient care activity (including interpretations of diagnostic procedures)
b. Invasive procedures
c. Osteopathic treatments and evaluations
d. Lectures and meetings attending
e. Reading

PROCEDURE:

Housestaff (Interns, Residents, Fellows) will concurrently complete monthly activity logs.

It is the responsibility of the trainee to complete the logs and deliver them to the Department of Medical Education at the end of the rotation.

Logs will be considered delinquent 15 days after completion of their rotation. Delinquent logs are not acceptable. Trainees with logs outstanding more than 15 days will not participate in patient care or educational activities until their logs are completed and submitted to the Department of Medical Education. Such time will be charged to the Trainee as PTO (paid time off) time. In the event the Trainee has utilized all their available PTO time for the year, the time required to complete and submit the logs will be added to the training

Trainees with logs delinquent more than 30 days following the rotation program will be prohibited from any outside professional activities (“moonlighting”) until the logs have been completed and accepted by the Department of Medical Education and the Director of Medical Education has approved the resumption of moonlighting activities..

Housestaff who are repetitively delinquent in submission of their logs (more than twice in any 12 month period) will be prohibited from moonlighting activity for at least 6 months after their logs are complete. Records of delinquency will be maintained in the Trainees’ file and may be available to prospective employers and hospital credentialing committees.

No training program will be considered complete until all monthly activity logs have been accepted by the Department of Medical Education

The Department of Medical Education will maintain the activity logs of the Trainees’ file in accordance with the AOA requirements.

ANESTHESIOLOGY ROTATION

Work Schedule:
- Monday 7:00 AM to 4:00 PM
- Tuesday through Friday, 6:30 AM to 4:00 PM

Attending physicians:
- Dr. Stoyanovich, D.O.
- Dr. Urbanowski, D.O.
- Dr. Ateeq, M.D.
- Dr.Kramer, D.O.
- Dr.Owens, M.D.

Residency Program Director:
- Dr. Kramer, D.O.

Residents 2012-2013:
- Ashley Prince & Lora Rigsby: OGME-4
- Miranda Reed & Chris Tresnicky: OGME-3
- Lindsey Kushner: OGME-2

This rotation provides exposure of the resident to the daily practices of the anesthesiologist inside and outside of the operating room. The rotation should be completed either in a two or four week block. It is expected that the resident will become more knowledgeable in basic pharmacology and physiology as well as evidence based practice guidelines in current anesthesia management.

Please seek out one of the above mentioned anesthesia personnel on the first day of your rotation and identify yourself! The OR is fast paced and unpredictable; therefore, it is your responsibility to be visible and seek out cases that interest you. Anesthesia residents are available to answer questions and will help you to get the most out of your rotation but you must be in the OR for that to happen. We understand that this rotation is very different in that the OR schedule is always changing and that can make it difficult to have a set resident "routine." If you have downtime please take advantage of the medical library and utilize it to your educational advantage.

The resident is expected to adhere to the following guidelines:

1. The resident will be given a monthly education schedule at the beginning of his or her rotation; instructions for required readings will be found at the bottom of the schedule. The education calendar is posted on the bulletin board in the physician lounge off of the OR if you need to refer to it at any time.
2. The resident will report to the Anesthesia Department (physicians lounge off of the OR) at 6:30 AM on Tuesday through Friday for lecture or board review DVD; there is no lecture schedule on Monday mornings due to the early OR start; report at 7:00AM on Monday.
3. The resident will review the anatomy and physiology of the respiratory tract with special emphasis on structures contributing to the Mallampati airway evaluation.
4. The resident will accompany the attending anesthesiologist and resident during preoperative evaluations and become familiar with an airway examination and obtaining a pertinent anesthesia related history.
5. The resident will become familiar with the techniques of venipuncture, lumbar puncture/subarachnoid block, endotracheal intubation, and LMA insertion.
6. The resident should attend the noon lecture series in medical education whenever the OR schedule is permitting.

The goals of this rotation are to:

1. Increase the acquisition of knowledge in the field of anesthesiology.
2. Introduce the resident to basic procedures in this field.
3. Provide knowledge in choosing the anesthetic plan on a patient and case specific basis.
4. Promote the resident's professional development as a physician.
5. Participate in the preoperative, operative and post-operative management of patients alongside the anesthesiologist.
6. Observe and participate in the placement of arterial lines, central lines, and neuraxial blockade.
7. Understand the challenges of the preoperative medical clearance for surgical patients as viewed by the anesthesiologist, including but not limited to: NPO guidelines, pre-op cardiac testing, beta-blockade, blood availability, special monitoring devices.

Objectives:

1. Endotracheal intubation and LMA insertion
2. Approach of the difficult airway.
3. Placement of arterial lines, central lines and other critical processes during the anesthesia rotation.
4. Anesthetic involvement with the management of the patients with specific types of surgery such as thoracic surgery, pediatric surgery, general surgery, orthopedic surgery, gynecologic surgery (including robotic assisted), neurosurgery, ENT surgery and maxillo-facial surgery.
5. Induction of anesthesia: drugs, doses, contraindications, side effects.

The department of Anesthesia looks forward to having you join us in the 2012-2013 academic year! Please feel free to bring any questions that you might have relating to anesthesiology and we will do our best to answer them. The better your knowledge of how the operating room works in regards to anesthesia, the better able you are to educate and optimize our patients pre-operatively as well as care for them post-op! A positive surgical experience involves <u>all physicians</u> involved in a patients care to be <u>working together</u>. If there is anything that we can do during your rotation to improve your educational experience please feel free to make recommendations. Likewise, please be open to suggestions or comments in regards to performing your anesthetic skills-remember that any constructive criticism that we might give is only because we want the absolute best for our patients. ☺

CARDIOLOGY ROTATION

Work Schedule:
Monday through Friday, 7:00 AM to 7:00 PM
Call Schedule:
Participation in General Medicine call
Fellowship Program Director:
Keith Atkinson, D.O.
Cardiologists:
Leonard C. Salvia, D.O. Mark P. Stuart, D.O.
J. Quen Dickey, D.O. Creagh Milford, D.O.
Fellows:
Soheil Assar, D.O. Amish Prasad, D.O.
Sara Rao, D.O.

The cardiology rotation at McLaren-Oakland provides a broad exposure to acute and chronic cardiovascular diseases, emphasizing accurate ambulatory and bedside clinical diagnosis, appropriate utilization of diagnostic studies and integration of all data into a well-communicated consultation. Sensitivity to the unique features of an individual patient will be recognized. The sensitivity, specificity, risk/benefit of newer diagnostic techniques will be discussed. The resident should learn the indications and expected outcomes for therapeutic options. It is expected that the residents will gain knowledge and acquire skills in cardiology. This experience should build on a foundation of general medicine. Residents will not only receive didactic training, but will also learn the humanistic, moral and ethical aspects of medicine.

Goals:

1. To educate the resident in identifying, triaging, and managing acute chest pain and dysrhythmias while on call.
2. Increase proficiency in performing comprehensive evaluations on patients with suspected cardiovascular disease.
3. Understand pathogenesis of cardiovascular disease.
4. Enhance knowledge in prevention, pathogenesis and treatment of hyperlipidemias and atherogenesis.
5. Enhance the residents' clinical skills in assessment and management of valvular heart disease.
6. Enhance residents' ability in interpreting EKG's
7. Afford the residents the opportunity of performing at least six supervised treadmill stress tests.
8. Enhance residents' ability in interpreting cardiac enzymes and other laboratory testing.
9. Acquire basic knowledge in pacemakers, inclusive in indication, recognizing malfunction and interpretation of EKG strips of patients with a pacemaker.
10. Develop comprehensive knowledge in the diagnosis and management of cardiac patients with proper utilization and interpretation of procedure that is necessary for general residents.
11. Develop comprehensive knowledge in the diagnosis and management of infections in the immuno-compromised host and acquired immunodeficiency syndrome.
12. Complete review of latest edition of the American College of Physicians Self-Assessment Cardiology Section, Pearls of Minnesota, and all other reading assignments.

Objectives:

A. Enhance the residents' physical exam skills of the cardiovascular system. (OGME 1-3)

1. Typical blood pressure in aortic stenosis, aortic insufficiency, cardiac tamponade, and the significance of measurement of blood pressure in different extremities.
2. Cardiac arrhythmias.
3. Recognize heart sounds S1, S2, S3, S4, summation gallop and splitting of S2 (normal and abnormal).
4. Heart murmurs and maneuvers that alter murmurs.
5. Pericardial rubs, mitral valve clicks, and other added sounds.
6. Visual estimation of venous pressure, hepatojugular reflex and A,c,v, waves.
7. Carotid pulses, bruits and peripheral pulses.
8. Breathing sounds and added sounds.

B. Enhance skills in ordering and interpretation of: (OGME 1-3)

1. Blood cell count
2. Cardiac enzymes
3. Electrocardiograms
4. Chest x-rays
5. Central venous pressure
6. Swan-Ganz catheter/hemodynamic profiles
7. Ambulatory monitoring of cardiac rhythm
8. VQ scans
9. Treadmill exercise testing

C. Enhance residents' ability to assimilate clinical information and formulate therapeutic plans by: (OGME 1-3)

1. Daily work rounds
2. Teaching rounds (1 1/2 hours three times per week)
3. Special conferences and journal club.

D. Recognize possible need for performance and interpretation of the following: (OGME 2-3)

1. Angiography, standard and digital subtraction
2. Heart catheterization
3. Cardiac pacing, intravenous and transthoracic
4. Pericardiocentesis
5. Echocardiography
6. Venography
7. Electrophysiology (EP testing)
8. Intro-aortic balloon pump
9. Myocardial profusion, radionuclide scan (rest and stress)
10. Thrombolysis
11. Cardioversion
12. Interventional cardiology - angioplasty
13. CABG

E. Enhance knowledge in diagnosis and options of treatment for: (OGME 2-3)

1. Angina pectoris, unstable angina pectoris
2. Myocardial ischemia, myocardial infarction

3. Cardiogenic shock
4. Acute pulmonary edema
5. Pulmonary embolism
6. Cardiac arrhythmias
7. Valvular heart disease
8. Congenital heart disease in adults
9. Cardiomyopathies
10. Dressler Syndrome
11. Hypertensive cardiovascular disease
12. Endocarditis
13. Cardiac tamponade
14. Hemodynamic instability

F. Enhance residents' knowledge in proficient use, side effects and interaction of drugs commonly used in cardiovascular disease. (OGME 1-3)
1. Vasopressors
2. Antiarrhythmics
3. Diruetics
4. Digoxin
5. Calcium channel blockers
6. Beta blockers
7. Ace inhibitors (ACE-1)
8. Angiotensin receptor blockers (ARB)
9. Anticoagulants
10. Aspirin
11. Antibiotics
12. Antihypertensives
13. Others

Residents will be given an orientation on the first day of the rotation. A specific cardiology manual will be given to the resident at that time.

The reference text for this rotation is *Braunwald Heart Disease: A Textbook of Cardiovascular Medicine*, E. Braunwald, editor and other timely journal articles as provided by the fellow or various topics.

CARDIOLOGY ROTATION DAILY ROUTINE

Prior to 6:45 a.m.	Check on the patients you are following
6:45 a.m.	Cardiology Department: Check in rounds with cardiology fellow Review patient list Assign new patients Outline plan for day (rounds, procedures, etc)
7:00-10:00 a.m.	See new patients/unstable patients first See established patients Morning Report Intermittent rounds with attending/fellow/other housestaff If finished with your patients, call fellow for further instruction
10:00 a.m.-12:00 p.m.	Atttending Rounds
12:00 - 12:30 p.m.	Lunch
12:30-1:00 p.m.	Lecture
1:30 - 3:30 p.m.	Attending Rounds Finish up any rounds not completed in the am Assign and complete any afternoon consults
3:30-4:00 p.m.	Educational Rounds Review physical exam findings from clinical rounds Review reading assignments Murmur rounds EKG review
4:00 p.m.	Cardiology Department: Check out rounds with fellow Review

Please understand this is an outline. Daily routine will be subject to daily events and adjustments made accordingly.

Please also be aware that everyone works until all patients on the list are seen, starting with the assigned patient.

CARDIOLOGY CHARTING AND DAILY NOTES

I. New Admits: Managed Care (MC) patients
   a. Cardiology is the managing service
      i. Care for all aspects of patient's needs
      ii. Complete H&P
      iii. Only need Impressions and Plan for Admit note on first day

II. Consults: Participate (P) Patients
   a. Cardiology limits scope to cardiovascular treatment
   b. Complete all parts of prepared consult sheets
      i. If there is a blank, fill it in
      ii. Can be found on 6E or Ann Fornwall, RN can direct you

III. Daily Notes
   a. Include basic SOAP format
   b. First sentence include brief summary statement as to why we are seeing patient
      i. Ex. 65 yo hypertensive, diabetic, tobacco abusing white male seen in follow up from unstable angina symptomatology
   c. Daily medications and dosages along left margin
   d. Include pertinent laboratory findings (enzymes, lytes, H/H, etc)
   e. Include pertinent imaging studies
      i. Echo, CXR, stress studies, CAT scans, EKG, Dopplers, etc.
   f. Don't forget vitals (and trends in same)
   g. On the left hand side of each SOAP note everyone should include the following: cardiac medications or other pertinent meds,quick Echo findings (EF) and daily Telemetry findings.

IV. Intermittently seen patients: Follow (F) patients
   a. Patients seen and written on only a few times each week
   b. Not typically seen daily

V. Discharge Summaries
   a. Should strive to perform at least one while on service
   b. Attempt to perform on patient you have helped to manage
   c. Fellow and/or Ann Fornwall, RN as resource people

CARDIOLOGY ROTATION – RESPONSIBILITIES ON SERVICE

I. Externs/Students
   a. Follow and help manage at least 5 patients daily and complete any other requests for patient management
   b. Complete readings and assigned projects in a timely fashion
   c. Act as an ambassador for the Cardiology Department
   d. Respect patients and ancillary staff

II. Interns
   a. Follow and help manage 10 patients daily and complete any other requests for patient
   b. Daily review of extern notes
   c. Complete readings and assigned projects in a timely fashion
   d. Act as an ambassador for the Cardiology Department
   e. Respect patients and ancillary staff
   f. Directly responsible for externs

III. Residents
   a. Follow and help manage 10-15 patients daily and complete any other requests for patient management
   b. Daily review of Intern and Extern notes
   c. Complete readings and assigned projects in a timely fashion
   d. Act as an ambassador for the Cardiology Department
   e. Respect patients and ancillary staff
   f. Directly responsible for interns and externs

EMERGENCY MEDICINE ROTATION

Work Schedule:
Scheduled shifts
Rotation Director:
Michael Q. Doyle, D.O.
Residency Program Director:
Michael Q. Doyle, D.O.
Associate Program Director
Nikolai Butki, D.O.
Attending physicians:
Tressa Gardner, D.O., FACOEP
Director, Emergency Medical Services/Associate Program Director
Chairperson, Division of Emergency Medicine
Michael Q. Doyle, D.O., FACOEP
Angela Cheers, D.O.
Jennifer Jones, D.O
Enash Moodley, D.O.
Matthew Swayze, D.O.
Harrison Tong, D.O.
Michael Tull, D.O.
R.Steven Hemby, D.O.
Robert T. May, D.O.
Christopher Steinacker, D.O.
Michael Remley, D.O.
Nikolai Butki, D.O.
Chief Resident:
Sara Ornazian, D.O.
Junior Chief Residents
Andrew Butki, D.O. and
Carrie Palazzolo, D.O.
Chief IM/EM Resident:
Elisha Botnick, D.O.

Emergency medicine has enjoyed increasing popularity and stature. It occupies a unique niche in medical education as it provides trainees with the opportunity to see an undifferentiated patient population with varying modes of presentation. This rotation will stress diagnostic skills such as the ability to prioritize patient care and learn new skills. Residents will receive training in toxicology and environmental injuries.

Externs – 12 hour shifts (7a, noon, 7p) – 13 shifts (includes 1 EMS shift)
-Urgent Care- 5 shifts at each (McLaren-Oakland Main, McLaren-Oakland Clarkston, McLaren-Oakland Oxford) and 1 shift with Pontiac Fire/EMS (8am start)
-Emergency Medicine- 13 shifts at McLaren-Oakland Main, 1 shift at McLaren-Oakland Clarkston, 1 shift at McLaren-Oakland Oxford, 1 shift with Pontiac Fire/EMS (8am start)

Interns – 10 hour shifts – 18 shifts
-18 shifts at McLaren-Oakland Main (may have occasional shift at McLaren-Oakland Clarkston or McLaren-Oakland Oxford)
-Work ½ of weekend days per month
-Get ½ of weekend days off per month

GOALS AND OBJECTIVES
EMERGENCY MEDICINE

Educational Purpose/Goals

1. To become knowledgeable of the principles of Emergency Care and to become familiar with their application and begin to develop competency in the evaluation, diagnosis and management of patients presenting to the Emergency Department.

2. To become knowledgeable of the indications for and interpretation of diagnostic modalities utilized in the evaluation of patients presenting to the Emergency Department.

3. To become familiar with the evaluation and resuscitation of critically ill patients and to function as an integral member of the Emergency Department.

4. To develop the skills needed to elicit an appropriate history and perform a clinically appropriate examination on patients presenting to the Emergency department with urgent and non-urgent complaints.

Principal Teaching Methods

1. Teaching is provided on a patient-by-patient basis involving direct, one-to-one interaction with the supervising attending physician. Instruction is accomplished through role modeling, discussion, observation, providing direct patient care, independent reading and consultation with supporting departments (e.g. radiology, surgery, intensivists, medical subspecialists).

2. Didactic instruction is incorporated into the Emergency Grand Rounds/Education Day every Wednesday from 6:30 a.m. to 11:30 a.m. Residents also participate in the Emergency Medicine Journal Club.

Educational Content

Mix of disease, patient characteristics, types of clinical encounters, procedures and services, didactic lectures.

The resident will experience first contact with unselected patients in the Emergency Department. The hospital is a Level II Trauma Center and the Emergency Department sees approximately 30,000 patients per year. The number of clinical encounters per resident is determined by the capability of the resident, as assessed by the supervising physician, as well as the intensity of the presenting illness. The patient characteristics include all races, ages, sexes and socioeconomic strata.

The resident will evaluate patients with a wide variety of clinical complaints. Some of the typical encounters include, but are not limited to: altered mental status, apnea, cardiac arrest, chemical intoxication, coma, dizziness, fever, hypertension, hypotension, pain, poisoning, seizures, syncope, weakness, chest pain, dyspnea, wheezing, abdominal pain, hematemesis, hematochezia, hematuria, nausea/vomiting, deformity of the extremity and swelling of the extremity.

The resident will gain experience in the performance of procedures and skills typically performed in the Emergency Department. The resident will understand the indications and contraindications for these procedures, as well as potential complications and after-care. These procedures and acquired skills may include, but are not limited to: intubation (nasotracheal, orotracheal, nasogastric), central venous access, cardiac resuscitation, thoracentesis, paracentisis, lumbar puncture, suturing techniques, local & regional anesthesia, wound management and bandaging techniques, casting and immobilization, and I&D of abscesses.

The interpretative skills that are reinforced and/or learned during the rotation include EKG, plain radiographs, urinalysis, head CT scans, arterial blood gasses and other laboratory assays.

Ancillary Education Materials Utilized

Reading List:

1. Tintinalli JR, Krome RL, Ruiz, et al, eds: Emergency Medicine: A comprehensive Study Guide, 7th ed., New York: McGraw Hill.
2. Rosen P, Baker FJ, Barkin RM, et al: Emergency Medicine concepts in Clinical Practice, 7th ed., St. Louis: C.V. Mosby.
3. Wilson JD, Braunwalk E, Isselbacher KJ, et al: Harrison's Principles of Internal Medicine, 17th ed., New York: McGraw-Hill.
4. The American college of Surgeons: Advanced Trauma Life Support Manual.
5. Simon & Konigsknecht: Orthopedics in Emergency Medicine.
6. Roberts and Hedges: Clinical Procedures in Emergency Medicine.
7. Grant, et al: Atlas of Anatomy.
8. Fitpatrick, et al: Color Atlas and Synopses of Dermatology.
9. Oske, et al: Principles and Practice of Pediatrics, JB Lippincott.
10. Ma et al: Emergency Ultrasound.
11. UpToDate.com.
12. Schaider et al: Rosen and Barkin's 5-Minute Emergency Medicine Consult.
13. Stedman's Medical Dictionary.
14. Fleisher, et al: Textbook of Pediatric Emergency Medicine, Williams and Wilkins.
15. American Psychiatric Association: The Diagnostic and Statistical Manual IV.
16. Wallak, et al: Interpretation of Diagnostic Tests: A Handbook Synopsis of Laboratory Medicine.
17. Goldfrank, et al: Toxicology Emergencies.
18. American Heart Association and American Academy of Pediatrics: Textbook of Pediatric Advanced Life Support.
19. American Heart Association: Textbook of Advanced Cardiac Life Support.

Methods of Evaluation

Using the written curriculum as a guideline, the resident is evaluated on the AOA core competencies. This is a summative evaluation by all attendings involved, prepared and submitted by Dr. Doyle and Dr. Butki. Feedback is also given informally throughout the rotation.

ROTATION SPECIFIC COMPETENCY OBJECTIVES

PATIENT CARE –

Chest Pain:

OGME-1

- obtains comprehensive primary assessment
- appropriately dispositions patients – properly identifies medical emergencies
- performs thorough physical exam with emphasis on system of chief complaint
- develops appropriate differential diagnosis
- determines likely diagnosis

- presents case to attending in organized manner

OGME-2

In addition to above:

- able to initiate and perform resuscitative protocols
- determines appropriate diagnostic testing
- identifies major physical exam findings
- after collaboration with attending, implements agreed upon plan for patient care

OGME-3

In addition to above:

- accurately interprets radiograph and laboratory findings
- identifies subtle physical exam findings
- after collaboration with attending, appropriately dispositions patient (i.e. discharge or admit - if admit, where, to whom, whom to consult)
- discusses patient care plans with consultants

OGME-4 (and above)

In addition to above:

- with minimal supervision, independently assesses and initiates diagnostics and treatment
- with minimal supervision, appropriately dispositions patient (admission or discharge)
- independently discusses patient with consultants
- coordinates advanced medical and trauma resuscitative protocols

Abdominal Pain

OGME-1

- obtains comprehensive primary assessment
- appropriately dispositions patients – properly identifies medical emergencies
- performs thorough physical exam with emphasis on system of chief complaint
- develops appropriate differential diagnosis
- determines likely diagnosis
- presents case to attending in organized manner

OGME-2

In addition to above:

- able to initiate and perform resuscitative protocols
- determines appropriate diagnostic testing
- identifies major physical exam findings
- after collaboration with attending, implements agreed upon plan for patient care

OGME-3

In addition to above:

- accurately interprets radiograph and laboratory findings
- identifies subtle physical exam findings
- after collaboration with attending, appropriately dispositions patient (i.e. discharge or admit – if admit, where, to whom, whom to consult)
- discusses patient care plans with consultants

OGME-4 (and above)

In addition to above:

- with minimal supervision, independently assesses and initiates diagnostics and treatment
- with minimal supervision, appropriately dispositions patient (admission or discharge)
- independently discusses patient with consultants
- coordinates advanced medical and trauma resuscitative protocols

Neurologic Complaint

OGME-1

- obtains comprehensive primary assessment
- appropriately dispositions patients – properly identifies medical emergencies
- performs thorough physical exam with emphasis on system of chief complaint
- develops appropriate differential diagnosis
- determines likely diagnosis
- presents case to attending in organized manner

OGME-2

In addition to above:

- able to initiate and perform resuscitative protocols
- determines appropriate diagnostic testing
- identifies major physical exam findings
- after collaboration with attending, implements agreed upon plan for patient care

OGME-3

In addition to above:

- accurately interprets radiograph and laboratory findings
- identifies subtle physical exam findings
- after collaboration with attending, appropriately dispositions patient (i.e. discharge or admit – if admit, where, to whom, whom to consult)
- discusses patient care plans with consultants

OGME-4 (and above)

In addition to above:

- with minimal supervision, independently assesses and initiates diagnostics and treatment
- with minimal supervision, appropriately dispositions patient (admission or discharge)
- independently discusses patient with consultants
- coordinates advanced medical and trauma resuscitative protocols

Shortness of Breath

OGME-1

- obtains comprehensive primary assessment
- appropriately dispositions patients – properly identifies medical emergencies
- performs thorough physical exam with emphasis on system of chief complaint
- develops appropriate differential diagnosis
- determines likely diagnosis
- presents case to attending in organized manner

OGME-2

In addition to above:

- able to initiate and perform resuscitative protocols
- determines appropriate diagnostic testing
- identifies major physical exam findings
- after collaboration with attending, implements agreed upon plan for patient care

OGME-3

In addition to above:

- accurately interprets radiograph and laboratory findings
- identifies subtle physical exam findings
- after collaboration with attending, appropriately dispositions patient (i.e. discharge or admit – if admit, where, to whom, whom to consult)
- discusses patient care plans with consultants

OGME-4 (and above)

In addition to above:

- with minimal supervision, independently assesses and initiates diagnostics and treatment
- with minimal supervision, appropriately dispositions patient (admission or discharge)
- independently discusses patient with consultants
- coordinates advanced medical and trauma resuscitative protocols

Trauma

OGME-1

- obtains comprehensive primary assessment
- appropriately dispositions patients – properly identifies medical emergencies
- performs thorough physical exam with emphasis on system of chief complaint
- develops appropriate differential diagnosis
- determines likely diagnosis
- presents case to attending in organized manner

OGME-2

In addition to above:

- able to initiate and perform resuscitative protocols
- determines appropriate diagnostic testing
- identifies major physical exam findings
- after collaboration with attending, implements agreed upon plan for patient care

OGME-3

In addition to above:

- accurately interprets radiograph and laboratory findings
- identifies subtle physical exam findings
- after collaboration with attending, appropriately dispositions patient (i.e. discharge or admit – if admit, where, to whom, whom to consult)
- discusses patient care plans with consultants

OGME-4 (and above)

In addition to above:

- with minimal supervision, independently assesses and initiates diagnostics and treatment
- with minimal supervision, appropriately dispositions patient (admission or discharge)
- independently discusses patient with consultants
- coordinates advanced medical and trauma resuscitative protocols

Gynecology

OGME-1

- obtains comprehensive primary assessment
- appropriately dispositions patients – properly identifies medical emergencies
- performs thorough physical exam with emphasis on system of chief complaint
- develops appropriate differential diagnosis
- determines likely diagnosis
- presents case to attending in organized manner

OGME-2

In addition to above:

- able to initiate and perform resuscitative protocols
- determines appropriate diagnostic testing
- identifies major physical exam findings
- after collaboration with attending, implements agreed upon plan for patient care

OGME-3

In addition to above:

- accurately interprets radiograph and laboratory findings
- identifies subtle physical exam findings
- after collaboration with attending, appropriately dispositions patient (i.e. discharge or admit – if admit, where, to whom, whom to consult)
- discusses patient care plans with consultants

OGME-4 (and above)

In addition to above:

- with minimal supervision, independently assesses and initiates diagnostics and treatment
- with minimal supervision, appropriately dispositions patient (admission or discharge)
- independently discusses patient with consultants
- coordinates advanced medical and trauma resuscitative protocols

Infectious Diseases

OGME-1

- obtains comprehensive primary assessment
- appropriately dispositions patients – properly identifies medical emergencies
- performs thorough physical exam with emphasis on system of chief complaint
- develops appropriate differential diagnosis
- determines likely diagnosis
- presents case to attending in organized manner

OGME-2

In addition to above:

- able to initiate and perform resuscitative protocols
- determines appropriate diagnostic testing
- identifies major physical exam findings
- after collaboration with attending, implements agreed upon plan for patient care

OGME-3

In addition to above:

- accurately interprets radiograph and laboratory findings
- identifies subtle physical exam findings
- after collaboration with attending, appropriately dispositions patient (i.e. discharge or admit – if admit, where, to whom, whom to consult)
- discusses patient care plans with consultants

OGME-4 (and above)

In addition to above:

- with minimal supervision, independently assesses and initiates diagnostics and treatment
- with minimal supervision, appropriately dispositions patient (admission or discharge)
- independently discusses patient with consultants
- coordinates advanced medical and trauma resuscitative protocols

Orthopedics

OGME-1

- obtains comprehensive primary assessment
- appropriately dispositions patients – properly identifies medical emergencies
- performs thorough physical exam with emphasis on system of chief complaint
- develops appropriate differential diagnosis
- determines likely diagnosis
- presents case to attending in organized manner

OGME-2

In addition to above:

- able to initiate and perform resuscitative protocols
- determines appropriate diagnostic testing
- identifies major physical exam findings
- after collaboration with attending, implements agreed upon plan for patient care

OGME-3

In addition to above:

- accurately interprets radiograph and laboratory findings
- identifies subtle physical exam findings
- after collaboration with attending, appropriately dispositions patient (i.e. discharge or admit – if admit, where, to whom, whom to consult)
- discusses patient care plans with consultants

OGME-4 (and above)

In addition to above:

- with minimal supervision, independently assesses and initiates diagnostics and treatment
- with minimal supervision, appropriately dispositions patient (admission or discharge)

- independently discusses patient with consultants
- coordinates advanced medical and trauma resuscitative protocols

Pediatrics

OGME-1

- obtains comprehensive primary assessment
- appropriately dispositions patients – properly identifies medical emergencies
- performs thorough physical exam with emphasis on system of chief complaint
- develops appropriate differential diagnosis
- determines likely diagnosis
- presents case to attending in organized manner

OGME-2

In addition to above:

- able to initiate and perform resuscitative protocols
- determines appropriate diagnostic testing
- identifies major physical exam findings
- after collaboration with attending, implements agreed upon plan for patient care

OGME-3

In addition to above:

- accurately interprets radiograph and laboratory findings
- identifies subtle physical exam findings
- after collaboration with attending, appropriately dispositions patient (i.e. discharge or admit – if admit, where, to whom, whom to consult)
- discusses patient care plans with consultants

OGME-4 (and above)

In addition to above:

- with minimal supervision, independently assesses and initiates diagnostics and treatment
- with minimal supervision, appropriately dispositions patient (admission or discharge)
- independently discusses patient with consultants
- coordinates advanced medical and trauma resuscitative protocols

MEDICAL KNOWLEDGE

Medical Imaging Interpretation

OGME-1

- appropriately identifies need for radiograph
- appropriately identifies proper imaging modality

OGME-2

In addition to above:

- identifies pathology found in each view of ordered radiograph (what do we look for in each view)

OGME-3

In addition to above:

- identifies obvious pathology

OGME-4 (and above)

In addition to above:

- identifies subtle pathology
- identifies findings specific to pathology (differentiates between subset of hip fractures: intertroch vs subcapital vs transcervical)

EKG Interpretation

OGME-1

- knows normal rate, rhythm, axis, intervals
- knows lead placement on patient
- able to identify normal EKG from abnormal EKG
- begin to develop differential diagnosis
- calculates rate, rhythm, intervals on EKG

OGME-2

In addition to above:

- appropriately identifies arrhythmias
- knows possible treatment options
- appropriately identifies ischemic findings (ST depression)
- understands pathology of findings (i.e. ST elevation is transmural infarction)
- can localize infarctions and identify involved vessels based on EKG findings

OGME-3 (and above)

In addition to above:

- identifies subtle findings (Wellens, Brugada syndrome, fasicular blocks)
- appropriately identifies treatment plan, including medication and intervention

Pharmacology

OGME-1

- understands mechanism of action of drug classes
- identifies to which class medications belong
- identifies appropriate class of drug for desired treatment

OGME-2

In addition to above:

- understands and can identify availability of and appropriate administration routes of desired medications
- begins to understand contraindications, adverse reactions, and side effects and class effects

OGME-3

In addition to above:

- identifies specific pharmacologic drug indications for specific pathology (i.e. esmolol or labetolol for HTN emergency)
- identifies contraindications, adverse reactions and side effect of medication for specific pathology (i.e. esmolol – hypotension or esmolol and cocaine use)

OGM-4 (and above)

In addition to above:

- identifies dangerous medication interactions
- identifies and appropriately treats overdose and dangerous side effects (dystonic reactions)

SYSTEMS BASED PRACTICE

OGME-1

- demonstrate an understanding of the national and local health care delivery systems and how they impact on patient care and professional practice
- identify the health needs of an individual patient
- begin to identify the resources available to deliver quality care and patient safety
- awareness of government rules and regulations on quality care and patient safety

OGME-2

In addition to above:

- describe and utilize the resources available to deliver quality care
- advocate for the patient in obtaining quality health care in complex systems
- participate in activities that contribute to the effectiveness of health care being delivered in our organization (i.e. committee participation)
- work collaboratively with members of our organization's health care team (i.e. social workers, case managers and finance) to deliver quality care and patient safety

OGME-3

In addition to above:

- set priorities and manage time to balance patient care, practice requirements, outside activities and personal life
- demonstrate an understanding of the methods of controlling costs and allocating resources in the health care system or organization
- describe the strengths and shortcomings of the US system for financing and delivering medical care, particularly to the underserved/minorities or uninsured
- methods for participation on healthcare policy (i.e. advocacy, advisory processes, opportunities to impact policy)

OGME-4 (and above)

In addition to above:

- participate in quality process evaluation and improvement activities and report to department
- manage a practice including finances and human resources
- describe principle of healthcare financing, including physician remuneration, budgeting and organizational funding
- serve in administration and leadership roles
- ability to utilize proper coding procedures

INTERPERSONAL AND COMMUNICATION SKILLS

Nursing Interactions

OGME-1

- respectful and professional with nursing staff

- utilizes nursing staff for medical and procedural instruction (foley, IV, medication administration)

OGME-2

In addition to above:

- obtains appropriate report, vitals, history and patient information from nurse and nurse notes
- communicates clearly with nursing staff regarding orders and patient plan of care in ED

OGME-3

In addition to above:

- troubleshoots and resolves patient care, institutional and interpersonal issues with nursing staff

OGME-4 (and above)

In addition to above:

- works independently, coordinating total patient care with nursing staff

Pre-Hospital Personnel Interactions

OGME-1

- identifies and greets pre-hospital personnel with respect and professionalism
- understands differences in pre-hospital licenses (EMT vs Paramedic)

OGME-2

In addition to above:

- obtains appropriate and relevant information from pre-hospital personnel
- performs radio and medical control responsibilities

OGME-3

In addition to above:

- identifies and asks appropriate questions to elicit complete pre-hospital history

OGME-4 (and above)

In addition to above:

- assumes complete transfer of patient care from pre-hospital personnel

PROFESSIONALISM

Professional Development

OGME-1

- reliable, punctual and prepared for shifts
- submits logs, licenses, medical records in timely fashion

OGME-2

In addition to above:

- displays empathy and sensitivity to patient's age, culture, gender and disabilities
- attends and actively participates in committee meetings and other department functions as deemed appropriate

- demonstrates accountability for actions

OGME-3

All of above.

OGME-4 (and above)

In addition to above:

- culminates professional development to provide complete independent advocacy for patients under care

PRACTICE BASED LEARNING

OGME-1

- describe and apply evidence based medicine principles and practice
    - define basic biostatistical and epidemiological terms and application: RRR, ARR, NNT, p-values, CI, morbidity, mortality, sensitivity, specificity, odd ratio, for example
    - convert the need for information into an answerable question
    - apply the five steps of evidence based medicine approach to a clinical question
- evaluate the relevance and validity of clinical research
- able to do a systemic research review
- use information technology to manage and access online medical information

OGME-2

In addition to above:

- evaluate the relevance and validity of clinical research
    - integrate the critical appraisal with clinical expertise as it relates to a specific patient's history, physical, and ancillary studies
    - demonstrate a hierarchical approach to levels of evidence and apply the information to the patient

- describe the clinical significance and apply strategies for integrating research evidence into clinical practice
    - interpret the results of various study designs
    - communicate the evidence to patients and colleagues
- critically evaluate medical information and its sources

OGME-3 (and above)

In addition to above:

- apply lifelong learning skills of the scholar role to implement a personal program to keep up to date and enhance areas of professional competence
    - assess personal gaps in knowledge
    - conduct a personal practice audit
    - recognize and reflect on learning issues in practice
    - describe the principles of maintenance of competence
- describe and apply systemic methods to improve population health
- integrate new learning into practice and utilize prevention recommendations to improve patient care
- implement practice-based improvements to reduce medical errors
- apply the principle of clinical uncertainty in clinical judgments

- contribute to the enhancement of quality care and patient safety in the practice, and integrating best evidence and best practice
    - monitor and evaluate outcomes in clinical practice
    - participate and perform quality assurance activities with the goal to change practice protocols as necessary
    - apply evidence and management processes for cost appropriate care

OSEOPATHIC PRINCIPLES AND PRACTICE

OGME-1

- perform complete osteopathic structural exam
- ability to identify somatic dysfunction
- begin to integrate osteopathic principles into care of hospitalized patient in that structure and function are interrelated

OGME-2

In addition to above:

- ability to diagnosis and treat somatic dysfunction
- implement osteopathic principles into care of hospitalized patient

OGME-3 (and above)

In addition to above:

- begin to teach colleagues how much to integrate/implement OMM and OPP into care of hospitalized patient
- utilize one or two OMM techniques on more than one body region
- begin to identify the benefits of OMM vs conventional medicine

FAMILY MEDICINE ROTATION

Work Schedule:
Monday through Friday, variable
Call Schedule:
May participate in general medicine or ICU call pool
FP/ER and FP OGME 2 and 3 participate in clinic home call
Didactics:
Didactics are held at 8 a.m. on Tuesdays, unless otherwise specified
Journal Club:
Journal Club is held on the 3rd Wednesday of the month, unless otherwise specified
Rotation Director:
Mark Schury, D.O.
Residency Program Director:
Mark Schury, D.O.
Chief Resident:
Erin Nanninga, D.O.

Family Medicine is a comprehensive specialty that deals not only with the treatment of diseases, but also with the total health care of the individual and his/her family. Physiological, emotional, cultural, religious, economic, psychological and environmental factors are all important in patient care. The "core" of family medicine is its longitudinal care component. Over time the family physician can become a trusted confidant, advisor and caregiver to family members of all ages. He/she may participate in diverse family milestones such as the birth of a child and the death of a family member.

The family physician requires the ability to balance a strong foundation in scientific theory and technical knowledge with empathy and wisdom. A successful family physician has:

- A sincere desire to care for the well being of people
- A broad interest in humanity
- An interest in the diseases affecting populations
- A superior ability to work with people
- Extensive knowledge of osteopathic medicine
- Desire to educate patients about preventative medicine

Goals:
The resident will become familiar with the evaluation and management of patients with the following medical problems:

Physical Examinations	Hypertension
Normal Pregnancy	Diabetes Mellitus
Pap Smears/Pelvic Exams	Coronary Artery Disease/Chest Pain
Obesity	Arthritis
Colds/Flu	Anxiety/Depression
Pharyngitis	Lower Back Pain
Sinusitis	Abdominal Pain
Bronchitis/Pneumonia	Headache
Otitis Media	Asthma/COPD
UTI	Congestive Heart Failure
Dermatitis	Lacerations/Abrasions
Cervicitis	

Objectives:

1. Provide office based primary health care to patients and families.
2. Assess and manage common medical problems encountered in Family Practice.
3. Learn preventive healthcare for various age groups including immunizations.
4. Learn the importance of patient education and how to provide it.
5. Gain an understanding of community medicine and the use of community resources in the care of patients and families.
6. Learn the importance of psychosocial factors in patient care.

Family Practice residents and any residents rotating on Family Practice are required to attend Tuesday conferences at 8:00 AM in the 6N Conference Room (when in-house) and journal club.

Family Practice OGME 1s are required to attend their continuity clinic on their assigned day regardless of the rotation, with the exception of ICU. FP OGME 1's are excused from clinic during their ICU month.

GENERAL SURGERY ROTATION

Work Schedule for PGY1/OGME 1 (a.k.a. intern):
Monday through Friday, 5:30 AM to 3:00 PM (with weekend call)
Monday through Friday, 5:30 AM to 5:00 PM (no weekend call)
Call Schedule for PGY1/OGME 1 (a.k.a. intern):
Monday – Friday, 5:00 PM to 7:00 PM
Saturday and Sunday, 7:00 AM to 5:00 PM (may include holidays)
Residency Program Director:
J. Ketner, D.O.
General Surgeons:

J. Ketner, D.O.	D. Busch, D.O.
E. Spohn, D.O.	E. Joseph, M.D.
B. Yaldo, M.D.	R. Gross, D.O.
T. Phan, M.D.	

Cardiothoracic/Vascular:

D. Forster, D.O.	J. Sealey, D.O.
I. Asfaw, M.D.	T. Phan, M.D.

Gynecology:

J. Zaidan, M.D.	R. Lambert, D.O.	T. Wynn, M.D.
G. Pimputkar, D.O.	D. Cohen, D.O.	G. Connors, M.D.

Residents:

Mabel Chu, D.O. (OGME5)	Elizabeth Renaker-Jansen, D.O. (OGME5)
Adriana Ardeljan, D.O. (OGME4)	Kelly Galster, D.O. (OGME4)
Leith Brown (OGME 3)	Adam Phillips (OGME 3)
Andrew Ray (OGME 2)	

General Surgery will expose the resident to a variety of surgical topics. The resident will learn about the practice of general surgery through reading, lectures, and patient care. The resident will have the opportunity to work with different surgeons. The chief surgical resident will assign residents to attendings.

At the beginning of the rotation, specific work assignments will be made. Highlights of the rotation will be given here.

General Info:

1. The PGY1 will have orientation during the first day of the surgical rotation.
2. Prior to beginning the rotation, the PGY1 should review the surgical scrub technique video (available in the library).
3. Please contact chief resident a few days prior to start of rotation to get information on where to meet on the first day of rotation.
4. It is expected that the PGY1 will complete history and physicals, PATs, consents, consults, and daily progress notes on surgical patients.
5. The PGY1 should be proficient with knotting/suturing prior to rotation (manuals are available in the library).
6. Each PGY1 is responsible for a case presentation to be given prior to the end of the rotation.
7. PGY1 should make all efforts to attend noon lectures, unless they are scrubbed in for surgery.
8. PGY1s are responsible for reading assignments and are expected to be active participants in surgical lectures/bedside didactics.
9. Each PGY1 is required to take at least one weekend call. Holiday call may also

occur. Call will be posted as a monthly on-call schedule and vary depending on the number of PGY1s assigned to each month.

10. PGY1s are to carry and answer their hospital personal pager and the assigned general surgery trauma or floor pager while on duty.
11. Days off or vacation should be requested at least one month in advance, unless an emergency or illness occurs. Please notify the senior resident of your absence, in addition to Medical Education Department.
12. Please arrange for PGY1 coverage (including pager) by your fellow colleagues on the general surgery rotation for MSUSCS/Educational meetings/clinic days. Please notify the Senior Resident of your schedule at the beginning of the rotation.

GENERAL SURGERY LECTURES

All house staff on the surgical services are expected to be at all surgical lectures. Attendance is mandatory. The lecture schedule will be posted in the general surgery on-call room (Fifth Floor, East Tower). Failure to attend posted meeting times will result in make-up lectures to be assigned and presented to the chief resident and reported to the department of medical education.

Typical Weekly Schedule
Mondays, 6:30 AM, (Library) Patient List Sign-off/orientation
Alternating Monday of the month meets at **7:15 AM** for Tumor board in the Corporate Auditorium, or Radiology Conference in the Radiology Department

Tuesdays, 10 AM-12 PM, (6N) – Gen Surgery Resident Education/M&M
Wednesdays, 6:30 AM
***__1St Wednesday__ of the month 6:30 AM
Trauma Symposium (Corporate Auditorium)
***__2nd Wednesday__ (every other month) 6:30 AM
Gen Surgery/ER Conference (6N)
*****3rd Thursday of the month** 6:30 AM
Trauma/Gen Surgery Meeting. (Non-general surgery PGY1s and medical students do not need to attend)
*****4th Wednesday (No AM Lecture)**
General Surgery COGMET. Non-general surgery PGY1s or medical students are welcome to attend but need prior written authorization by MSUSCS (applications are on MSUSCS webpage).

Thursdays, 6:30 AM, (Library) lecture series
***last Thursday of the month - PGY1 topic directed lecture for medical students & fellow interns. (General surgery residents are required to attend 6:30 AM trauma dept meeting & 7:30 AM general surgery department meeting in 6N).
Fridays, 6:30 AM (ICU)
Grandrounds. Rounds will be headed by chief or senior residents

INTERNAL MEDICINE ROTATIONS

Work Schedule:
Monday through Friday, 7:00 AM to 5:00 PM
Call Schedule:
variable, including weekends and holidays
Residency Program Director:
Jeffrey Mason, D.O.
Chief Resident:
Erica DiCicco, D.O.
Co-Chief Resident:
Elisha Botnick, D.O.

The purpose of the general internal medicine rotation (at your level) is:

1. To obtain information from the patient (history);
2. To obtain physical findings and integrate this with the history to develop a differential diagnosis;
3. To develop the differential diagnosis and order the appropriate tests to rule in or rule out a diagnosis as it relates to the patient complaint;
4. To institute initial therapy to sustain life (CPR/ACLS) or support the patient until the diagnosis is known;
5. To recognize the "acute" patient and initiate therapy.

General Medicine

This rotation refers to the "floors". There are three in-patient rotations. All interns/OGME 1 residents will have at least one month of general medicine. There is a rotation manual for general medicine and it is the same manual for all three rotations. Additionally, there is a list of academic competencies that each resident should learn. This will help you on your board exams and with patient care.

Resident Responsibilities

This is what is expected of you when you are on a Medicine rotation. This includes General Medicine as well as Medical Subspecialties.

1. Please remember that you are a professional and behave accordingly.
2. When you are called to see a patient, you are expected to make an adequate evaluation consisting of pertinent history, physical examination, and review of the chart data. Always formulate your impression and what you feel should be done for the patient. Depending on the nature of the case, you will either institute therapy or discuss the case first with the medical resident or attending physician. *<u>You must go see the patient</u>!!!
3. There is always a medical resident in house. The resident on call is designated the House Resident. His/her primary responsibility is to the patients in the Critical Care Units. However, the residents are expected to help you if you need it.
4. Residents are responsible for students. Residents are responsible for both students and interns. This is the hierarchy of medicine. You are expected to teach those junior to you.
5. Interns/OGME 1 may **NOT** transfer patients from the ICU to the floor. Residents may NOT transfer patients to the ICU or Intermediate ICU except under the direction of the medicine resident or an attending physician.

6. The Critical Care Medicine (CCM or ICU) intern/OGME 1 resident is responsible for evaluating any admission to the 9th floor. He/she will discuss the admission with the medical resident. This resident will also be responsible for writing an admit history and physical. The resident will review this. Residents are called with admissions from attendings or the Emergency Department. The resident then assigns the admission to an intern/OGME 1 resident or student.
7. Complete H&Ps as assigned.
8. **NOTIFY ATTENDING PHYSICIAN and FAMILY PHYSICIAN** of critical changes in the patient. Also notify Surgery or Critical Care Team if involved in the case.
9. ***In the case of a hospice patient***, **notify the ATTENDING PHYSICIAN and FAMILY PHYSICIAN.**

Internal Medicine Education and Patient Sign Out

The first day of each rotation each month the following should occur: all general IM services will meet in Doctors Dining Room at **7:**00 am **SHARP** to discuss the following (with the exception of ICU team who will meet in the Critical Care Complex):

1. Expectations of the Medical Student and OGME 1 or 2 on service
   - **a.** Including number of patients, how to write notes, and what physician expects etc.
2. Discussion regarding when the attending will be rounding for the week
3. Reading Assignments for the week
4. Expectations the student has of the service/residents
5. DIVIDE and Discuss the patients
6. HOW TO DO MORNING REPORT

Monday thru Friday Mornings 7:00 a.m.:

1. The house night's intern will report to the Doctor's Dining room at 7:00 a.m. with the ***On Call Work list*** and run through the list of admissions, consultants and observation patients of the previous evening. Focus should be on those patients that have issues/pending issues or patients that were transferred to a higher level of care.
2. The house nights intern shall leave promptly at 7:30 a.m.

Tuesday and Thursday Mornings 7:00 a.m. Doctors Dining Room:

1. Morning Case Report-The house night's resident and student should be prepared to discuss one interesting case including H and P, diagnostic studies and management plan. *This activity is a house night's resident responsibility. The medical student may present IF it was there H and P!!*
2. A sign in sheet should be completely filled out with date/time and topic and placed in the binder in the doctors' dining room.
3. The Chief Resident or his/her designee will be responsible for overseeing and attending ALL MORNING REPORTS.
4. ALL RESIDENTS ON INTERNAL MEDICINE are REQUIRED TO ATTEND UNLESS THERE IS A PATIENT EMERGENCY.
5. ***The house night's intern must leave promptly at 7:30am***.

Wednesday Mornings 7:00 a.m. Doctors Dining Room:

1. OMM Case Report- The medical student (who was on call the previous evening) is responsible for presenting the H and P and OMM Structural Exam of one of the patients they saw including the Diagnosis and Treatment Plan.
2. The medical student should demonstrate (set up) the technique utilized to reinforce to the other residents and students.

THURSDAY - Mitchell IM Conference - 10:00am-1:00pm (time varies):

1. ALL INTERNAL MEDICINE RESIDENTS and IM/ER RESIDENTS ARE REQUIRED TO ATTEND unless you are on ER or other arrangements have been made. ICU Residents do NOT have to attend. All non emergent patient care activities should be done before or after the conference. Please advise the nursing staff accordingly.
2. IM Residents are required to READ the BOARD REVIEW SECTION before attending BOARD REVIEW if at all possible.
3. ALL STUDENTS ARE REQUIRED TO ATTEND.

Friday - GRAND ROUNDS WITH DR VOELPEL 7:30 a.m. (Fridays may vary):

1. ALL RESIDENTS on EACH SERVICE should have a CASE in MIND to present. (Not the student)
2. RESIDENTS SHOULD PRESENT AND FIND CASE

Noon Lectures Case Report:

1. Each week a junior/senior level resident will be responsible for an Internal Medicine Case presentation. A junior or senior level resident is responsible for presenting a case. The object is to engage the medical students and interns to develop differential diagnoses and based on this develop a management and treatment plan. The resident should also have an evidence based article to support their findings. All radiographic, laboratory etc information should be brought to the case report and shared with the house staff. OMM findings and treatment plans should also be included.

Please check the monthly lecture schedule for dates/times of Tumor Board, Chest Conference, IM/ER Morbidity/Mortality, Mortality Review, OMM Conference, Code Review, Bioethics Conference, Pediatrics lecture or other Educational sessions. The Monthly Lecture Schedule can also be found on the McLaren-Oakland Intranet.

INTERNAL MEDICINE CALL

The call schedule for both the ICU and the general medicine rotations for residents (house) are done by the chief medicine resident. The call schedule for the ICU and general medicine (house) for interns/OGME 1 residents are done by the IM/ER chief resident.

The monthly Internal Medicine on call schedule lists the on-call team. The team is composed of an intern or OGME 1 resident and one or two students.

House Call

House call consists of day call and night call.

Day call starts at 7:00 a.m. The day call person picks up the house pager from the night call person in the doctor's dining room at 7:00 a.m. The night call person will always report to regular work assignment at 7:30 a.m., including weekends. From 7:00-7:30 a.m., there is morning report/sign off in the doctor's dining room

The night call person will work their regular work day from 7:30 a.m. to 5 p.m. At 5 p.m. the night call person will pick up the house pager from the day call person and sign out.

The intern/OGME 1 resident on call is required to answer all Code Blue call and complete all H&P's and answer all house calls for their shift.

You may be assigned to either house call or ICU call.

There will be an additional house resident, to assist the house intern with questions/teaching from July-December from 12p-12a.

ICU Call

ICU call starts at 5 p.m. and ends 6 a.m., Monday through Friday.

On Saturday and Sunday, ICU call starts at 6 a.m. and ends at 6 a.m.

INTERNAL MEDICINE SERVICES

General Medicine attendings (inpatient services): Dr. Jeffrey Mason, Dr. Fadi Salloum and Dr. David Minter Dr. John Zazaian and Dr. Andrew Zazaian Dr. Angela Xavier and Dr. Anu Varadarajan Dr. Jo Ann Mitchell (Float)

General Medicine: Drs. Mason and Salloum

Drs. Mason and Salloum are board certified internists who have a private practice. They conduct clinical daily rounds on their hospitalized patients, both in the ICU and general medical floors. They will be joined by Dr. David Minter, a recent IM/ER graduate.

Dr Zazaian and Dr. Zazaian

One of the major features of this rotation is the autonomy that you will have in managing your patients. The time of rounds is variable. You are expected to complete the academic competencies.

Drs. Xavier and Anu:

Drs. Xavier and Anu are board certified internists who are hospitalists. Their partners have ambulatory practices and transfer temporary care to these doctors when their patients are hospitalized.

How the rotation works:

1. Your time is divided between Drs. Xavier and Anu.
2. Patients in the acute care units (9th floor) and rehabilitation unit (7th floor) are divided among the attendings.
3. You are expected to follow patients for continuity of care. Ideally, you should do the history and physical, write daily progress notes and manage the same patients.
4. Impromptu lectures and reading assignments will be given.
5. You are expected to learn the academic competencies for your level of training.
6. You are expected to participate in the teaching of medical students and junior house staff. This includes reviewing H and P's, consultations, SOAP notes, and assigning topics from the reading list. Please contact the Medical Librarian, Sheela John for the list.
7. Encourage your attendings to review your notes and reading assignments. **Be proactive.**

Ambulatory Medicine

These rotations are outpatient Internal Medicine rotations. Your in-house lecture expectations are fewer because you are "out of house." Each attending has his/her individual style. Your responsibilities and expectations will be discussed with you at the beginning of your rotation. You should complete the Ambulatory Academic Competencies while on this rotation.

Ambulatory attendings are:

1. Ammar Hatahet, M.D.
2. Robert Barnes, D.O.
3. David Pinelli, D.O.
4. Lisa Dietz, D.O.

MEDICAL SUBSPECIALTY ROTATIONS

Work Schedule:	Call schedule:
Variable	Variable

This group of rotations includes Cardiology, Pulmonary, Neurology, Infectious Disease, Gastroenterology and Critical Care Medicine. Cardiology and Critical Care Medicine are discussed separately. Guidelines for each rotation will be discussed at the beginning of the month. Please contact Sheela John, Medical Librarian or your attending for a reading list. Below is a brief summary of how to begin your rotation. You should also call the attending the day before your rotation to find out where and when you should meet on the first day.

You are expected to attend morning report and noon lectures if you are in-house.

Pulmonary

The pulmonary rotation deals with inpatient diagnosis and management of patients with chest and airway diseases. Hours are from 7:00 AM until 6:00 PM. You will do consultations on patients and make daily recommendations as a consultant. Pulmonary/Critical Care Journal Club will be held one evening a month and you are expected to attend. Call schedules should be adjusted to accommodate attendance, while complying with the AOA Work Hour Regulations. Changes in the call schedule will be the responsibility of the individual house staff while on service. Articles will be assigned for presentation.

Attending Physicians:	
Scott Simecek, D.O.	Robert Reagle, D.O.
Ron Sherman, D.O.	Jack Belen, D.O.
Lisa Kaiser, D.O.	Mary O'Connor, D.O.
Jeffrey Marshick, D.O.	
Fellows:	
Natasha Joshi, D.O.	
Elisabeth Chapaton-Rivard, D.O.	

SUGGESTED REFERENCE TEXTS: (ON RESERVE IN LIBRARY)

A. Pulmonary Medicine - Gunter and Welsh, Bone
B. Respiratory Physiology - West
C. Chest Radiology - Felson
D. Pulmonary Function – Chernick
E. American Review of Respiratory Disease Journal

Infectious Disease

This rotation is under the guidance of Dr. Franklin Rosenblat. You will have both an in-patient and ambulatory experience. The hours of the rotation are variable. You will perform consultations on hospitalized patients as well as follow-up care. Clinic Goals:

1. Increase proficiency in performing comprehensive evaluations on patients with suspected infectious disease illness.
2. Learn the broad range of infectious disease illnesses including etiology, diagnosis, management plan and proper use of antimicrobials.
3. Learn all aspects of prevention and treatment of travel related illnesses.
4. Learn the appropriate measures for prevention and treatment of sexually transmitted diseases.

5. Develop comprehensive knowledge in the diagnosis and management of infections in the immunocompromised host and acquired immunodeficiency syndrome.

Objectives:

1. Integrate the history and physical to achieve a satisfactory differential diagnosis on infectious diseases.
2. Develop a treatment plan based on the differential diagnosis in regard to appropriate therapy. Microscopic interpretation of a body fluid specimen in regard to a possible infection such as pleural fluid, peritoneal fluid, CSF fluid, synovial fluid and other areas.
3. Basic understanding of all different categories of antibiotics and be able to apply logic in regard to types of infection and the most appropriate type of antibiotics used to treat that infection. This would include community acquired pneumonia, urinary tract infections and some more complex diseases such as tuberculosis.
4. Understand the basic pathophysiology of HIV infection, concurrent infections and the treatment thereof.

Neurology

Residents are expected to be available from 7:00 AM to 7:00 PM, Monday through Friday. Weekend responsibilities are variable. There is a suggested reading list that you should pick up before you begin the rotation. In addition to the in-patient consult service, you will go to the Michigan Institute of Neurological Diseases (MIND).

Goals:

1. Enhance the proficiency of the resident in performing comprehensive evaluation of patients with neurological illnesses with main emphasis on the outpatient experience.
2. Understand pathogenesis of disease, environmental factors, genetic propensities and lifestyle impact on disease.
3. Enhance the resident's skills in assessment and management of strokes, dizziness, dementia, headaches, demyelinating disease, neuropathies and other illnesses that commonly present to the office of the primary care physician.
4. Afford the resident the opportunity to perform lumbar puncture and enforce the knowledge of indications and contraindications.
5. Enhance the resident's management ability in the proper selection and interpretation of CT, MRI, EEG, evoked studies, EMGs, angiography and other tests.
6. Comprehensive review of the latest edition MKSAP, Pearls of Minnesota, University of Wisconsin curriculum and other reading assignments with specific emphasis on the list attached with this curriculum.

Objectives:

1. This rotation is one month duration. The rotation is structured to give the resident the opportunity of first encounter and follow up of patients assigned by the teaching faculty.
2. Residents are to be given the opportunity of evaluating patients of all socioeconomic status, both sexes, including adolescent and geriatric patients.
3. The rotation enhances the skills of the residents in lumbar puncture. The rotation also emphasizes the knowledge of indication and interpretations of procedures such as EEGs, MRIs, CT, angiography, evoked studies, EMGs and other testing.

4. The Neurology rotation is mainly structured to enhance the residents' skills in diagnosis and management of neurological problems encountered in the office of an internist.

There are two Neurology services. One is under the guidance of Dr. Aaron Ellenbogen. The other is directed by Dr. Lee Marshall.

Gastroenterology

Dr. Ronald Rasansky is the rotation director. He has an in-patient consultative rotation, and performs both in-patient and outpatient endoscopies. He also has an office in Madison Heights. The office portion of the rotation is necessary and an important part of the educational process. Office hours are:

Tuesday	1:00 PM to 5:30 PM
Thursday	8:30 AM to 12:30 PM

Goals:

1. Enhance the clinical skills in understanding the pathogenesis, diagnosis and management of gastrointestinal disease that is essential to the practice of the primary care internist.
2. Enhance the skills of the resident in patient education of gastrointestinal disease.
3. Emphasize the history of dietary habits, food intolerance, medication use, drug interaction, use of laxative and anti-diarrhea medication, gastrointestinal bleeding, functional bowel syndrome and sexual dysfunction.
4. Demonstrate knowledge in risk factors and prevention of gastrointestinal malignancy including liver, biliary, pancreatic and gastrointestinal malignancy. Understand surveillance exams, genetic counseling and new test of genetic faults.
5. Comprehensive knowledge of gastrointestinal complication of immunosuppressed patients.
6. Residents are to participate in endoscopy and acquire detailed knowledge of indications and complications of procedures.
7. Prepare the residents for the Internal Medicine board certification examination.
8. Understand endoscopy, both the upper and lower GI tract, depending on patient load and diversity of patient disease processes.
9. Be able to have basic interpretation of plain film GI series along with CT scans of the abdomen and pelvis.

Objectives:

1. Perform comprehensive history and physical in regard to the gastrointestinal tract and the liver.
2. Understand the pathophysiology of rectal examination and be able to interpret occult blood in the stool.

A list of 25 questions is provided as a guideline with the goal of a one question per day discussion. You must read and prepare an answer to each question before discussion. There is also a monthly GI journal club in the evening and attendance is expected.

Nephrology

There are two nephrology groups who provide both inpatient and ambulatory experience.

Goals:

At the end of the month's rotation, the resident should be familiar with:

1. Physiology of fluids and electrolytes and its disorders, its symptoms and presentations, its workup, complications and management.
2. Physiology of acid-base balance and its disorders, its symptoms and presentations, its workup, complications and management.
3. Physiology of primary and secondary hypertension, its symptoms and presentations, its workup, complications and management.
4. Symptoms and signs of kidney disorders, including glomerulonephropathies, cystic diseases, inherited and metabolic diseases, nephrolithiasis, connective tissue disorders, and renal diseases of pregnancy, renal failure (acute and chronic); their disease mechanisms and physiopathology, treatment and management.
5. Physiology of, indication for, management and complications of renal replacement therapy, including dialysis, transplantation and CRRT.
6. Changes in pharmacodynamics and kinetics in the setting of the renally impaired patient, epidemiology of renal failure, including its impact on public health and medical economics.

Objectives:
Since the trainee may or may not pursue a career track in Internal medicine, the specific instructional objectives will be tapered toward a more general approach. The trainee must become familiar with the principles and fundamentals of:

1. Fluids and electrolytes
2. Acid-base equilibrium
3. Primary and secondary hypertension
4. Renal failure, both acute and chronic
5. Glomerulonephritides, nephritic and nephritic syndrome
6. Familial and inherited diseases, including cystic and metabolic diseases, of the kidney
7. Renal replacement therapy
8. Diseases of the kidney in pregnancy

The trainee will:

1. Elicit a history and complete a thorough physical examination with particular attention to the symptoms and signs of volume disorders and renal disease.
2. List a focused and appropriate differential diagnosis.
3. Perform a complete dipstick and microscopic urine analysis.
4. Order appropriate laboratory and other diagnostic studies to secure one's diagnosis.
5. Assess volume status and order appropriate replacement fluids
6. Appreciate some basic sonographic patterns of renal disease, including cysts, masses and hydronephrosis
7. Identify patients at risk for secondary forms of hypertension and purse the investigations appropriate to the specific case.

Specific diseases or disease states that will be encountered and/or discussed include:

1. Disorders of volume
2. Disorders of sodium and potassium balance
3. Metabolic acidosis and alkalosis
4. Primary and secondary hypertension, with particular attention to renovascular disease and hyperaldosteronism
5. Glomerulonephritides, including SLE
6. Inherited diseases of the kidney, including PCKD

7. Acquired cystic diseases of the kidney, including renal cell CA
8. Obstructive uropathy, including nephrourolithiasis and its metabolic workup
9. Altered normal physiology in pregnancy, and aberrant forms, including pre-eclampsia
10. Acute renal failure
11. Chronic renal failure, including ESRD and transplantation

Remember to get the information for each of your subspecialty rotations from Medical Education.

CRITICAL CARE MEDICINE ROTATION

Work Schedule:
Monday through Friday, 6:00 AM to 6:00 PM
Weekends have 24 hour call
Call schedule:
Every fourth night, including weekends and holidays

Attending Physicians:
Scott Simecek, D.O.
Ron Sherman, D.O.
Lisa Kaiser, D.O.
Jeffrey Marshick, D.O.
Robert Reagle, D.O.
Jack Belen, D.O.
Mary O'Connor, D.O.
Fellows:
Natasha Joshi, D.O.
Elisabeth Chapaton-Rivard, D.O.

Critical Care Medicine is actually a multidisciplinary field. It is a fast paced rotation. You will work hard, but the amount of knowledge you will gain is amazing!

This is a typical day's schedule:

6:00 AM to 9:00AM	Patient care
9:00 AM to 12 Noon	Patient rounds Some of the attendings like to round as early as 8 AM so you may have to get to the hospital earlier to see your patients
12 Noon to 1:00 PM	Noon lecture
1:00 PM to 6:00 PM	Patient care

You are not expected to go to morning report—this **is the ONLY in-house medicine rotation during which you are exempt from morning report**. **You are expected to go to noon lecture, work schedule permitting**. You are also **expected to go to any conferences such as Chest Conference. Pulmonary/Critical Care Journal Club** will be held one evening a month and you are expected to attend. Call schedules should be adjusted to accommodate attendance, while complying with the AOA Work Hour Regulations. Changes in the call schedule will be the responsibility of the individual house staff while on service. Articles will be assigned for presentation.

Goals:
The resident will become familiar with the principles involving the following disorders:

1. Cardiac arrhythmias
2. Myocardial infarction
3. Hypertensive emergencies
4. Aortic dissection
5. Intracranial hemorrhage
6. Acute deep venous thrombosis
7. Penetrating trauma to the heart
8. Blunt trauma to the heart
9. Acute arterial obstruction
10. Dissecting aortic aneurysms
11. Cardiac tamponade
12. Pulmonary embolism
13. Respiratory failure
14. Pneumothorax

15. Adult respiratory distress syndrome
16. Drowning
17. Shock (hypovolemic, cardiogenic, septic, hyperthermic, hypothermic)
18. Endocarditis
19. Diabetic ketoacidosis
20. Lactic acidosis
21. Adrenal insufficiency
22. Acute renal failure
23. Gastrointestinal hemorrhage
24. Intestinal infarction
25. Status epilepticus
26. Acute spinal cord compression
27. General principles of overdosage
28. Line sepsis
29. Hepatic encephalopathy
30. Fulminant hepatic failure

Objectives:

1. Basic concepts of shock-blood volume, ECF, classification.
2. Fluid resuscitation, crystalloid vs. colloid.
3. Indications and hazards of blood transfusion.
4. DIC and other coagulopathies.
5. Sepsis, septic shock and multiple organ failure.
6. Pulmonary edema - cardiogenic and non-cardiogenic.
7. Ventilator management; use of PEEP, different modes of ventilation, pressure support, pressure control, inverse ratio, intermittent mandatory ventilation.
8. Weaning techniques.
9. Airway management; management of pneumothorax.
10. Invasive procedures; arterial, central venous and pulmonary artery catheterization, indications and complications.
11. Interpretation of hemodynamic profiles, optimization with fluids, inotropes, vasopressor and vasodilators. Treatment of cardiac failure.
12. Acid-base disorders.
13. Nutritional support; enteral and parenteral indications, abuses.
14. Alcohol withdrawal, drug overdose, seizure disorders, comatose patient, ICP monitoring.
15. Diabetic ketoacidosis.
16. Scoring systems.
17. Ethical considerations related to DNR, CPR, life support interventions. Considerations of informed consent and refusal of treatment.
18. Evaluation of fever in the ICU.
19. ICU sedation
20. Use of kinetic therapy beds
21. Post v tach arrest cooling protocol

Please refer to the Critical Care Medicine rotation manual for additional information.

OBSTETRICS

INTRODUCTION

Primarily, the OB/GYN rotation will be at St. Joseph Mercy Oakland in Pontiac.

This rotation is designed to expose the resident and student to the management and care of the obstetrical patient. The resident and student will have the opportunity to participate in the prenatal, labor, and postpartum care as is appropriate.

It is difficult to formulate rules of procedure for the management of obstetrical patients because of the many variables involved. It is, therefore, essential that everyone concerned in the management of these patients be **"extremely vigilant."** Physical findings of a patient in labor may change abruptly. The necessity of close attention and accurate recording cannot be over-emphasized.

Those charged with the responsibility of care of obstetrical patients should constantly remind themselves that they are attending patients who are anticipating one of the most joyful, but potentially tragic of all human experiences. The responsibility involves the care of two lives, which are intimately interdependent. A reduction of morbidity and mortality can be accomplished only if all concerned are sincerely attentive and conscientiously alert. Close cooperation between nurses, house staff, attending physicians, and anesthesiologists will aid in the identification and correction of complications present or potential. The patient's welfare should be the paramount consideration in this relationship.

GOALS OF TRAINING

The goal of this service is to provide the resident and student with an opportunity to develop a working knowledge of obstetrical care and management of routine obstetrical patients. In addition, some of the more common complicated obstetrical patients that are routinely managed by general obstetricians in the office and hospital setting will be seen. This includes both hospital and office-based participation in the antenatal, intrapartum, and postpartum care**. The OB/GYN Residency coordinator will give a formal service orientation at 9:00 a.m. on the first day of the rotation. This will take place in suite 501 in the Medical office building adjacent to the hospital. All residents and students on the service are expected to attend!**

DUTIES AND EXPECTATIONS

The obstetrical patients admitted to Labor and Delivery is the ***residents' first responsibility***. The utmost cooperation between residents, resident, attending physician, and nursing staff is essential. In no other department of this hospital is there a greater opportunity for practical experience. This, of course, is dependent upon the interest and initiative of the individual.

The resident and student should feel free to approach a resident or any member of this department with questions and suggestions. The following is not all-inclusive.

1. The residents and externs are responsible to see that the history & physical exam is completed on all patients admitted to the obstetrical service, (L&D, Postpartum, and Medical).
2. The resident or extern is responsible to chart labor progress, (Progress Notes), and update the labor board.

3. The resident or extern is to manage the labor of assigned patients under the supervision of the obstetrical resident. This includes vaginal exams and assessment of patients for possible amniotomy, insertion of Internal monitoring devices, and administration of medications for augmentation, induction, tocolysis, and pain control. Any pathological condition of pregnancy, (Premature Labor, Pre-eclampsia, Mitral Valve Prolapse, GBS, Gestational Diabetes, etc…), that the resident or extern finds should be reported to the OB resident.
4. The resident and extern are to be cognizant of the fetal monitors and respond when indicated, notifying the resident. In addition, the resident and extern are expected to be proficient in all basic functions of the central fetal monitoring system.
5. The resident and extern are to scrub and assist with deliveries, (routine and surgical).
6. The resident and extern are responsible for the examinations of patients prior to admission under the supervision of a resident. **The resident must be notified, prior to examination, of all patients.**
7. The resident and extern are to begin rounds on postpartum patients and write his/her ***daily progress notes***, particularly, but not limited to, those patients in which he/she assisted with their delivery. A morning report is held Monday – Friday at 7:00 a.m. in conference room on labor and delivery.
8. The resident is to become proficient in performing circumcisions under the supervision of one of the senior obstetrical residents.
9. The resident and extern are to follow a preset in-house rotation schedule so that your limited exposure to OB/GYN may be rewarding. This schedule will allow exposure to obstetrical, gynecologic surgical, and office-site patients.

GYNECOLOGY

Most Gyn rotations will be with Dr. Zaidan or Dr. Cohen.

INTRODUCTION

An increasing number of office and hospital visits each year are for gynecologic complaints. As these numbers increase, we need to increase our knowledge and awareness of the female patient. As new information is obtained in areas such as the diagnosis and treatment of sexually transmitted diseases, gynecologic malignancies, contraception, and infertility, we must have physicians ready to utilize this information.

GOALS OF TRAINING

The goal of this service is to provide the resident and extern with a working knowledge of gynecologic assessment, diagnosis, and treatment in a hospital and clinic setting. It is hoped that with active participation on the service, both the resident and extern will learn the skills necessary to manage routine gynecologic patients. Upon completion of the service, the resident and extern should be able to perform a proper history and physical, pap smear, pelvic examination, breast examination, identify and treat genital tract infections, counsel patients on contraception, select the appropriate type of contraceptive method when indicated, and be able to identify common gynecologic problems requiring diagnostic studies or surgery. The resident and extern will also have the opportunity to participate in both major and minor gynecologic surgery as the opportunities present.

DUTIES AND RESPONSIBILITIES

The residents and students are responsible for the following:

1. To see that the history and physical exam has been completed on all patients admitted to the gynecologic service.
2. To participate in daily rounds, including both surgical and non-surgical GYN patients.
3. To participate in the OB/GYN clinic. Here outpatient care of routine gynecologic patients will be learned (contraception, STD's, yearly exams, etc…).
4. To scrub and assist on major and minor surgeries when possible.
5. To perform gynecologic consults with resident supervision in the emergency room or on in-house patients.
6. To respond to problems that patients have on the gynecologic service floor.

ORTHOPEDICS ROTATION

Work Schedule:
Monday through Friday, 6:15 AM to 7:00 PM
Weekends' variable
Rotation Director:
Michael Fugle, D.O.
Residency Program Director:
Michael Fugle, D.O.
Chief Resident:
Robert Render, D.O.

During the Orthopedics rotation you will learn how to perform a thorough musculoskeletal examination, develop an understanding of orthopedic procedures and participate in pre- and post-operative patient care.

Resident responsibilities:

1. The work schedule is from 6:15 AM until 7 PM. The workday begins with morning report that is held in the 7 North conference room, Monday through Friday.
2. Residents will do the admission history and physicals on patients admitted to an orthopedic physician. Residents will also be available to do pre-admission history and physicals (PATs), especially those planned for orthopedic procedures.
3. The orthopedic chief resident will assign the resident to a certain attending/attendings.
4. If the resident will rotate through Crittenton Hospital, clearance must be obtained from Medical Education, call Gloria for a badge.
5. You will participate in daily rounds with residents and attendings. Rounds begin after morning report usually at 6:45 or 7:00.
6. You are expected to attend the monthly orthopedic journal club. Only Ortho PGY1s are expected to attend the monthly Division of Orthopedics meeting. It is held on the first Tuesday of each month at 7:00 AM in the 6 North Classroom.
7. Please check with your resident regarding weekend responsibilities.
8. You are responsible for one topic based lecture or case presentation to be given your last week on service.

Evaluations will be completed by the McLaren-Oakland orthopedic attending and chief resident. Points of consideration include; quality of soap notes and orders, weekly x-ray conference participation, preparedness, office participation, presentation, progression of orthopedic knowledge and surgical skills throughout your rotation.

How to survive this rotation:

- Be on time!
- Participate in lecture, office and rounds.
- Be familiar with orthopedic surgical procedures
- Know the surgical schedule
- Know your anatomy!

There are a few guidelines when you are in the office:

- DO NOT WEAR SCRUBS!!! Be professional!
- Be on time. Office hours begin at 8:00 AM
- See the patient, read x-rays, participate in patient care
- Learn how to apply and remove casts

OTOLARYNGOLOGY ROTATION

Work Schedule:
Monday through Friday, 7:00 AM to 7:00 PM
Call Schedule:
None
Program Directors:
Carl Shermetaro, D.O.
Gary Kwartowitz, D.O.
Chief Resident:
Ahmed Maki, D.O. Adam Rourke, D.O.

ENT is a surgical subspecialty rotation. To obtain a copy of the Rotation Description/reading suggestions please contact Sheela John, Medical Librarian (Sheela.John@McLaren-Oaklandmedical.org). You will have both in-patient and ambulatory exposure to patients. As a resident on this rotation, you will participate in the preadmission history and physical assignment pool, monthly journal clubs, weekly education meetings.

You will prepare one short lecture for this rotation. It will be given on the Thursday or Friday of your last scheduled week or during dept. meetings. Please discuss the topic with the resident in advance. We encourage it to be applicable to the field of your interest. The department meets the 2nd Friday of every other month.

Rotator Responsibilities:

1. See consults and round on patients in house when applicable
2. Get Primary Care in Otolaryngology Text from your the resident (Academy website) and read it during the first week on service
3. Give a 15 minute powerpoint presentation on an ENT topic (chosen by you and approved by the resident) on last or 2nd to last day of rotation
4. Take a Quiz on the last day of your rotation
5. Prior to your first day of rotation or your first day at Crittenton Hospital (when possible), verify with McLaren-Oakland Medical Education that papers for Crittenton have been sent and go to Crittenton to obtain badge. (further instructions below)
6. Attend weekly Wednesday night education sessions from 6:30-9 p.m.

Rotation Objectives:

1. Understand the difference between Otitis Media, Bacterial Otitis Externa, and Otomycosis and the organisms responsible for each.
2. Be able to read and understand the three basic types of tympanograms.
3. Know basic causes of Sensorineural Hearing Loss and Conductive Hearing Loss and be able to distinguish the two types on audiogram.
4. Know and identify the four sets of sinuses on CT imaging. Know anatomically where the sinuses drain.
5. Understand basic salivary gland anatomy and the most common neoplasms of the salivary glands.
6. Understand the basic anatomy of the tonsils and adenoid and their grading system for size.
7. Be able to list the four basic types of thyroid cancer and their distinguishing characteristics.
8. Be able to differentiate between central and peripheral presentations and causes of facial nerve palsy.
9. Understand basic facial nerve anatomy (the 5 peripheral branches).

10. Be able to classify the two main types of nosebleeds; understand the differences in anatomy, presentation, and treatment. Know the anatomy of the nasal septum.
11. Know the difference between dizziness and vertigo; be able to identify the features of BPPV and Meneire's disease.
12. Create a differential diagnosis for congenital neck masses.
13. Create a differential diagnosis for hoarseness.

Rotation Reading Suggestions:
Primary Care Otolaryngology Text from the American Academy of Otolaryngology
Lalwani's Current Diagnosis and Treatment in Otolaryngology (in McLaren-Oakland medical library)
Bailey's and Cummings are other ENT textbooks also available in the McLaren-Oakland library for those who are interested

Hospital Coverage
McLaren-Oakland Hospital
50 N. Perry St., Pontiac, MI 48342
(248) 338-5000

Crittenton Hospital
1101 W. University Dr., Rochester, MI 48307
(248) 652-5000

Clarkston Surgery Center
5701 Bow Pointe Dr., Clarkston, MI 48346
(248) 922-4800

ENT Attending Physicians

Attending	Address	Office number
Dr. G. Kwartowitz	1. Clarkston Office: 5701 Bow Pointe Dr., Suite 200 Clarkston, MI 48346 2. Rochester Hills Office: 75 Barclay Circle, Suite 105 Rochester Hills, MI 48307	248-628-3100 248-299-6100
Dr. C. Shermetaro	Please see Dr. Kwartowitz Also, Metamora Office 809 W. Dryden Rd., Metamora, MI 48455	Same as Dr. Kwartowitz
Dr. A. Downs	Please see Dr. Kwartowitz	Same as Dr. Shermetaro
Dr. E. Monsell	43494 Woodward Ave. Bloomfield Hills, MI	248-335-9800

PEDIATRIC ROTATIONS

Pediatric rotations may be at one of the following locations:

1. Children's Hospital of Michigan
2. McLaren-Oakland Medical Center

The rotation at Children's Hospital of Michigan is pediatric emergency medicine. This rotation has shift work. Educational lectures will be on-site.

The McLaren-Oakland rotation is under the guidance of Dr. Peter Alnajjar. There is both in-patient and clinic experience.

Residents on house are expected to evaluate pediatric patients when they are admitted.

REHABILITATION UNIT

Kenneth Richter, D.O.
Answering service 248-858-6420 #2730
After 9 PM: 248-391-4121
Answering service 248-858-6240 #4404

The Rehabilitation (Rehab) Unit at McLaren-Oakland Medical Center is a discrete, separate unit of the hospital campus. Patients are discharged from the medical complex and re-admitted to the Rehab Unit, with a new history and physical. Dr. Richter and his staff usually complete this history and physical. Medicine attendings are asked to consult. You may be asked to do the consultation on patients on this unit. You may be asked to do a history and physical on a rehab patient on rare occasions by your medicine attendings. Otherwise, these history and physicals DO NOT go into the assignment pool.

Although the Rehab Unit is discrete from the medical complex, it is still part of McLaren-Oakland Medical Center. So if you are called to see a patient, you must go to evaluate the patient and write a progress note. You should then call Dr. Richter to let him know about your assessment. You may also have to call another attending. Dr. Richter will take care of routine matters such as medication renewals. This means that the only calls you get from Rehab should be those to evaluate a patient with an acute problem.

If you decide that a patient needs to be transferred to a Medical Unit, please call Dr. Richter. He wants to know what is happening to his patients. He may have valuable information regarding the treatment of the patient. (This is true with all attendings.) Sometimes you may change your mind about the need to transfer after Dr. Richter gives you pertinent information. If a patient is transferred back to a Medical Unit, please ask Dr. Richter which physician the patient should be admitted to.

Dr. Richter invites any house officer to do an elective rotation with him.

OSTEOPATHIC MANIPULATIVE MEDICINE CONSULT SERVICE

Rotation coordinator:
Mary Goldman, D.O.
Phone (248) 338-5562

Mission:
Integration of osteopathic practice (OMT) into all community based osteopathic medical education programs. Provide and document consultation and treatment to hospitalized patients upon request.

OMT Online module:
(www.com.msu.edu/scs/mm - Login: scsmedia Password: scsmedia)

Purpose:
To provide a self-directed module for community training programs to instruct osteopathic physicians with one method of performing an osteopathic musculoskeletal exam on the hospitalized patient.
Expected Outcomes:

- Increase frequency of documented OME on hospitalized patients
- Improve standardization of OME documentation
- Improve qualitative information on OME forms
- Provide each DME/Program Director with tools to measure and document OPP integration into the internship and residency programs

Instructions for use:

- DME assigns house staff to view the module and return the following OPP competency forms:
  - OME Content Exam score
  - Pre and Post self-efficacy questionnaire
- Dr. Goldman schedules an OME "live performance" assessment workshop for all house staff
  - OME Critical Action Worksheet

This rotation exposes the house staff to the osteopathic consultation and management of patient care. An outpatient osteopathic clinic is part of the outpatient clinic department and sees patients four days per week. This constitutes the continuity of care component of OMT. The OMT service crosses all medical and surgical specialties.

The didactic component is in the form of lectures and individual demonstrations. The osteopathic component is supplied by this department to all other departments upon request. The monthly didactic lectures will integrate with the topic of that month.

OSTEOPATHIC MANIPULATIVE THERAPY PROTOCOL COMPETENCIES

TECHNIQUE	***Competence Confirmed***
Anterior Cervical Traction • Patient supine, physician standing or seated at the head of the table • Place second through fifth fingers along cervical paravertebral muscles • Gently lift muscle tissues anterior and lateral • Do not allow fingers to slide across skin	☐
Rib Raising • Patient supine, physician at patient's side • Finger pads over rib angles posteriorly • Apply traction to rib angle while keeping wrists straight	☐
Thoracic Pump • Patient supine, physician at the head of table • Place hands just inferior to clavicles with heels of hands over ribs 2-4 • Angle hands laterally with fingers spread • Apply gentle rhythmic pumping through flexion-extension motion of elbows (120x/min)	☐
Pedal Pump • Grasp patient's feet in each hand • Dorsiflex feet and gently directly force cephalad in a rocking motion	☐
Thoracolumbar Diaphragm Release • Thumbs on lower costal margin with fingers over lateral thoracic cage • Rotate to the restrictive barrier • Ask patient to "breath in and out through mouth" • Adjust tension until there is equal excursion of the right and left diaphragm	☐
Document on OMT Record	☐

Comments: _____

_____

_____

Name:_____ Date:_____

Level: Extern Intern Resident Attending

_____

Signature of authorized Osteopathic Methods and Concepts Committee representative

GERI PSYCHIATRIC UNIT

Rotation Directors:
Srinivasa R. Kodali, M.D.
Jayswant Bagga, MD
Beeper: (248) 333-6645

The Geripsychiatric Unit at McLaren-Oakland is a discrete, separate unit of the hospital campus. Patients may be admitted directly into this unit, or are discharged from a Medical Unit to the Geripsychiatric Unit. When patients are admitted to this unit, they need a history and physical, even if it is a transfer from a Medical Unit. Although it looks like an in-hospital transfer, it is actually to a different type of unit, just in the same Medical Complex as McLaren-Oakland. If there is an emergency and you are asked to evaluate the patients on this unit, please respond. You should not receive routine calls about patients. If the patients have any medical problems, there is usually an internist on the case. The internist will handle routine problems.

If you decide to transfer the patient to a Medical Unit after your evaluation, please call Dr. Bagga. He would like to be informed of the course of his patients. If there is no medicine attending on the case, please ask Dr. Bagga which physician the patient should be admitted to.

The Geripsychiatric Unit is not equipped or licensed to manage IVs or any intravenous medications. There is no pulse oxymetry or EKG machine on the unit. If any medical intervention is needed on a patient, the patient must be transferred to the Emergency Medicine Observation Unit, or admitted to a Medical Unit.