Introduction:
The goal of the Internal Medicine Residency Program is to train physicians to achieve the knowledge, skills, and attitudes required of a specialist in Internal Medicine. All graduating residents meet the certification requirements of the American Board of Internal Medicine (ABIM). The program strictly follows the training requirements provided by the Internal Medicine Residency Review Committee of the Accreditation Council of Graduate Medical Education (ACGME) and endorses the six competencies recommended by it.

Training Requirements for Admission to the Certifying Examination in Internal Medicine:

1. Each resident must complete 36 months of residency training. He/she must complete a minimum of 33 months of actual training. The board allows 3 months for vacations or other leave of absence. Vacation leave may not be forfeited to reduce the duration of training to less than 36 months.

2. Of the 33 months of minimum required training, 30 months must be spent in internal medicine. A maximum of 3 months may be spent in structured supervised electives such as research or administrative chief resident.

3. The 30 months of internal medicine training must include rotations in general internal medicine, subspecialty internal medicine, critical care medicine, geriatric medicine, and emergency medicine. Included in these 30 months is a maximum of 4 months of non-internal medicine primary care such as neurology, dermatology, office gynecology, and pediatrics.

4. Each resident must complete 24 months of "Direct Patient Responsibility". This does not include electives on primarily consultative services such as cardiology, gastroenterology, and pulmonary.

5. Each resident must complete ACLS.

6. Each resident must develop proficiency in drawing blood, start intravenous fluids, performing pelvic examinations and pap smears, and insertion of nasogastric tube. Further more each resident must become proficient in interpreting ECG’s.

7. Each resident must understand the indications, contraindications, complications, and the technique of performing abdominal paracentesis, arthrocentesis, central lines, lumbar punctures, and thoracentesis so that an informed consent can be obtained.

Please note these are the minimum ABIM requirements, not the program’s requirements. See section 19 regarding Departmental Procedure Policies.
1. A resident may have a maximum of 6 months of critical care training. He/ she may have an additional 2 months of electives in critical care related areas.

2. A resident may have a maximum of 3 months of Emergency Room training.

3. A resident's workweek must not exceed *80 hours per week, when averaged over any 4-week rotation or assignment*. Residents must log their duty hours on the New Innovations residency management suite. Furthermore, time cards will periodically given to the residents to confirm the data entered into the New Innovations residency management suite. Faculty will attempt to complete teaching rounds by 11:00 AM so that the residents can complete their work in time to attend the noon mandatory conference. To assure compliance with the 80 hour work week, the hospitals will be checked for stragglers.

4. *Averaged over a 4-week period, each resident should have an average of one day per week free of patient care responsibilities.*

5. Residents must attend at least 60% of required conferences. Each resident must sign the attendance sheet at the beginning of the conference to receive credit for attendance. This includes noon didactic lectures and subspecialty conferences. The conference schedule may vary or change during the academic year as conferences are reevaluated. Residents who do not attend at least 60% of the required conferences cannot be advanced to the next level (year) of training and will be placed on observation in accordance with the TTUHSC House Staff Administrative Guidelines, section V.C.9.a.

**Internal Medicine Departmental Policies:**

1. **Benefits:**
   a. Educational Allowance:
      - PGY-1 Residents: $1000 for books, subscriptions, and travel – may not be carried forward to second year if not used.
      - PGY-2 Residents: $1600 for books, subscriptions, and travel – may not be carried forward to third year if not used.
      - PGY-3 Residents: $1750 for books, subscriptions, and travel – must be used before graduation date or it will be forfeited.
      Allowance will be prorated when post graduate year (PGY) is off cycle.
   b. ACLS Course
   c. Each PGY-1 resident will receive a $5000 sign-on bonus.
   d. Each PGY-2 resident will receive a $2500 retention bonus.
   e. Lab Coats – 3 Lab coats are provided for PGY1. 1 Lab Coat for PGY II and PGY III at department expense, to all new residents. Replacement lab coats, embroidery, and sewing of TTUHSC patch, will be at the expense of the resident. (TTUHSC patches are provided by the department)
   f. Meals - Meals at Memorial Hospital and Medical Center are provided by the hospital. Each resident will be provided with an $80.00 per rotation meal ticket when on rotations at Medical Center Hospital and an unlimited meal ticket when on rotations at Midland Memorial Hospital. At Midland Memorial Hospital meals are provided at lunch and for the residents on call.
g. Copier/Coping Privileges - copies and transparencies for conferences will be provided at no charge.

h. Travel - Educational funds may be used for travel to educational and/or scientific meetings (one per year) with prior approval of the Program Director. Travel to scientific meetings where the resident is presenting a paper or poster session will be paid by the department.
   - Travel to Big Spring: Travel to the VAMC is reimbursed at the State Rate effective at the time of the elective. Two round trips to Big Spring is allowed per week. If continuity clinics must be attended to meet ACGME regulations, those trips will be reimbursed at the same rate.
   - Local travel is not reimbursed.
   - Travel while on the consultation service may be reimbursed at the discretion of the Program Director.

i. Pagers - Medical Center Hospital provides Pagers. Lost pagers will be replaced at the resident’s expense.

j. Immunizations - First year residents are given Hepatitis B and MMR vaccinations. Residents who where previously vaccinated must provide proof of vaccination and immunity.

k. Tuberculosis skin testing - Annual tuberculosis skin testing is required by TTUHSC Policy. Prior BCG vaccination does not exclude the need for tuberculosis skin testing. A chest X-ray will be required for all residents with positive tuberculosis skin tests. The expense will be carried by the Department of Internal Medicine.

2. Leave
   a. All requests for leave must be submitted in writing, using the designated form, to the Department Coordinator. The form must be completed in its entirety. Prior to approval of any leave all medical records must be completed and current as well as time cards.

   b. Requests for vacation must be submitted at least 3 months before the planned date.

   c. Requests for sick leave must be submitted at the earliest practicable time. The use of sick leave is strictly limited to the time when sickness or injury prevents the resident from performing his/her duty. Abuse of sick leave such as frequent requests, calling in sick only on Fridays and weekends, calling in sick only on days when on-call, or calling in sick only when the service is heavy will not be tolerated. Time taken for illness on either side of vacation requires a physician’s statement; otherwise, the leave will be counted as vacation or leave without pay, if all vacation leave has been exhausted.

   d. Leave for education and career advancement is subject to approval by the Program Director or the Associate Program Director. Such leave shall not be more than 5 working days per academic year. Documentary evidence such as conference schedule and subsequently documentation of conference registration or letter of invitation for the interview must be submitted.
e. For parental leave of absence and unpaid leave under the Family and Medical Leave Act of 1993 (FMLA), please refer to the sections II.C.3 and II.C.4 of TTUHSC Housestaff Policies and Procedures. Please note that leave under these categories are unpaid leave.

f. You must be free of clinical duties on the dates requested for leave. Clinical duties include on-call duties, Clover House assignment, back-up call, and outpatient clinics. The request for leave will not be approved until you have made arrangements for coverage of your clinical responsibilities.

g. You may not request leave during ward rotation, ICU rotation, consult rotation, and VA rotation. Under extraordinary circumstances when you need to request leave during these rotations, the following steps must be followed.
   1. The request must be first approved by the Chief Resident and the attending physician.
   2. You must arrange coverage for clinical duties other than on-call. It must be in writing and signed by both parties.
   3. You must arrange coverage for on-call. It must be in writing and signed by both parties.

h. The allowable paid leave should be used judiciously. If you have used all your allowable paid leave, no additional paid leave will be granted for any reason, including job interviews, fellowship interviews, USMLE examinations, personal issues, immigration-related issues, and departure from the program.

i. There will not be “departure leave” at the end of the training. You must use your own vacation time for that purpose.

j. In general, vacations are not allowed in July.

k. For PGY-2 and 3 residents, only those who are completing their training on June 30 will be allowed to take vacation in June.

l. It is not desirable to take vacation during 2-week rotations, in order to gain maximum experience from the rotation and to receive credit for the rotation.

m. Leave is not approved until the Program Director or the Associate Program Director has signed the request form and a copy of the approval has been returned to you.

n. Failure to complete medical records before taking leave will result in being placed on observation or probation status in accordance with the TTUHSC House Staff Administrative Guidelines, sections V.C.9.a and b.

o. Leave Policies:
   House Staff Administrative Guidelines, sections II. C; Leaves:
   Vacation Leave (may not be carried forward to the next year):
   - PGY-1 and PGY-2: 15 working days per year
   - PGY-3: 20 working days
   Sick Leave (may be carried forward to the next year)
   - 12 working days per year

3. **Professional Conduct:** Fellow residents, patients and their family members, nursing and ancillary staff must be treated in a courteous and professional
manner. Discussions regarding patients, physicians, or nurses must not occur in public areas. Disputes must not occur in public areas. Unprofessional conduct is not tolerated and is subject to either immediate dismissal or placement on probation in accordance with the TTUHSC House Staff Administrative Guidelines, sections V.C.9.d and V.C.9.b.

4. **Attire:** Residents must dress professionally during rounds, clinics, and conferences. “Scrubs” may be used only when on-call at night but, should be changed to professional dress (shirt and tie, etc.) before morning report.

5. **Line of responsibility** – Interns and residents are expected to assume increased responsibility for patient care as they progress through the residency program. The level of responsibility is determined by the resident’s level of knowledge, ability to manage medical problems (simple or complex), the resident’s ability to communicate with members of the health care team, and meeting overall incremental education goals. It should be remembered that the standard line of communication is from the intern to the senior resident to the attending faculty member. Communication should be carried out in a timely and an appropriate fashion. It should furthermore be acknowledged that legally the ultimate responsibility for patient care rests with the attending faculty member.

6. **Hospital Admissions:** Each admission History and Physical Examination (H&P) must be comprehensive, regardless of the complexity of the admission. If the patient had been discharged within seven days of readmission, a brief interval note will be adequate with reference to the prior admission. A comprehensive H&P includes a chief complaint, present illness including pertinent positives, negatives, and modifying factors, past medical history, review of systems, social history, family history, physical examination, differential diagnosis based on presenting symptom(s), physical or laboratory findings, and a comprehensive plan of treatment for each problem. Management plans should be detailed including, for example, specific IV fluid rates, medication dosages as well as oxygen flow rate. The completion of the admission H&P is the responsibility of the PGY-1 resident after discussion of the admission with the senior resident. The senior resident is to write an admission note in the progress section of the medical records.

7. **Notification of hospital admissions:** The attending physician should be informed of each patient’s admission in a timely fashion once the initial assessment has been completed. For ICU admissions follow the ICU protocol. Residents are responsible for the continuing care of their own patients. If a resident’s patient is admitted to either hospital and the patient’s primary resident is not the admitting resident, the admitting resident should notify the primary resident of the patient’s admission. The same policy is true if a resident other than the primary resident sees the patient in the clinic. Full time faculty should be notified, and consulted when appropriate, when their patients are admitted to the hospital.

8. **Patient Load (hospital):** Residents must balance the need for patient care responsibilities with their own educational responsibilities and their own needs for good mental and physical health. Patient loads will depend on the complexity and severity of the medical problems of the hospitalized patients.
a. In general, PGY-1 residents should not have more than five admissions in any 24-hour period or eight admissions in any 48-hour period. After PGY-1 residents reach this level, the senior resident should assume all responsibility for additional admissions.

b. In general, PGY-1 residents should not carry more than ten patients on their inpatient service.

c. In general, senior residents are expected to manage a larger patient load including the patients under the care of the PGY-1 resident. Senior residents, however, should not admit more than eight patients in any 24-hour period or 16 patients in any 48-hour period. When the admissions exceed this number the backup resident should be called to assist. The senior resident should not manage more than 16 patients including those of his junior resident.

9. **Order Writing:** PGY-1 residents under supervision of the senior resident should write all the orders on their patients. Orders must be dated and timed. The resident writing an order must place their hospital physician number beneath his/her signature. Upper level residents should write orders on their patients when PGY-1 residents are unavailable (e.g. continuity clinic). The attending faculty may only write orders under emergent situations when patient care precludes the use of the usual line of responsibility.

10. **Hospital Discharges:** At the time of discharge, a discharge form must be completed, checked for accuracy, and reviewed with the patient. Appropriate prescriptions are to be written clearly. The discharge form is to be completed by the discharging resident with a copy to the medical record, the patient, and the Internal Medicine clinic. The resident discharging the patient is to call the clinic and establish a follow-up date and time (except on weekends). The resident discharging a patient on a weekend must call the clinic the following Monday morning and arrange for the follow-up visit. The resident must then notify the patient of the date and time of the follow-up. The Discharge/death Summary must be dictated at the time of discharge and should include admitting diagnoses, discharge diagnoses, consultations, procedures and findings, brief summary of the present illness and pertinent physical finding, summary of the hospital course, and discharge instructions (including diet, activity, and all medications). The discharge summary is to be dictated by the resident of record. A copy of the discharge instructions must be forwarded to the appropriate clinic in a timely fashion. Any “pending laboratory tests” should be noted to facilitate appropriate follow-up.

11. **Care of the patient seen in the Emergency Department:** All patients discharged from the emergency department must be discussed with the attending faculty member prior to discharge. No patient may be discharged from the emergency department prior to discussion with the attending faculty member.

12. **Care of the “non-teaching” patients:** Residents are not expected to care for patients that do not provide an educational experience. This includes patients admitted by a faculty member for a procedure only, patients that belong to private physicians not associated with Texas Tech, and any patient that the resident does not have primary responsibility for the initial history & physical, and
diagnostic plan and treatment. The resident, however, should respond to any
emergency and manage the urgent situation until the appropriate attending
physician can arrive to take over the medical care.

13. Service needs of the hospitalized patient: Residents are not expected to
provide intravenous, phlebotomy, or messenger/transport services for their
patients. These services are provided by both Medical Center Hospital and
Midland Memorial Hospital.

14. Duty hours must be limited to 80 hours per week averaged over four weeks.
Post-call residents may remain on duty for up to 6 additional hours to participate
in didactic activities, transfer care of patients, and to assure appropriate
continuity of care of their patients. To assure this, continuity clinics will be
cancelled on post-call days. Each resident must remember that should have 10
hours of rest between all daily duty periods. Duty hours will be monitored by
having residents sporadically keep time cards. Residents are assured one day
per week free of clinical, educational and administrative responsibilities.

15. Continuity Clinics:
   a. Resident continuity clinics begin promptly at 1:30 PM for all residents.
      Late arrival to a continuity clinic is not acceptable.
   b. All new patients, regardless of level of service, are to receive a
      comprehensive History and Physical Examination. This note is to be
dictated.
   c. Progress notes should include the patient’s current medications.
   d. Each patient’s “Problem List” is to be kept current.
   e. Laboratory and Radiology reports must be signed and dated before being
      filed in the patient’s medical record.
   f. Health maintenance data (vaccinations, pap smears, rectal examinations,
      etc.) must be recorded on the appropriate flow sheet.
   g. All communication with a patient must be documented in the body of a
      progress note.
   h. The HIV clinic (Clover House) is on Thursday. The clinic schedule varies
each month. Residents are assigned to this clinic by the Program Director
based on their rotations. The clinic begins promptly at 1:30 PM for junior
residents and 1:30 PM for senior residents.

16. Morning Report
   a. Goals:
   - Practice, education, and improvement of:
     - Systematic data gathering, synthesis of data, and analytic skills
     - Decision-making process and ability to properly define priorities in
diagnosis, management, and triage in a cost effective manner
     - Understanding of long-term aspects of patient care, including but
       not limited to prognosis, quality of life, ethics, and psychosocial
       issues
     - Presentation skills
   b. Content:
- Brief presentation of all new admissions as well as patients dismissed from the emergency room, with the most likely diagnosis
- Thorough discussion of selected new admissions
- Scheduled discussions of previously admitted patients, consultations
- Review of the diagnoses and outcomes of previously admitted patients

**c. Format:**

- All new admissions will be briefly presented (max. of 1 min. each). Presentations will include the chief complaint and the working diagnosis/differential diagnosis.
- An *uninterrupted* detailed, pertinent history and physical examination of selected cases (5-10 min) followed by clarification, development of a differential diagnosis (in order of likelihood), and treatment plan by the participating residents. Treatment and ancillary studies must be justified. The decision-making process from the start of the physician-patient encounter will be emphasized. Results of ancillary studies will be discussed including their impact on the diagnosis, severity of illness, and outcome.
- A brief review of pertinent literature will be performed by the presenting resident, and supplemented by the attending faculty.
- Additional hospital admissions will be assigned to individual residents for presentation along with a discussion of pertinent literature
- The senior resident will tally all admissions for comparison of the morning report diagnosis and final diagnosis. Factors affecting discrepancies will be addressed.
- Complications of disease, as well as hospital complications will be discussed.

17. **Attending Rounds/ Work rounds** – Attending rounds will follow morning report and will follow a similar format as the morning report. The exact format will vary according to attending preference. All admissions will be presented, *uninterrupted*, by the first year resident. Again, the emphasis is on development of a differential diagnosis and treatment plan based on the most likely diagnosis (es). Work rounds with the attending will follow, during which individual patient needs will be addressed. The attending work rounds are separate from the resident work rounds.

18. **Call** – Night call is every fourth night while on inpatient rotations. Residents may be assigned call during electives, as required to cover the in-patient services. Senior residents are assigned emergency (disaster) back-up call.

Beginning July 1, 2006 a night float system will be implemented. The night float will come into the hospital at 8:30 PM and leave after morning report. The emergency backup resident is assigned according to the following: consult
resident, third year resident on elective, second year resident on elective. Each month an emergency backup schedule will be posted. Night float residents are to turn off at the completion of their call. Residents are also expected to turn their pagers off on their day off to be free of clinical responsibilities.

19. **Procedures** – All procedures must be recorded in the ABIM procedure logbook and the yellow copy turned into the Program Director within 72 hours of performance. Procedures turned in after 72 hours may not be accepted or credited. Prior to graduation each resident must complete and be certified to independently perform and teach the minimum ABIM required procedures. The Program Director prefers these to be completed by the end of the first year of training. Regardless of the level of training, each resident must satisfy the following requirements prior to performing a procedure (emergency procedures are discussed separately below):

   a. Each resident must be knowledgeable in the procedure to be performed, including:
      - Indications
      - Contraindications
      - Anatomic considerations
      - Patient evaluation and preparation
      - Personnel and equipment
      - Technique
      - Specimen examination and interpretation
      - Post-procedure care
      - Complications

   b. Obtain permission from the supervising attending physician.

   c. Clarify with the attending physician the nature of the supervision the attending will provide (e.g., direct physical presence or indirect supervision without physical presence). While an attending physician may determine on the basis of a resident’s knowledge, experience, and demonstrated ability that the resident no longer requires direct supervision to perform a given procedure, this applies only to the specified procedure and attending. Only the program director can certify a resident competent to perform a procedure independently or supervise a junior resident. As such, a resident must obtain clarification on the nature of the supervision for other procedures with each attending physician.

   d. Fully inform and obtain written consent from the patient (or designated representative as indicated). Procedures requiring written consent include lumbar puncture, paracentesis, thoracentesis, and placement of a central line.

   e. Have a chaperone of the same sex as the patient present if the procedure involves the
      - Female breasts
      - Genitals
      - Anorectal area

(Whenever a resident performs a procedure on a patient of the opposite sex that involves the breasts, genitals, anorectal region or pelvic region, a
A chaperone must be physically present in the room with the patient and resident. All breast and pelvic examinations of the female patient must be performed in the presence of a chaperone. The chaperone must be present throughout the entire examination. The chaperone must be a health care professional and may include other physicians, nurses, or health care assistants. Family members, friends, significant others are unacceptable as chaperones.

In the event of a life-threatening emergency, there may not be enough time to complete items b, c, d, and e above. Further, an unresponsive patient, or a patient judged incompetent to provide informed consent (e.g., intoxicated, acutely psychotic, or for whom a surrogate is not immediately available) may require a life-saving procedure before consent can be obtained. A resident certified by the program director to perform a procedure independently may be required to perform a life-saving procedure before all steps can be completed. Even under such conditions, the resident must have a chaperone present when applicable. The resident should inform the attending physician as soon as possible following completion of the procedure, as well as the patient’s representative when applicable.

Certification to teach a procedure or to perform a procedure independently can be granted only by the Program Director or Associate Program Director and only after thorough review of the resident’s logbook and discussion with each attending physician. Performance of the ABIM’s required number of procedures does not guarantee that a resident is ready to be certified to perform a procedure independently. Each resident must maintain ongoing proficiency to maintain certification to perform independently or teach a given procedure. Certain procedures (e.g., central lines) will be certified according to placement site (e.g., internal jugular, subclavian, and femoral). Attending physicians on a specific service (e.g. ICU/CCU) may elect to require continued supervision of procedures.

Failure to follow these procedural regulations will result in dismissal from the program in accordance with the TTUHSC Housestaff Administrative Guidelines, section V.C.9.d.

20. Committees
   a. Residents will elect representatives to participate on institutional committees including the Quality Assurance/ Risk Management Committee, the Graduate Medical Education Committee, and Infection Control Committee, and the Patient Notification Committee
   b. Residents will elect representatives to participate on the departmental Curriculum Committee, Quality Improvement Committee, Clinical Competency Committee and Resident Recruitment Committee
c. Residents will elect representatives to participate on the following committees at MCH: Cancer, Ethics, Pharmacy and Therapeutics, Quality Management, Quality Monitoring.

d. Residents are encouraged to attend the Department of Internal Medicine meetings at Medical Center Hospital and Memorial Hospital and Medical Center.

21. **Moonlighting** - Second and third year residents in good academic standing (In-training examination scores above the national average and monthly evaluations rated as above average [>5]) may moonlight with the approval of the Program Director. Each resident must provide their own malpractice insurance and must be independently licensed by the state of Texas. The hours spent moonlighting are considered part of the eighty-hour maximum work week. Unauthorized moonlighting will result in dismissal from the program in accordance with the TTUHSC Housestaff Administrative Guidelines, section XVII.

22. **Resident Responsibilities:**

   a. PGY-1: The PGY-1 resident has primary care responsibility for hospitalized patients. He/she will perform and dictate all H&P’s under the direction and supervision of the senior resident. The PGY-1 resident will dictate all discharge summaries under the direction and supervision of a senior resident after completion of six months of training. He/she is responsible for writing daily progress notes. The PGY-1 resident is the managing resident and will write all orders unless an emergency situation dictates that the senior resident or attending faculty do so. By the completion of the first year of training the resident should be capable of managing all uncomplicated admissions without assistance. The resident must develop teaching skills and be proficient in communication with patients, patient families, peers, hospital personnel, and other physicians. The resident must demonstrate the highest degree of professionalism. Residents who have not achieved these goals will be placed on observation in accordance with the TTUHSC House Staff Administrative Guidelines, section V.C.9.b, and not be advanced to the second year of training.

   b. PGY-2: The PGY-2 resident is a supervising resident and will see and evaluate all new hospital admissions and consultations with the PGY-1 resident. He/she will verify the PGY-1’s H&P and assist in the development of an appropriate differential diagnosis of the admitting complaint as well as a cost effective management plan (including the ordering of ancillary tests). The PGY-2 resident must write a brief admission note and treatment plan as well as daily progress notes. The PGY-2 or supervising resident will dictate all discharge summaries with the PGY-1 resident in attendance during the first six months of the academic year. At the completion of the PGY-2 year of training the resident should be able to manage all uncomplicated admissions and the majority of complicated admissions with little assistance. The resident must demonstrate further development of his/her teaching, communication, and professional skills. Failure to achieve these goals will
result in observation and/or probation in accordance with the TTUHSC House Staff Administrative Guidelines.
c. PGY-3: The PGY-3 resident is the supervising resident on the ward and ICU/CCU rotations. His/her responsibilities include organization of daily work rounds, preparation for morning report, preparation for attending rounds, preparation for selected conferences, and regular meetings with the hospital case managers and social workers. The PGY-3 resident is the principal teaching resident and as such must provide appropriate literature to the junior residents. The PGY-3 resident must know all the patients on service. At the completion of the PGY-3 year of training the resident must be able to manage essentially all admissions without assistance and know when to request appropriate consultations. The PGY-3 resident supervising a first year resident will write a brief admit note and daily progress notes. During the PGY-3 year of training the resident must understand the principles of a general medical consultation for services such as surgery, obstetrics and gynecology, and psychiatry. Failure to accomplish these goals will result in being placed on observation or probation in accordance with the TTUHSC House Staff Administrative Guideline, sections XIV and XV. Residents cannot graduate while on disciplinary status.

23. **Resident Scholarly Activity** - All residents are expected to initiate and successfully complete projects of scholarly activity, as part of the requirements for successful completion of residency training. Residents are encouraged to get involved in research and other scholarly activities conducted by faculty. However, at the minimum, each resident is required to complete projects from one of two mandatory scholarly activity “tracks”.

Residents can choose between completing at least one original research project or identify and write-up of a minimal of three case reports. All scholarly activities will be conducted under supervision of departmental faculty (with or without collaboration with community physicians or faculty from other departments). See Resident Research Curriculum and Resident Research Requirements, in this handbook, for curricular details and objectives and detailed timeline and steps for design and execution of clinical research by residents; further departmental policy details are available in the handbook; additional educational resources are available in the Scholarly Activity binder.

Each scholarly activity project proposed by the resident will require approval by the departmental research committee. It is the responsibility of each resident to initiate and complete all phases of chosen scholarly activity in a timely manner. The departmental Director of Research, Program Director, Associate Program Director, faculty advisors and other faculty are available for advice and support for the initiation, execution and completion of scholarly activity projects.

Resident’s performance on mandatory scholarly projects will be evaluated at least quarterly by the Clinical Competency Committee, with input from the faculty
overseeing specific projects, as well as independent review by Director of Research, Program Director and Research Committee. Failure to meet expected goals of knowledge, skills and related professional attitudes can require remediation steps and may affect resident’s overall evaluation, advancement and completion of training.

A Research Curriculum is delivered through didactic sessions, guided self-study and problem-specific written assignments, and research conferences. Residents may take research electives, with the approval of Program Director.

Failure to meet these requirements will result in being placed on observation in accordance with the TTUHSC House Staff Administrative Guidelines, section XIV, and retention at the PGY-1 year of training.

24. **Evaluation and Promotion:**
Assessment of resident’s performance is competency-based and is performed by integrating data from the following sources: written and verbal (as documented by Program director/Associate program Director) evaluations and observations by faculty, resident colleagues, nursing staff, other members of the healthcare team, and TTUHSC staff; mini-CEX (clinical evaluation exam) and full CEX. Input from patients and family members is also incorporated in the evaluation process.

Judgment of resident’s competency-specific and overall performance is done through careful review of each source of evaluation on its own merits and is not based on plain arithmetic averaging of numeric ranking.

Advancement to the next level of training (i.e., PGY-2, 3, and program “graduation”) is not automatic or calendar-based. Resident promotion is based on meeting all competency-specific expectations for resident’s level of training. Specific educational competency objectives are detailed under educational expectations.

25. **Counseling:**
   a. The department has a full time counselor to provide support, as needed, e.g. stress management, family counseling, and bereavement.
   b. Complaints regarding conduct, poor performance, etc will be investigated by the Program Director. Following completion of the investigation the Program Director will provide formal written feedback.

**PROGRESSIVE LEARNING OBJECTIVES FOR INTERNAL MEDICINE RESIDENTS**

The Progressive Learning Objectives document presents the collected Core Competency learning objectives. These learning objectives are collected for the convenience of residents and faculty, allowing rapid review of expectations for each training level.
Please note that stated objectives should never limit our achievement expectations. Residents of all training years should strive to continuously improve their competency in the diverse skills of consummate internists. These collected objectives simply guide faculty and resident progress expectations.

I. Specific Competency Objectives for Patient Care

1. Relationship-building skills. Residents must demonstrate the importance of effective communication when caring for patients as they collect highly personal information
   a. PGY-1 and PGY-2 residents should consistently demonstrate integrity, respect, compassion and empathy for patients and their families. They should establish trust and recognize that the primary concern is the welfare of the patient. Residents at this level of training will respect personal preferences and understand patient rights. They will engage in shared decision making with their patients.
   b. PGY-3 residents should demonstrate the above and aid junior peers in effective communication with patients.

2. History taking. Residents must demonstrate an understanding of the importance of history in deriving a differential diagnosis.
   a. PGY-1 residents will consistently gather essential and accurate information in a timely manner. The database will be organized in a manner consistent with accepted medical convention and charted in a timely and efficient manner. The information will be comprehensive and include data gathered by other providers and laboratory investigations. By completion of PGY-1, histories will be completely hypothesis driven.
   b. PGY-2 and PGY-3 residents will be precise, logical, and efficient in their data collection in addition to the above.

3. Physical Examination. Residents will demonstrate the importance of performing an appropriate and relevant physical exam.
   a. PGY-1 residents will perform a comprehensive physical exam with a consistent sequence. Residents at this level will identify normal from abnormal and will describe the physiological and anatomical basis for findings. Residents will demonstrate the ability to augment their physical exam to elicit data not obtained with standard maneuvers.
   b. PGY-2 residents, in addition to the above, will correctly detect subtle findings and understand their significance. They will be able to teach appropriate physical exam skills to junior peers and medical students.
   c. PGY-3 residents additionally will strive to perform a focused physical exam at the level similar to a sub-specialist, and understand the sensitivity and specificity of maneuvers.

4. Clinical Judgment, Medical Decision-Making and Management Plans. Residents will progressively become more adept at assimilating information that they have gathered from the history and physical exam.
   a. PGY-1 will be able to identify all patients’ problems and develop a prioritized differential diagnosis. PGY-1 residents will begin to develop therapeutic plans that are evidenced or guideline based. Residents will
establish an orderly succession of testing based on their history and exam findings. They will demonstrate appropriate use of diagnostic and therapeutic procedures. Residents will be able to translate all management plans into a properly detailed order format.

b. PGY-2 residents will additionally regularly integrate medical facts and clinical data while weighing alternatives and keeping in mind patient preference. They will regularly incorporate consideration of costs, risks, and benefits when considering diagnostic tests and therapies. They will consistently monitor and follow-up patients appropriately.

c. PGY-3 residents will demonstrate the above and in addition, will demonstrate appropriate reasoning in ambiguous situations, while continuing to seek clarity. Residents at this level of training will not overly rely on tests and procedures. They will assist junior trainees and medical students to become efficient managers through the appropriate use of clinical judgment and effective decision making. PGY-3 residents will consistently establish monitoring procedures and demonstrate the ability to change therapeutic programs for ineffectiveness or adverse side effects.

5. **Oral Case Presentation Skills.** Residents at all levels of training will be adept in oral presentation skills. This will be demonstrated by delivering a case presentation that is organized consistent with medical convention. They will include all important aspects of the history, physical exam, and laboratory investigations. The assessment will be well developed and include an in-depth differential diagnosis and carefully executed diagnostic and therapeutic plan. Extraneous information will be deleted and residents will appropriately and accurately field audience questions. Pertinent materials such as x-rays and EKG's will be included and correctly interpreted.

6. **Counseling.** Residents will recognize the importance of clear and accurate instructions for patients and their families.

a. PGY-1 residents will give patients accurate instructions regarding usage of their medications and follow-up care. They will document their counseling conversations and use flow sheets as necessary. Residents will demonstrate improving skills in assessing patients' health literacy and using such skills to enhance patients' understanding of counseling and care.

b. PGY-2 residents will effectively counsel and educate patients about pertinent health issues, tests and treatments. They will recommend appropriate screening exams by gender and age. Residents will routinely assess and assure patients' health literacy and take proper steps to maximize patients' ability to understand their clinical condition, its management and expected outcomes.

c. PGY-3 residents, in the addition to the above, will consistently and thoroughly educate patients and their families, using patient education as a form of intervention and partnering.
7. **Procedures**: Residents will competently perform medical procedures essential for the practice of general internal medicine. All residents will be supervised for all procedures until certified competent by Program Director.
   
a. PGY-1 residents will demonstrate knowledge of procedural indications, contraindications, necessary equipment, process for handling specimens and patient after-care. They will participate in informed consent and assist the patient with decision making through their knowledge. Residents will attend to the comfort of the patient. Procedures will be thoroughly documented.

   b. PGY-2 and PGY-3 residents will be supervised where skill level dictates. They will demonstrate extensive knowledge and be facile in the performance of procedures while minimizing risk and discomfort to patients. They will assist their junior peers in skill acquisition.

8. **Patient-centered care.** Residents at all levels of training will demonstrate sensitivity and responsiveness to patients’ age, culture, gender and disabilities. Residents will work effectively with allied health care professionals and physician consultants to provide effective, efficient, timely and safe patient-focused care.

II. **Specific Competency Objectives for Medical Knowledge**

Residents must demonstrate progressive expansion of knowledge about established and evolving biomedical, clinical, and cognate (e.g. epidemiological and social-behavioral) sciences and the application of this knowledge to patient care. Residents are expected to:

1. **Know and apply the basic and clinically supportive sciences which are appropriate to their discipline**

   a. PGY-1 residents will
      
      i. Demonstrate knowledge of common procedural indications, contraindications, equipment, specimen handling and patient after-care.
      
      ii. Demonstrate progressive knowledge expansion of basic and clinical sciences.
      
      iii. Demonstrate satisfactory knowledge of common medical conditions, sufficient to manage urgent complaints with supervision. Residents must exhibit sufficient content knowledge of common conditions to provide care with minimal supervision by completion of the PGY1 year.
      
      iv. Take the USMLE Step 3 exam.

   b. PGY-2 residents will additionally
      
      i. Demonstrate a progression in content knowledge and analytical thinking in order to develop well-formulated differential diagnoses for multi-problem patients.
      
      ii. Demonstrate understanding and responsiveness to socio-behavioral issues.
      
      iii. Develop knowledge of statistical principles. Understand and appropriately use sensitivity, specificity, predictive values, likelihood ratio, number needed to treat, and odds ratios.
iv. Pass the USMLE Step 3 exam, with documented passing grade required for promotion to PGY 3.

c. PGY-3 residents will additionally
   i. Demonstrate growing knowledge in the area of their chosen career path.
   ii. Demonstrate knowledge regarding performance of procedures while minimizing patient risk and discomfort.
   iii. Exhibit knowledge of effective teaching and evaluation methods, including RIME, one-minute preceptor, and evaluation techniques.

2. Demonstrate an investigatory and analytic approach to clinical situations.
   a. PGY-1 residents will
      i. Exhibit use of TTUHSC library resources.
      ii. Demonstrate self-motivation to learn.
      iii. Demonstrate sufficient analytic skills necessary to develop appropriate assessments and plans for common medical diagnoses and complaints.

   b. PGY-2 residents will additionally independently present up-to-date scientific evidence to support hypotheses.

   c. PGY-3 residents will additionally
      i. Regularly display self-initiative to stay current with new medical knowledge.
      ii. Regularly demonstrate knowledge of the impact of study design on validity or applicability to practice.
      iii. Present a formal didactic Core Curriculum conference, demonstrating in-depth knowledge of a clinical topic of their choice.

III. Specific Competency Objectives for Practice Based Learning and Improvement Objectives
The ability to use clinical practice and direct patient care as a venue for practice improvement and learning is a life long process; however it is expected that a resident will satisfactorily function as follows:

1. Evidence-Based Medicine. Location, appraisal, and assimilation of evidence from scientific studies related to patients’ health problems. Application of knowledge of study designs and statistical methods to the appraisal of clinical studies and other information on diagnostic and therapeutic effectiveness.
   a. PGY-1 residents should demonstrate the ability to
      i. Be self motivated to acquire knowledge
      ii. Locate scientific literature to support decision-making

   b. PGY-2 residents should additionally
      i. Be able to appraise and assimilate scientific literature
      ii. Demonstrate understanding and use of an evidence-based approach in providing patient care
      iii. Quickly access appropriate reference material for patients in the ICU and general wards
iv. Voluntarily (without prompting or assignment) discuss and research relevant literature to support decisions

c. PGY-3 residents should additionally
   i. Effectively and efficiently use consulting services to improve both patient care and self-knowledge, appropriately integrating evidence-based medicine with expert opinion and professional judgment
   ii. Acquire and use appropriate evidence-based information when acting as a consultant
   iii. Learn and be able to research non-internal medicine patient care issues
   iv. Apply knowledge of study design and statistics to relevant literature
   v. Respond to critical problems in a manner reflecting more than rote learning and protocol management. Residents should be able to utilize and suggest data-driven modification of protocols

2. Continuous Quality Improvement and Quality Assurance. Analysis of practice experience and performance of practice-based improvement activities using a systematic methodology. Obtaining and using information about their own population of patients and the larger population from which their patients are drawn.

   a. PGY-1 residents should demonstrate the ability to
      i. Understand his or her limitations of knowledge
      ii. Ask for help when needed
      iii. Admit to errors and seek help in remedying them
      iv. Accept feedback and develop self-improvement plans
      v. Seek formative feedback on performance
      vi. Deliver care that reflects learning from previous experiences
      vii. Assess patient adherence to ambulatory regimens and accordingly modify prescribing practices
      viii. Participate actively in quality improvement practices pertaining to patient care (e.g., morbidity and mortality conferences)
      ix. Review autopsy findings to understand illness and the care of critically ill patients
      x. Demonstrate improvement in clinical management by continually improving on their various rotations

   b. PGY-2 residents should additionally:
      i. Use self-assessments of knowledge, skills and attitudes to develop plans with insight and initiative for addressing areas for improvement
      ii. Voluntarily plan learning experiences in procedures not yet mastered
      iii. Use unique cases seen in a rotation to self-assess performance patterns

   c. PGY-3 residents should additionally:
      i. Analyze personal practice patterns systematically, and seek to improve patient care
      ii. Utilize ambulatory practice data to actively improve practice and patient management
iii. Compare personal practice patterns to larger populations and seek to improve disparities in own patient care.

3. **Information Technology.** Using information technology to manage information, access on-line medical information; and support their own education
   a. PGY-1 residents should be able to:
      i. Use web-based curricular modules, handheld computers, and web-based resources to access medical literature and data to support and enhance patient care.
   b. PGY-2 and PGY-3 residents should additionally
      i. Independently use PubMed or Ovid and other computerized connections to primary literature to enhance patient care.

4. **Teaching.** Facilitation of learning of students, resident colleagues, and other health care professionals
   a. PGY-1 residents should be able to
      i. Facilitate learning of students and other PGY1 residents
   b. PGY-2 residents should additionally:
      i. Facilitate education of PGY-1 residents and other health care professionals
      ii. Demonstrate evidence-based independent research and preparation when teaching
      iii. Use interactions with nursing staff and other professionals as two-way educational opportunities
   c. PGY-3 residents should additionally:
      i. When acting as a consultant, identify the questions and wishes of the physician requesting the consultation, and respond to these issues.
      ii. Present a formal didactic for resident peers, lasting approximately 45 minutes with additional time to respond to questions and answers. The didactic should reflect significant independent reading of evidence-based literature. The didactic may occur during the standard resident teaching conferences, or upon approval of a mentor the resident may present for Internal Medicine Grand Rounds.

IV. **Specific Competency Objectives for Interpersonal and Communication Skills**
   a. PGY-1 residents should be able to:
      i. **Communication of patient data with members of the healthcare team:**
         1. Provide thorough, yet succinct oral presentations regarding patient care, using appropriate medical terminology;
         2. Provide thorough and complete written or electronic documentation of patient care (i.e., progress or procedure notes, history and physical exams, consultant notes, discharge summaries), which are legible, timely and use appropriate medical terminology.
         3. Demonstrate proficiency in use of verbal and nonverbal skills in interactions outside of the context of patient care.
ii. **Communication with patients and families:**
   1. Residents should be able to establish rapport with patients from a variety of backgrounds; perform a medical interview that elicits patient and physician-centered information, as well as testing diagnostic hypotheses; and effectively communicate uncomplicated diagnostic and therapeutic plans to patients or their advocates.

iii. **Ethically sound relationships:**
   1. Residents should follow the tenets of ethics in patient care. See also objectives for Professionalism Competency below.

iv. **Team work:**
   1. Residents should be able to work as team members with senior residents and attending physicians, including the communication skills outlined above and the coordination of patient care. When supervising medical students, first year residents should be able to observe students, demonstrate skills, and give constructive feedback. First year residents should be able to communicate effectively with ancillary staff to enhance patient care.

b. The successful PGY-2 residents meet all PGY-1 learning objectives and in addition, have further mastered the following:
   i. **Communication with patients and families:**
      1. Residents should be able to engage patients in shared decision making for ambiguous or controversial scenarios, and conduct family meetings, as in the setting of end-of-life decision-making. They should be able to successfully negotiate most “difficult” patient encounters, such as the irate patient.

ii. **Team Work:**
   1. Residents should progressively assume a leadership role, facilitating interactions between team members. This includes establishing expectations, overseeing patient care, ensuring participation in academic discussions, etc.

iii. **Continuity of Care:**
   1. Residents leading general medicine and ICU teams are responsible for ensuring and overseeing successful inpatient-outpatient provider communications to maintain appropriate continuity of patient care.

c. The successful PGY-3 residents meet all PGY-2 learning objectives and in addition, have further mastered the skills below:
   i. **Communication with patients and families:**
      1. Residents should be able to successfully negotiate nearly all “difficult” patient encounters with minimal direction.

ii. **Team Work:**
   1. Residents should function as team leaders with decreasing reliance upon attending physicians. They should also be able to function as a consultant (including completion of appropriate
documentation and verbal communication with the requesting physician), whether serving as a general medicine consultant to other services or when on elective rotations.

V. **Specific Competency Objectives for Professionalism**

<table>
<thead>
<tr>
<th>Virtue</th>
<th>Skill, Behavior, or Attitude</th>
<th>PGY-1 Expectation</th>
<th>PGY-2 Expectation</th>
<th>PGY-3 Expectation</th>
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<tbody>
<tr>
<td>Competence</td>
<td>Administrative competence (punctual, completes tasks as asked, follows directions, timely response to staff needs including pages and abnormal lab results, follows up on patient care issues without prompting)</td>
<td>Essential</td>
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<td>Self-directed learning (e.g. reads about patients)</td>
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<td>Expected (i.e. spontaneously presents literature and evidence related to patient care)</td>
<td>Expected (i.e. spontaneously presents literature and evidence related to patient care)</td>
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<td>Able to deliver bad news</td>
<td>Appreciated</td>
<td>Expected</td>
<td>Essential</td>
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<td>Understands and competent to work with patients and their advocates regarding advanced directives, DNR status, futility, withholding* or withdrawing therapy.</td>
<td>Appreciated</td>
<td>Expected</td>
<td>Essential</td>
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<td>Able to assess and use informed consent and</td>
<td>Expected</td>
<td>Essential</td>
<td>Essential</td>
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<td>Provision of Care</td>
<td>Essential</td>
<td>Essential</td>
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<td>Honesty</td>
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<td>Tells the truth and is trustworthy</td>
<td>Essential</td>
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<td>Makes honest use of coding, billing, and referral</td>
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<td>principles.</td>
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<td>Understands and appropriately maintains patient</td>
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<td>confidentiality</td>
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<td>Compassion</td>
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<td>Resident’s attitude manifests an interest in helping</td>
<td>Essential</td>
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<td>providing compassionate, quality care to all</td>
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<td>patients</td>
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<td>Respect for Others</td>
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<tr>
<td>Demonstrates respect and compassion for all patients</td>
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<tr>
<td>Understands and compassionately responds to issues</td>
<td>Appreciated</td>
<td>Expected</td>
<td>Essential</td>
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<td>of culture, age, sex, sexual orientation, and</td>
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<td>disability in patient care.</td>
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<td>Professional Responsibility</td>
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<tr>
<td>Recognizes that physicians have a</td>
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<td>responsibility for the safety and well</td>
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<td>Being of patient, colleagues, and staff;</td>
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<td>Understands that there are moral and ethical concerns about receiving gifts from patients and pharmaceutical representatives.</td>
<td>Essential</td>
<td>Essential</td>
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<tr>
<td>Able to discuss and defend own ethical understanding of his or her relationship with pharmaceutical representatives.</td>
<td>Appreciated</td>
<td>Expected</td>
<td>Essential</td>
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<tr>
<td>Willing to provide coverage for sick/unavailable colleagues</td>
<td>Expected</td>
<td>Expected</td>
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<td>Demonstrates intellectual curiosity</td>
<td>Appreciated</td>
<td>Expected</td>
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<tr>
<td>Spontaneously teaches and exhibits concern for the educational development of fellow residents and students</td>
<td>Appreciated</td>
<td>Expected</td>
<td>Essential</td>
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<tr>
<td>Provides leadership on teams and in the residency.</td>
<td>Appreciated</td>
<td>Expected</td>
<td>Expected</td>
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<tr>
<td>Understands that in the patient-physician relationship, the physician's prime concern is the patient's interest and not his or her own. (A fiduciary relationship)</td>
<td>Expected</td>
<td>Essential</td>
<td>Essential</td>
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<tr>
<td>Social Responsibility</td>
<td>Volunteers for activities that are for the “good of the institution” (e.g. recruiting interviews, committee membership, etc.)</td>
<td>Appreciated</td>
<td>Expected</td>
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<tr>
<td>Participation in community organizations</td>
<td>Not an objective</td>
<td>Appreciated</td>
<td>Expected</td>
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<tr>
<td>Responsive to the needs of society that supersede self-interest</td>
<td>Expected</td>
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VI. **Specific Competency Objectives for Systems-Based Practice**

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

1. **Reflect on how their patient care and other professional practices affect other health care professionals, the health care organization, and the larger society and how these elements affect their own practice.**
   a. By completion of PGY-1, residents should display ability to work well within their core clinical team, including other residents/attending physicians/directly involved nurses/respiratory therapists/other professionals involved in the care of their patients.
   b. By completion of PGY-2, residents must in addition be able to work well with multidisciplinary teams, coordinate multi-specialty care and effectively work with case management and nursing in team settings, such as family meetings and large team discussions. By completion of PGY-2, residents must also be able to provide and document care in a timely and thorough manner to facilitate analysis of practice patterns and use of information by other health care professionals.
   c. By completion of PGY-3, residents should, in addition to meeting the above objectives, also strive to effectively coordinate care with other health care professionals as needed, and should strive to provide leadership role in management of complex care plans. By completion of PGY-3 residents should also reflect understanding of external regulations and expectations and appropriately acknowledge effects of these elements on their own practice.

2. **Know how types of medical practice and delivery systems differ from one another, including methods of controlling health care costs and allocating resources.**
a. PGY-1 Residents will actively participate in educational sessions relating to medical practice and delivery systems.

b. By completion of the PGY-2 year, residents should, in addition, demonstrate a satisfactory level of understanding regarding medical delivery systems, including alternative care resources, ambulatory care resources, rehabilitation resources, and other continuing care resources. Residents should also have a satisfactory understanding of methods of controlling health care costs and appropriate allocation of resources.

c. By completion of the PGY-3 year, residents should demonstrate all the above skills and knowledge, and in addition should demonstrate a high level of understanding regarding medical practice and delivery systems, including methods of controlling health care costs and appropriate allocation of resources.

3. Practice cost-effective health care and resource allocation that does not compromise quality of care.

a. By completion of PGY-1, residents must identify, implement, document, and monitor established local patient care plans consistent with nationally published clinical practice guidelines. Throughout the PGY-1 year, residents must demonstrate dedication to high quality patient care and be able to identify the potential of specific components of health care systems to contribute to errors.

b. By completion of PGY-2, residents must in addition demonstrate ability to effectively guide patients through the complex health care environment and to work with other members of the healthcare team to prevent errors in care.

4. Advocate for quality patient care and assist patients in dealing with system complexities.

a. By completion of PGY-1, residents must identify, implement, document, and monitor established local patient care plans consistent with nationally published clinical practice guidelines. Throughout the PGY-1 year, residents must demonstrate dedication to high quality patient care and be able to identify the potential of specific components of health care systems to contribute to errors.

b. By completion of PGY-2, residents must in addition demonstrate ability to effectively guide patients through the complex health care environment and to work with other members of the healthcare team to prevent errors in care.

c. By completion of PGY-3, residents should demonstrate the above and in addition should be capable of acting as a team leader during interdisciplinary Family Meetings regarding complex patient care needs. Residents should demonstrate ability to use system-based approach to reduce errors.
5. **Know how to partner with health care managers and health care providers to assess, coordinate, and improve health care and know how these activities can affect system performance.**
   
a. By completion of PGY-1, residents must demonstrate ability to regularly and effectively work with the case managers, social workers, and other health care professionals to assess, coordinate, and improve patient care. The resident should reflect understanding of the benefits of such partnering activities on the operation of the health care system.

b. By completion of PGY-2, residents must in addition also demonstrate ability to regularly and effectively work with utilization review personnel, physician assistants, ambulatory practice office managers, and other providers within the larger health care system.

c. By completion of PGY-3, residents must demonstrate all the above skills and in addition should also be able to partner with case managers and other providers to identify and act on improvement opportunities for the health care system.