INTERNAL MEDICINE
RESIDENCY
OPERATION POLICIES
# TABLE OF CONTENTS

Program Leadership…………………………………………………………………. 3

Performance Standards……………………………………………………………… 4
  Objective………………………………………………………………………… 4
  Standards……………………………………………………………………….. 4
  Probation…………………………………………………………………….. 9

Operation Policies…………………………………………………………………. 12
  Patient Care Responsibilities………………………………………………… 12
  Patient Load…………………………………………………………………… 13
  Order Writing…………………………………………………………………… 14
  Non-Teaching Patients………………………………………………………… 15
  Moonlighting…………………………………………………………………… 15
  Away Rotations/International Health Elective……………………………… 15
  Policy for Resident Travel to Scientific Meetings………………………… 16
  Clinical Rotations with Meaningful Responsibility………………………… 16
  Procedures……………………………………………………………………... 17
  Certification of Competence in Required Procedural Skills………………… 17
  Leave Policies…………………………………………………………………… 18
  Internal Medicine Resident Benefits………………………………………… 19
  Residency Rotations and Scheduling………………………………………… 21
  Guidelines for Resident Selection…………………………………………….. 22
**PROGRAM LEADERSHIP**

Chairman of the Department: Cynthia Jumper, MD

Program Director: Michael P. Phy, DO

Associate Program Director
Kenneth Nugent, MD
Zack Mulkey, MD

Chief Residents: Aleem Mughal, MD and Khalid Sherif, MD

Administrator: Lindsey Tubbs

The Internal Medicine Residents are supported by the Residency Coordinator, Brandi McKinnon. Her contact information is below.

Room 4B074
806.743.3155 ext 237
806.743.3143 fax
Brandi.mckinnon@ttuhsc.edu
INTERNAL MEDICINE RESIDENT PERFORMANCE STANDARDS

1. OBJECTIVE

All residents completing Internal Medicine Residency Training should have the clinical skills and overall medical competence necessary for certification of their clinical competence to the American Board of Internal medicine, should demonstrate moral and ethical behavior, and should have a reasonable expectation of passing the certifying examination of the American Board of Internal Medicine.

2. STANDARDS

A. Satisfactory ratings on all evaluations.

   Rationale

   (1) The American Board will not admit residents with unsatisfactory evaluations to the qualifying examination.

   (2) An unsatisfactory rating usually indicates significant performance problems.

   Process

   (1) Any unsatisfactory rating (≤3) on ANY competency, on an end of the month rotation by a faculty member on a resident's evaluation form will trigger a review of the problem with the program director, the resident, and the faculty member. This trigger will come to the Program Director by New Innovations report. If the rating is correct, then corrective measures will be identified and instituted. Future evaluations will be critically reviewed to determine whether or not this problem has been corrected.

      a. Decisions regarding circumstances such as placing a resident on warning status, probation or termination from the program will be made by the Program Director, Associate Program Director(s), Post-graduate medical education committee and the Chairman on a case by case basis.

B. Clinical Skills
Rationale

(1) Residents must demonstrate expertise in patient assessment, including thorough and well documented histories and physical examinations.

Process

(1) Each PGY 1 resident will have a MINIMUM of 6 direct observations in this year. It is expected that the PGY 1 resident will approach faculty to accomplish these observations. More is, of course, better. These direct observations may take place in the inpatient or outpatient setting.

(2) Each PGY 2 and 3 will have a MINIMUM of 4 direct observations per year. It is expected that the upper level resident will approach faculty to accomplish these observations. More is of course, better. These direct observations may take place in the inpatient or outpatient setting.

(3) Written records (histories, physical examinations, clinic notes, and progress notes) must steadily improve during the 3-year program and ultimately reflect high quality and thorough patient evaluation and assessment.

C. Procedural Skills

Rationale

(1) The American Board of Internal Medicine requires documentation of procedures skills for clinical competence certification.

Process

(1) Residents must undergo training in procedural skills to be certified as clinically competent to the American Board of Internal Medicine. This will include instruction and supervised practice.

(2) The resident will maintain and update an electronic logbook in New Innovations.
D. Advanced Cardiac Life Support

Rationale

(1) The American Board of Internal Medicine requires proficiency in basic life support, advanced cardiac life support, and cardiac defibrillation. ACLS certification documents competence in these areas.

Process

(1) Residents will maintain ACLS certification. Residents without such certification cannot be certified as clinically competent for the American Board of Internal Medicine.

(2) Residents without up-to-date certification will have three months to obtain certification.

E. Educational Responsibilities

Rationale

(1) The American Board of Internal Medicine requires each resident to have a significant fund of knowledge and to develop methods for maintaining this fund of knowledge. Internal medicine residency TRAINING implies participation in as many educational activities as possible. Failure to participate in on-going departmental activities makes no sense and cannot be justified.

Process

(1) Residents will attend at least 60% of conferences (after correction for vacation and special rotations).

(2) residents who do not maintain a 60% moving average over 3-month periods will be issued a written warning.

(3) residents who receive one written warning will have their attendance monitored for another 1 month period. If the resident fails to maintain a 60% attendance over this time period, the resident will be placed on probation (see 4).
(4) Residents are provided a listing of conference attendance requirements based on rotation at orientation and when revised. This listing determines the above mentioned attendance rule.

F. Medical Records

**Rationale**

(1) The American Board of Internal medicine requires timely and legible records as one indicator of professional attitude and behavior. Proper records are essential for patient care.

**Process**

(1) Residents will maintain records, including all dictations and signatures, on a timely basis (<14 days). Senior residents on teams with out of department rotators will be responsible for ensuring the completion of those rotators medical records if they are incomplete or pending.

(2) Attending physicians are ultimately responsible for record completion.

(3) Residents with persistent delinquencies may be placed on warning status or on probation depending on the nature of circumstances.

G. In-training Examination

**Rationale**

(1) The in-training examination allows residents to identify areas of strengths and weaknesses and allows the resident to compare his/her overall performance with other residents at similar levels of training.

**Process**

(1) Residents at the PGY I, PGY II, and PGY III level will take the in-training examination in October of each year, excluding preliminary residents.

(2) The Program Director or his/her designate will review ITE scores with all residents.
(2) PGY I residents below the 25th percentile will review their test results to identify areas of weakness. They must participate in a structured program of improvement in medical knowledge as outlined by the Program Director or their designee.

(3) PGY II and PGY III residents below the 30th percentile may have a serious deficiency in their fund of knowledge. These residents must participate in intensive and prolonged preparation for the American Board of Internal Medicine as directed by the Program Director or their designee. These residents will not moonlight. PGY III residents who score below this level should strongly consider a formal board review course.

H. Ethical and Moral Behavior

Rationale

(1) The ABIM expects all candidates to exhibit appropriate moral and ethical behavior in the clinical setting.

Process

(1) Each resident should demonstrate integrity, respect, and compassion when providing medical care. These attitudes will be assessed by the residents’ action and behavior at work. Input will come from patients, nurses, other residents, and faculty.

(2) Residents are expected to demonstrate:
   a. Compassion, integrity, and respect for others
   b. Responsiveness to patients’ needs that supersedes self-interest
   c. Respect for patient privacy and autonomy
   d. Accountability to patient, society, and the profession

(2) Residents with unacceptable behavior patterns will receive counseling, written warnings and eventually probation if problems persist. This evaluation is admittedly subjective and will utilize all resources available to make proper decisions.

Comment [b1]: Nugent and Mulkey – do you think this needs to be higher?

Comment [b2]: Nugent and Mulkey- Do you think this needs to be higher as well.
I. Promotion Policies

(1) Preamble – The Internal Medicine Residency Program expects all residents who enter the program to satisfactorily finish the program with appropriate clinical skills, clinical knowledge, and professional attitude.

(2) Promotion Criteria for PGY-1 Residents:
   a. Satisfactory evaluations (4 or greater) for the first six months of training.
   b. Completion of a minimum of 6, “marginal” or better, direct observations. **Remember, it is the responsibility of the resident to have these completed by faculty.**
   c. Experience with important procedures including paracentesis, thoracentesis, lumbar puncture, and central line placement.
   d. Review and approval by faculty members at the December quarterly meeting for resident evaluation. Unsatisfactory issues or evaluations that arise at these meetings can be taken into consideration for not promoting the resident, depending on the individual circumstances.
   e. Review and approval by Core Faculty and Post Graduate Education Committee quarterly meetings for resident evaluation.

(3) Promotion Criteria for PGY-2 Residents:
   a. Satisfactory performance on all evaluations during the first 6 months of the PGY-2 year.
   b. Completion of a minimum of 4, satisfactory direct observations. **Remember, it is the responsibility of the resident to have these completed by faculty.**
   c. Review and approval by faculty at the December meeting for resident evaluation. Unsatisfactory issues or evaluations that arise at these meetings can be taken into consideration for not promoting the resident, depending on the individual circumstances.
   d. Review and approval by Core Faculty and Post Graduate Education Committee quarterly meetings for resident evaluation.

3. PROBATION

Internal Medicine Residency Policies
Revised 6/20/11
Rationale

(1) Residents who are placed on probation have a serious performance problem and have a high likelihood of not being certified as clinically competent to the American Board of Internal Medicine.

Process

(1) Residents will be placed on a three-month probationary period after they have received a written warning(s) regarding a deficiency in performance but fail to correct this deficiency. There may be circumstances where automatic probation (or termination) is warranted. These will be decided on a case by case basis and will include the Program Director, APD(s), Post-graduate medical education committee and the Chairman.

Placement on probation will require a majority vote by the Postgraduate Education Committee and approval by the Chairman of the Department of Internal Medicine. The resident may make a direct appeal to the Postgraduate Education Committee at the time of this determination. At the time of probation, measures for corrections will be identified and instituted.

Follow-up evaluation and reassessment will occur monthly for three months and will involve the Program Director and may involve the Associate Program Director and the Chief Residents. After three months the Postgraduate Education Committee will review recent evaluations and determine whether or not the problem has been corrected.

(2) If deficiencies persist after 3 months, the resident may be placed on continued probation (time determined by PD, APD, Post-graduate medical education committee) or terminated from the program. The resident may make a direct appeal to the Postgraduate Education Committee at the time of this determination. Residents placed on a second probationary period will not be certified at the end of their three-year training program. They may be asked to leave the program at the end of the contract year or they may be asked to extend their period of training for six to twelve months, depending on the deficiency and evidence for progress and improvement.
(3) Department policies will be consistent with institution policies.

4. Internal Medicine Residency training requires significant and prolonged efforts to develop clinical skills and to master a large fund of medical knowledge. Outside activities such as moonlighting should not interfere with the residents' training responsibilities. The Department of Internal medicine has the following guidelines for moonlighting.

   (1) Residents in the PGY I year, regardless of prior clinical experience or prior training, will not moonlight.

   (2) Upper level residents on either General Medicine floor services, MICU/CCU, Hem/Onc or Consult/Night Float services will not moonlight.

   (3) When averaged over a four week period, residents work, and moonlighting activities should not exceed 80 hours per week.

   (4) It will be the resident’s responsibility to inform the department and program director as to moonlighting status.

5. These performance standards are not all inclusive. Performance problems not covered by these guidelines will be addressed by the program Director and the Postgraduate Education Committee on an individual basis.

6. This policy goes into effect July 1, 2009 and applies to all residents in Internal medicine, including residents in preliminary slots.

   ___________________________________________________________
   Michael P. Phy, DO
   Program Director

   ___________________________________________________________
   Cynthia Jumper, M.D.
   Chairman

**(revised 4/2011 by Program Director and all members of PGY1 and PGY2 classes)**

Internal Medicine Residency Policies
Revised 6/20/11
OPERATION POLICIES FOR DEPARTMENT OF INTERNAL MEDICINE RESIDENCY PROGRAM

1. **PATIENT CARE RESPONSIBILITIES**

**PGY-I RESIDENTS**

A. PGY-I residents are responsible for the admission, history and physical examination on each patient admitted to the teaching service. After reviewing the patient with the senior resident and the attending physician, if needed, PGY-I residents are responsible for writing the initial orders and for initiating diagnostic and therapeutic plans.

B. PGY-I residents with adequate supervision are responsible for performing all routine procedures on their patients. These procedures include arterial blood sampling, venous blood collection, nasogastric tube placement, thoracentesis, paracentesis, lumbar puncture, central vein cannulation, arterial cannulation, right heart catheter floatation, and bone marrow aspirate and biopsy. PGY-I residents should attend and assist with other procedures performed on their patient as time permits.

C. With the advice of senior residents and attending physicians, PGY-I residents are responsible for coordinating care provided by consultants.

D. PGY-I residents are responsible for reviewing pathological material and autopsies on their patients.

E. PGY-I residents will help coordinate discharge planning and providing patient education.

**UPPER LEVEL RESIDENTS**

A. Upper level residents (PGY-II and PGY-III) residents are responsible for supervising PGY-I residents throughout all aspects of each patient's in-hospital care, including history and physical examinations, diagnostic and therapeutic planning, and performing procedures.

B. Upper level residents are responsible for developing a differential diagnosis and for reviewing therapeutic and/or diagnostic options early in each patient’s hospitalization. These considerations should be reported in a progress note within 72 hours after admission.
C. Upper level residents are responsible for discharge summaries and final coordination of discharge planning.

D. Upper level residents are responsible for coordinating work rounds and supervising medical students.

E. Upper level residents are responsible for reviewing and providing clinical correlation needed for the interpretation of pathologic material and autopsies.

ATTENDING PHYSICIANS

A. Attending physicians are responsible for informing senior level residents about each patient admitted by them to the teaching service and for providing an overview of diagnostic or therapeutic plans.

B. Attending physicians are responsible for supervising all aspects of patient care during each hospitalization and for leading teaching rounds.

2. PATIENT LOAD

A. 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 clearly depend on the complexity and severity of the medical problems in hospitalized patients.

B. PGY - I residents should not have more than five admissions in any 24-hour period or eight admissions in any 48-hour period. After PGY - I residents have reached this level, the upper level resident should assume all responsibility for additional patients.

C. PGY - I residents should not carry more than ten patients on their inpatient service.

D. Upper level residents are expected to take a larger patient load. Upper level residents should not have more than 10 admissions during a 24 hour period. Upper level residents should not be responsible for more than 10 new patients and transfer patients in any 24 hour period. Upper level residents will share admission responsibilities with the night float resident. When confronted with an unmanageable patient load, upper level residents should activate the backup system.

1. The MICU/CCU resident should back up the admitting resident and/or the consult/night float resident when the patient load in the MICU/CCU...
becomes unmanageable.

2. The resident assigned to the Hematology/Oncology service should back up the in-house senior level residents when patients admitted to the Bone Marrow Transplant Unit require additional care.

3. The following physicians will provide additional back up if patient load becomes unmanageable after the back-up residents have come into the hospital.
   a. Internal medicine resident on consultation service
   b. Chief Resident
   c. Associate Chairman
   d. Chairman
   e. Any other faculty member available for back up

E. The upper level residents should not be responsible for the on-going care of more than 14 patients.

F. Patients with limited hospital stays for specialized procedures or patients with limited educational value may be admitted by their attending physician with or without the assistance of residents on that subspecialty service.

G. Residents should not work more than eighty hours per week when averaged over four weeks.

H. Residents should have one day off every seven days when averaged over a 4 week period.

3. **ORDER WRITING**

   A. PGY - I residents with appropriate supervision should write all the orders on all their patients.

   B. Upper level residents should write orders on their patients when PGY - I residents are unavailable (for example, in Continuity of Care Clinic) or when the patient load prevents the PGY - I residents for providing timely orders.

   C. The attending faculty may write orders in the following circumstances.

      1. Urgent patient care considerations preclude the use of the usual line of responsibility.
2. The pharmacy requires faculty signatures for certain classes of medication, such as chemotherapeutic agents.

3. The faculty writes brief orders on clinic patients to initiate the admitting process.

4. **NON-TEACHING PATIENTS**
   
   A. Residents are not expected to provide physician services to non-teaching patients except in emergencies. However, when time permits, residents may be expected to provide minor services to these patients or to their physicians when such service does not require significant patient assessment and when such services are requested by the attending physician.

5. **MOONLIGHTING**
   
   A. Residents in the PGY -1 year, regardless of prior clinical experience or prior training, cannot moonlight.
   
   B. Upper level residents on General medicine floor services, MICU/CCU, Night Float/Consult service, or Hematology/Oncology services should not moonlight.
   
   C. When averaged over a four-week period, residents work, and moonlighting activities should not exceed eighty hours per week.
   
   D. All residents will inform the department as to whether or not they are moonlighting or if any changed occur with regards to your moonlighting. This includes changes in facilities etc.
   
   E. Moonlighting Policy Form shall be distributed and signed annually during biannual evaluations.

6. **AWAY ROTATIONS/INTERNATIONAL HEALTH ELECTIVE**
   
   A. International Health Elective: This rotation is not approved by the Internal Medicine Residency Program Director. For more information please visit the GME website for more information: www.ttuhsc.edu/som/gme
   
   B. Away Rotations: The following must be submitted the Program Administrator or Program Director by April 1 of the academic year prior to the rotation. Any away rotations requested after this date will be denied. Submit the following:

Internal Medicine Residency Policies
Revised 6/20/11
• Goals and objectives of the rotation.
  • Length of the elective/rotation.
  • Qualifications of the preceptor.
  • Educational Values of the elective rotation.

C. For further information visit www.ttuhsc.edu/som/gme/policies.aspx

7. **POLICY FOR RESIDENT TRAVEL TO SCIENTIFIC MEETINGS**

A. The Department of Internal Medicine will support resident travel to scientific meetings if the resident is making a presentation. The department will support each resident once a year for this travel unless preapproved by the Program Director.

B. Institutional Travel Guidelines must be used for airfare, hotel costs, and meal costs.

C. Any money awarded to the resident for TRAVEL COSTS must be returned to the department to support the travel.

D. Any money given to the resident as a scholarly award may be kept by the resident.

E. Expenses incurred in the meeting city outside of the meeting dates for vacation must be paid for by the resident.

F. All travel must be approved in advance and the resident and the department will make efforts to limit costs. The Residency Coordinator will be your contact person to arrange your travel plans.

G. Unusual circumstances will be reviewed the Program Director and the Chairman.

8. **CLINICAL ROTATIONS WITH MEANINGFUL RESPONSIBILITY**

A. Certification by The American Board of Internal Medicine requires 36 months of training in Internal Medicine. 24 months must involve "meaningful" patient care responsibilities. This means that the resident is directly involved in patient care, including the initial assessment, daily progress notes, order writing, test scheduling and interpretation, and management. In our departments the
following rotations qualify as meaningful patient care months:

ER
GENERAL INTERNAL MEDICINE FLOOR ROTATION
MICU/CICU ROTATION
VA OUTPATIENT CLINIC ROTATION
GENERAL MEDICINE CONSULT ROTATION
URGENT CARE CLINIC ROTATION
HEMATOLOGY-ONCOLOGY FLOOR ROTATION (STARTING 1995)
NIGHT FLOAT ROTATION

B. In general, subspecialty rotations do not count toward months of meaningful patient responsibility as the resident primarily provides advice to the primary care team.

9. PROCEDURES

DOCUMENTATION OF PROCEDURES

A. Record every procedure in Documentation Log. (This documentation log is provided at orientation and is for the resident to keep track of procedures personally, does not need to be turned in to the program).

B. The Supervising Resident should also make a record in his/her Documentation Log and log in New Innovations.

C. The procedure should then be added into New Innovations at the residents discretion but before mid/end of year reviews.

D. Any procedures recorded in New Innovations will only be counted towards your procedure numbers by the program.

10. CERTIFICATION OF COMPETENCE IN REQUIRED PROCEDURAL SKILLS

A. The American Board of Internal Medicine now requires certification that residents who take the certifying examination for the American Board of Internal Medicine are competent in certain required procedural skills which are commonly performed by internists. This process will involve instruction, performing procedures under supervision, performing a certifying procedure which demonstrates competence, and continued experience throughout the residency which will include both teaching and documentation. The diagnostic and therapeutic procedures required for certification are listed below. The
recommended minimum number of procedures to be performed successfully under direct supervision before certification is listed below:

- Abdominal paracentesis (3)
- Arterial puncture for blood gas analysis (5)
- Arthrocentesis of knee joint (3)
- Central venous line placement (5)
- Lumbar puncture (5)
- Nasal gastric intubation (3)
- Thoracentesis (5)
- Breast examinations (5)
- Rectal examinations (5)
- Pelvic examinations, and pap smear including wet mount (5)

B. New residents will receive instructions on these procedures throughout the year. They will initially perform these procedures under direct supervision by other residents or by attending faculty.

11. LEAVE POLICIES: VACATION, SICK, EDUCATIONAL

A. Residents in Internal Medicine will take their vacations on their elective rotations only. Residents are required to turn in a leave form in order to cancel clinics within 30 days. If 30 days notice is not given, your clinics will be rescheduled instead of canceled. If the Coordinator does not receive a leave request form in the mandatory 30 day time frame, your leave may be denied. In addition, vacation will not be allowed on the Covenant and VA rotations.

B. LEAVE FORM PROCESS:

- You must go to Residency Coordinator (Brandi McKinnon)(4B074) and fill out leave form/clinic cancellation form (minimum 30 days in advance) (this will be sent to Patient Services Supervisor - allowing her to block your clinic time). You must provide the name of the doctor that will provide coverage for you. Leave forms must be completed and given to Program Coordinator for all leave including sick and educational.

- VACATION:
  PGY I, II, & III: 15 working days per year. We prefer that the resident only takes two weeks of vacation on any one particularly service (this cannot be carried over from one year to the next).

- SICK:
  PGY I, II, III: 8 working days per year - can be carried over from year to year, but this form of leave can only used for sick or
medical reasons. Please note that the ABIM rule of only 30 days absent per year will over rule using this time once past the 30 day maximum.

- **EDUCATIONAL LEAVE:**
  1. PGY-1 residents receive 5 days of Educational Leave, PGY-2 residents receive 5 days of Educational Leave, and PGY-3 residents receive 7 days of Educational Leave. Educational Leave cannot be carried over from year to year.
  2. Residents will be allowed to use Educational Leave for essential examinations, such as Step III of the USMLE.
  3. Residents may attend professional meetings when on elective rotations.
  4. Residents may present information at professional meetings regardless of their current clinical responsibility provided they notify the chiefs to identify adequate coverage (Jeopardy) and is approved by the program director. It is the residents’ responsibility to find coverage for his/her clinical duties if chiefs are unable to assign Jeopardy coverage. In these cases, the resident should limit his/her absence from his/her clinical responsibility to the shortest time necessary to travel to the meeting, make the presentation, and return to Lubbock.
  5. Residents in the PGY-III year applying for fellowships positions may have 7 days of Educational Leave for both professional meetings and fellowship interviews. Time required beyond 7 days will be taken from vacation. If you are applying for fellowships and you do not request elective rotations during interview season, YOUR LEAVE CAN BE DENIED. Also, pay close attention to using your vacation if planning on taking vacation at year end. You must manage your educational days effectively. Please be responsible and make sure you have planned well.
  6. Up to one month (30 days) per academic year is permitted for time away from training, which includes vacation, illness, parental or family leave, or pregnancy-related disabilities (ABIM). Training must be extended to make up any absences exceeding one month per year of training. Vacation leave is essential and should not be forfeited or postponed in any year of training and cannot be used to reduce the total required training period. ABIM recognizes that leave policies vary from institution to institution and expects the program director to apply his/her local requirements within these guidelines to ensure trainees have completed the requisite period of training.

12. **INTERNAL MEDICINE RESIDENT BENEFITS**

Internal Medicine Residency Policies
Revised 6/20/11
1st YEAR RESIDENTS: Current MKSAP (or book of choice by program director).

2nd YEAR RESIDENTS: $400 allowance for *travel, books, subscriptions. Remaining amount can be carried forward to 3rd year if not used in 2nd year.

3rd YEAR RESIDENTS: $600 allowance for *travel, books, subscriptions. All remaining funds must be used before June 30th of your third year. Any funds carried forward from PGY II year must be used by this date also. If funds are not used by June 30, we cannot process paperwork.

ACLS COURSE: Paid for by the department, whether recertification or initial certification.

LAB COATS: 3 coats per PGY I residents, thereafter replaced on an AS NEEDED basis. Coats will not be replaced unless they are worn out. Cost per coat: $38.00

MEALS: Meal cards will be provided for all Internal Medicine Residents for $95.00 per month for PGY-1’s and $75.00 per month for PGY-2’s and 3’s. Meal money cannot be carried over from month to month if not used in the month issued.

XEROX PRIVILEGES: Copies and transparencies for conferences (as long as cost is not excessive).

*TRAVEL: For educational and scientific meetings ONLY. You must notify the Residency Coordinator once the travel has been approved by the program director. Your travel arrangements will be made with the information you give to the coordinator. You will turn in receipts at the end of trip for reimbursement. Reimbursement check will not be issued unless paper with scholarly information is provided to the coordinator. In essence, you pay your own way then submit receipts for reimbursement. Your check will be issued when scholarly activity information is provided to coordinator. Further information can be found in the Travel to Scientific Meeting Policy.
### 13. **RESIDENCY ROTATIONS AND SCHEDULING**

- **PGY I**
  - General Medicine: 4 months
  - MICU/CICU: 3-4 months
  - Heme-Onc In-Patient Service: 1 month
  - ER: 1 month
  - Electives: 2-3 months

- **PGY II**
  - General Medicine: 4 months
  - MICU/CICU: 2 months
  - Heme-Onc In-Patient Service: 1 month
  - Consults/Night Float: 2 months
  - VA Clinic: 1 month
  - Electives: 2 months

  - GI
  - Cardiology
  - Pulmonary
  - Nephrology
  - Other

- **PGY III**
  - General Medicine: 1 month
  - MICU/CICU: 1 month
  - Neurology: 1 month
  - VA Clinic: 1 – 2 months
  - Geriatrics: 1 month
  - Neurology: 1 month
  - Jeopardy: 1 month
  - Electives: 4 months

  - Allergy
  - Endocrinology
  - Hematology/Oncology
  - Infectious Disease
  - Rheumatology
  - Other

- Final schedules will depend on multiple intra and extra-departmental factors. Residents in the three year program should rotate through all subspecialties available in Lubbock.

---

Comment [mpp9]: Needs revising and updating
14. GUIDELINES FOR RESIDENT SELECTION

Selection

A. Academic Ability
   Rationale: Internist must acquire and utilize a complex fund of knowledge.
   Sources of Information: Medical school transcripts, standardized test scores, letters of recommendation.

B. Clinical Skills
   Rationale: Clinical skills represent the basis for all medical care in Internal Medicine.
   Sources of Information: Letters of recommendation.

C. Professional and Interpersonal Skills
   Rationale: Internist must have high quality professional and interpersonal skills.
   Sources of Information: Personal statement, letters of recommendation, and personal interview.

D. Internist in Internal Medicine
   Rationale: Training in Internal Medicine requires significant effort. Applicants with a high level interest are more likely to succeed.
   Sources of Information: Personal statement, letters of recommendation, personal interview, prior training in Internal Medicine and related subspecialties (IMG Physicians).