

MERCY HOSPITALS EAST COMMUNITIES

***POLICY AND PROCEDURE GUIDE
FOR
GRADUATE MEDICAL EDUCATION PROGRAMS***

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**GRADUATE MEDICAL EDUCATION
POLICY AND PROCEDURE GUIDE**

Table of Contents

	<u>Page</u>
I. Graduate Medical Education	
A. Administrative Structure for Graduate Medical Education	4
B. Graduate Medical Education Committee	5
C. Program Directors and Coordinators Meeting	6
II. Residencies	
A. New Programs	8
B. Distribution of Institutional Resources	8
C. Closure or Downsizing of Programs	8
D. Existing Programs	9
1. Internal Review	9
2. General Essentials	9
3. Correspondence with Accrediting Bodies	9
4. Restrictive Covenants	9
III. Faculty	
A. Program Directors	9
B. Faculty Appointment	10
C. Faculty Evaluations	10
IV. Educational Programs	10
V. Residents	
A. Residency Application, Recruitment, Selection and Appointment	10
B. Resident Duties and Resident Supervision	11
C. Resident Attending Physician Interaction	12
D. Responsibilities of Resident Physicians	12
E. Responsibility of Supervising Attending	14
F. Resident Participation in Educational Activities and Committees	14
G. Resident Committee	15
H. Advancement and Reappointment	15
I. Resident Evaluations	15
J. Resident Performance Deficiencies and Corrective Actions	16
K. Resident Appeal Rights and Due Process	18
L. Failure to Certify Resident for Board Eligibility	21
M. Resident Duty Hours and Work Environment	21
N. Leave Policy	23
O. Training Obligations	25
P. Resident Stipends	25
Q. Quality Improvement & Safety	25
VI. The following can be found on Baggot Street.	

- Anti-Bullying Policy
- Anti-Harassment Policy
- Attendance Policy
- Drug-Free Workplace Policy
- Employment Verification and Background Check Policy
- Impaired Resident Policy
- Influenza Vaccination Policy
- Leave of Absence Policy (residents are under contract and will need to contact GME with questions)
- Pharmaceutical/Vendor Representative Policy
- Relationships in the Workplace Policy
- Resident/Fellow Agreement
- Social Media Policy

(See ACGME.org) program specific requirements

**MERCY HOSPITALS EAST COMMUNITIES
GRADUATE MEDICAL EDUCATION
POLICY AND PROCEDURE GUIDE**

I. Graduate Medical Education

A. Administrative Structure for Graduate Medical Education

Mercy Hospitals East Communities (MERCY) commitment to medical education dates back to 1908 when it took in its first intern. In the ensuing years MERCY has committed itself and its resources to the education of physicians, nurses and allied health personnel; to patient care and community service including the sponsoring of JFK Clinic and to the overall pursuit and advancement of high quality graduate medical education.

MERCY Graduate Medical Education (GME) is an extension of a medical school's education process, and prepares a resident for independent medical practice by providing a graduate training period which varies in length depending upon the type of specialty practice the resident selects. In this document the term "resident" will include both residents and fellows.

MERCY is currently involved as both a Sponsoring and Participating institution in the training of physicians in the following specialty areas:

Sponsoring Institution

Internal Medicine, Family Medicine
Obstetrics and Gynecology,
General Dentistry,
Transitional Year,
Hospice and Palliative Care

Participating Institution

Critical Care Medicine, Pulmonary,
General Surgery, Otolaryngology,
Plastic Surgery, Emergency Medicine, Vascular
Surgery, Anesthesiology, Colorectal Surgery
Neurology and Emergency Medicine

Organizational Structure:

MERCY, through Mercy Hospital St. Louis serves as a sponsoring and participating Institution for GME programs exercising authority and control as defined by the Accreditation Council for Graduate Medical Education (ACGME) and the Chairman of Graduate Medical Education serves as the Designated Institutional Official (DIO) who has the authority and responsibility for oversight of all GME programs. The DIO administratively chairs the Graduate Medical Education Committee (GMEC) which is responsible for assuring program compliance with all institutional, common and program specific ACGME / ADA requirements. The DIO reports to the Chief Medical Officer (CMO) who serves as an agent of the MERCY Administration and the Board of Trustees for the appropriate distribution of educational resources. The DIO reports at least annually to the Medical Executive Committee and the Board of Trustees on the activities of the GMEC and residency programs. The DIO and Department Chairs for GME sponsored Programs are members of the Medical Staff Executive Committee (MEC) and are available at all times to address any concerns expressed by the Medical Staff with respect to resident education. The CMO approves and signs for ACGME documents when the DIO is unavailable.

B. Graduate Medical Education Committee

1. Organization

The Graduate Medical Education Committee (GMEC) consists of the following members:

Educational Program Directors and/or Department Chairs from the Departments of Medicine, Surgery, Family Medicine, OB/GYN, Critical Care Medicine, Palliative Care, Pediatrics, Dental Medicine, Psychiatry and Transitional Year, as well as, the Chairman of GME, CMO and two resident representatives from each MERCY-sponsored Program. Program Coordinators & the GME Supervisor are also voting members.

All are appointed by the President of Mercy Hospital St. Louis (President) for one year with privilege of reappointment. The Chairman of Graduate Medical Education (GME) chairs the Committee. Members ex officio include the CMO & Saint Louis University (SLU) DIO. The GMEC meets four times a year for monitoring and advising on all aspects of residency education. Specific responsibilities include:

- a. Establishment of institutional policies regarding quality of education and the work environment for all training programs.
- b. Collecting intra-institutional information and making recommendations on reasonable and fair funding of all GME programs, including salaries, benefits and support services.
- c. Establishment of appropriate oversight of and liaison with all Program Directors.
- d. Appraisal of the appropriateness of working conditions and duty hours for all residents
- e. Assure that all programs provide appropriate supervision for all residents that is consistent with proper patient care, the educational needs of residents, and all program specific requirements.
- f. Assure that each training program provides a curriculum and an evaluation system to ensure that residents demonstrate achievement of the six core competencies and residency specific milestones.
- g. Establishment and implementation of policies and procedures for selection, evaluation, promotion and dismissal of residents in compliance with both Institutional Requirements and Program Specific Requirements.
- h. Regularly review all accreditation letters and monitor action plans for correction of concerns and areas of non compliance. This process will include:

- 1) Written summary from Program Director of plan for corrective action presented to GMEC with initial review of accreditation letter.
 - 2) Written six month progress report.
 - 3) Other documentation as deemed appropriate by GMEC.
- i. Regular Review of Sponsoring Institutions accreditation Letter of Report from Institutional Review committee and development and monitoring of corrective action plans.
 - j. Review and approve prior to submission to the ACGME
 - 1) all applications for ACGME accreditation of new programs and subspecialties;
 - 2) changes in resident complement;
 - 3) major changes in program structure or length of training;
 - 4) additions and deletions of participating institutions used in a program;
 - 5) appointments of new Program Directors;
 - 6) progress reports requested by any Review Committee;
 - 7) responses to all proposed adverse actions;
 - 8) requests for increases or any change in resident duty hours;
 - 9) requests for “inactive status” or to reactivate a program;
 - 10) voluntary withdrawals of ACGME-accredited programs;
 - 11) requests for an appeal of an adverse action, and
 - 12) appeal presentations to a Board of Appeal or the ACGME

C. Program Directors and Coordinators Meeting

An executive committee of the GMEC composed of the DIO, Program Directors, GME Supervisor and Program Coordinators will meet in the months that the full GMEC does not meet in order to address specific GME issues in detail. Minutes of all activities will be presented to the full GMEC for discussion and/or approval.

II. Residencies

GME programs are formal educational or research programs for physicians who have completed their medical school requirements and have been awarded an M.D. or equivalent degree (D.O., DDS, DMD).

Definitions:

Resident – a physician in a graduate medical education program approved and accredited by the ACGME. Such individuals are eligible candidates for general board certification, or certification of added or special qualifications upon successfully completing the residency. Recently some emerging residencies may be approved and accredited by the ACGME but may not lead to certification.

Fellow – a physician in a graduate medical education program that may be approved for accredited by the ACGME.

For the purposes of this document, the term “resident” will refer to both residents and fellows.

Residencies at MERCY:

ACGME Accredited:

Family Medicine
Internal Medicine
Obstetrics/Gynecology
Transitional Year
Hospice and Palliative Care

ADA Approved:

Dental Medicine

SLU Sponsored ACGME Accredited - in which Mercy Hospital a participating hospital:

Critical Care Medicine	Otolaryngology
Pulmonary	Plastic Surgery
Psychiatry	Emergency Medicine
General Surgery	Vascular Surgery
Anesthesiology	Colorectal Surgery
Neurology	

A. New Programs

A department that desires to institute a new residency or fellowship training program must provide the requisite information to the GMEC. The GMEC will review the request from the standpoint of educational goals and objectives, resources available within the organization, overall inter-relationship of this residency program with other residency or fellowship

programs, appropriateness and demonstrated need for establishment of this program, and make recommendation to the President of the Institution in this respect.

B. Distribution of Institutional Resources

MERCY is responsible for the costs of the residency education programs. The institution must provide appropriate facilities and staff sufficient to meet the requirements of the Joint Commission and the respective residency review committees for educational programs. Each teaching department is responsible for the provision of an adequate teaching/learning environment for residents, incorporating them into medical staff programs of education and patient care. The GMEC will review residents salaries, benefits and overall institutional support yearly.

C. Closure or Downsizing of Programs

If MERCY reaches a decision to reduce the size or close any of its residencies, the institution will inform the GMEC, DIO, and residents as soon as possible. In addition, the institution commits to the full completion of training for residents already enrolled in the residency or to assist the residents in enrolling in another acceptable accredited program to complete their training.

D. Existing Programs

1. Annual Program Evaluation

The Program Director must appoint the [Clinical Competency Committee \(CCC\)](#) that must be composed of at least two program faculty members and include at least one resident from the program. Residents and faculty must have the opportunity to evaluate the program confidentially at least annually and the program and [CCC](#) must use the results of these assessments to improve the program. The CCC should actively participate in developing, implementing and evaluating educational activities of the program. It should also address areas of noncompliance with ACGME standards. The residency program, through the CCC, must document a formal, systematic evaluation of the curriculum annually and render a written Annual Program Evaluation that will be submitted to the GMEC. The Annual Program Evaluation must include a written plan of action to improve performance and delineate how improvement will be measured and monitored. The CCC must also monitor and track resident performance, faculty development, graduate performance and progress on the previous year's action plan. ACGME performs Self-Study Visits every 10 years and the prior 10 years of Annual Program Evaluations must be included in the Self-Study. The year prior to the 10 year ACGME Self-Study Visit, the program should do an internal Self-Study of the prior 9 years.

2. General Essentials

AMA and IHI modules will be used as housewide curriculum covering topics such as Quality/Safety, Sleep/Deprivation/Fatigue/Management, Physician Work/Life Harmony, Diversity/Cultural Competency.

3. Correspondence with Accrediting Bodies

The DIO must review and approve all correspondence with accrediting bodies prior to submission. The GMEC will review all correspondence and reserves the right, prior to submission, to have individual subcommittees evaluate programs for specific areas of either non-compliance or perceived difficulty. All correspondence from accrediting bodies to Program Director should be presented to the GMEC at the meeting following receipts of said communication.

4. Restrictive Covenants

The institution or the residency program will not require any resident to sign a non competition guarantee or clause as a condition of residency enrollment.

III. Faculty

A. Program Directors

Recommendation for a new Program Director must be approved by the GMEC before presentation to the President for final approval. Program Directors must meet the standards of the appropriate accrediting body. The institution must provide salary support appropriate for the time commitment required to discharge the Program Director's responsibilities. The Program Director should attend yearly seminars focused on the duties and responsibilities of residency leadership.

B. Faculty Appointment

Recruitment of faculty members is the responsibility of each Department Chairman. Prospective faculty members should be interviewed within the department by appropriate departmental faculty. Prospective faculty must be approved by the Program Director. The Board of Trustees makes appointment of faculty members upon the recommendation of the Department Chairman, the Department Credentials Committee, and the Executive Committee of the Medical Staff.

C. Faculty Evaluations

Residents must be given the opportunity to provide anonymous written evaluations of teaching faculty as well as their educational rotations at least annually.

IV. Educational Program

Residents must be given the opportunity to provide **anonymous** evaluations of their educational experience including but not limited to program curriculum, faculty, leadership, working environment and overall program efficacy .The educational effectiveness of each program

should be evaluated annually in a method compliant with the ACGME's common program requirements. At the end of each academic year, the GME office sends out an anonymous survey to each resident. In addition, each graduating resident is given the opportunity to have a confidential exit interview with Mercy Human Resources personnel to give further input regarding the Mercy St. Louis residency training programs. The GME office reviews and trends the data collected to identify opportunities for improvement.

V. Residents

A. Residency Application, Recruitment, Selection and Appointment

MERCY requires that all applicants for admission to a residency-training program fulfill the entrance requirements established by the relevant accrediting agency and specialty board.

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

1. Graduates of medical schools/dental schools in the United States and Canada accredited by the Liaison Committee on Medical Education (LCME).
2. Graduates of colleges of osteopathic medicine in the United States accredited by the American Osteopathic Association (AOA).
3. Graduates of medical schools/dental schools outside of the United States and Canada who meet one of the following qualifications:
 - a. Have received a current valid certificate from the Educational Commission for Foreign Medical Graduates, or
 - b. Have a full and unrestricted license to practice medicine in a U.S. licensing jurisdiction.
4. Graduates of medical schools/dental schools outside the United States who have completed a Fifth Pathway program provided by an LCME-accredited medical school.

Residency applicants must provide a Dean's letter from Medical School and letters of reference. A personal interview is required for selected well-qualified applicants. Selection of residents is based on preparedness, ability, aptitude, academic credentials, communication skills and personal qualities. MERCY does not discriminate with regard to gender, race, age, religion, color, national origin, sexual orientation, disability or veteran status. In selecting among qualified applicants, all ACGME residency programs for PGY-1 positions will utilize the National Resident Matching Program (NRMP).

For residents transferring from other programs or filling open PGY-2, 3, 4 positions, a satisfactory summary evaluation must be received from all previous Program Directors prior to offering a position at Mercy Hospital.

The following must be on record in the Office of Graduate Medical Education before a physician may begin residency:

Application, including all backup information: Curriculum Vitae, Personal Statement, Letters of recommendation, USMLE Scores, Medical School Dean's letter, Transcripts – 3rd and 4th year final evidencing MD or DO degree granted, copy of MD or DO diploma, Undergraduate Transcript, Agreement completely executed by the Resident and MERCY, Licensure: Missouri State Physician License, Missouri State BNDD, Physical Exam by MERCY, background check, Valid ACLS & BLS (from American Heart Association) and current citizenship/visa status with I9 completed.

B. Resident Duties and Resident Supervision

This is a general policy encompassing residents from multiple specialties training in Mercy Hospital. It is recognized that each specialty has specific program requirements which guide the residency training and resident duties in those respective specialties. All programs must comply with the requirements of the ACGME or ADA. All patient care activities must be supervised by a credentialed attending physician. Since the position of resident involves a combination of supervised, progressively more complex and independent patient evaluation and management functions, the competence of the resident must be evaluated on a regular basis. It is the responsibility of each Program Director and attending physician to assess the abilities of each resident and provide the appropriate supervision for that level of training. The residents and supervising attending physicians are guided by specific roles and responsibilities delineated for residents at certain levels of training. Residents should never be expected to perform patient care activities for which they are not qualified. Quality care of patients must always take precedence over education and service. Quality patient care is achieved by developing an environment conducive to quality working relations with all the care givers including attending physicians, residents, nursing, therapists, and administrators. All residents must act within the policies outlined in the Mercy Hospital GME Policy and Procedure Manual. Each program is responsible for providing rapid reliable systems for communicating with supervisory faculty. On call schedules for teaching staff must be structured to ensure that supervision is readily available to residents on duty. Faculty and residents must be educated to recognize the signs of fatigue and adopt and apply policies to prevent and counteract the potential negative effects.

C. Resident Attending Physician Interaction

Inpatient medical care begins with admission of the patient, continues through the daily progress of the hospitalization, and concludes with discharge of that patient from the hospital with completion of the permanent medical record on that patient. Key, specific responsibilities of the supervising attending physician and of the resident are listed below:

1. The attending physician shall evaluate the patient in person and be in a position to confirm the findings of the resident and discuss the care plan.
2. The attending physician confirms the subjective and objective findings of the resident, reviews the differential diagnosis, and patient care management with the resident.

3. At least on a daily basis (more often as the needs of the individual patients may dictate), the resident and the attending physician will review progress of the patient, make the necessary modification in the care plan, plan family conferences as needed, and agree on the type and scope of documentation for the medical record.
4. If a patient develops a condition that the resident feels is potentially dangerous for that patient, the resident will contact the attending physician and report these developments.
5. As the level of skill and knowledge increases for individual residents, attending physicians may delegate increasing levels of responsibility and allow increasing levels of participation in patient care; including the performance of procedures. The specific privileges for procedures for each resident are available to all staff on the Mercy Procedure Share Drive.

The attending physician should ensure the completeness of the medical record by offering suggestions to the resident or by making additional comments in the progress notes.

Outpatient medical care begins with the resident interviewing and examining the patient, devising a plan of care and discussing it with the attending physician, discussing the plan of care with the patient, and documenting the history, physical and plan of care in the electronic medical record. The attending physician should ensure the completeness of the medical record by offering suggestions to the resident or by making additional comments in the progress notes.

D. Responsibilities of resident

In general, a resident is a physician in training for a specific specialty or subspecialty who has completed medical school or dental school. All residents must meet qualifying requirements of the State of Missouri and the ACGME or ADA. During training residents will assume progressive clinical responsibility and autonomy under the supervision of licensed, privileged attending staff that function as faculty within the graduate medical education programs.

Major Responsibilities:

1. Residents assume clinical responsibilities according to their year of training as directed by each program. Responsibilities include:
 - a. Participating in providing safe, compassionate and ethical care.
 - b. Developing an understanding of how to provide cost-efficient care in an environment that seeks to minimize errors, while delivering evidence-based care.
 - c. Developing an understanding of the medico legal and ethical principles of care.

- d. Understanding the socio-economic aspects of medicine and the delivery of care within the various systems of care.
 - e. Understanding the role of the resident within the health care team.
 - f. Participating in the various committees and councils, if invited or elected, to assure effective communication, improve care, and monitor the care provided to the patients within the facility.
 - g. Participating in research programs and educational presentations, as required by the individual programs.
 - h. Adhering to the guidelines and regulations of the medical staff as well as the policies of the graduate medical education program.
2. Residents will assume progressive clinical responsibility as training progresses. Each program will assess the competency of the resident to assume these responsibilities.
 3. The resident, in turn will evaluate the program's effectiveness in teaching and in providing the necessary supervision.
 4. The senior resident will provide supervision to medical students and more junior resident staff. The resident will provide informal feedback and evaluation to these individuals.
 5. The resident will maintain an accurate log of procedures performed under appropriate supervision in accordance with specific program requirements.
 6. The resident will provide accurate and necessary documentation within the medical record of the care provided to patients.
 7. Residents will enter orders for patients under their care with the supervision of privileged attending staff.
 8. Residents are responsible for the timely completion of medical records as per the policies of the Medical Staff, under the guidance and supervision of the attending staff.
 9. Residents will understand the value of safety and quality improvement and will participate in safety and quality improvement activities.

E. Responsibility of Supervising Attending

In the supervision of resident-patient management the assigned attending physician should:

1. Review all resident historical and physical examination information for accuracy and completeness;

2. Be knowledgeable of and approve of, either directly or by the care patterns, all diagnostic tests ordered by the resident;
3. Be sufficiently knowledgeable and responsible as to assure the proper quality of the management of the patient including the transmittal of information;
4. Directly supervise or have certain knowledge concerning the capability and experience of a resident performing and/or interpreting a diagnostic procedure or initiating a therapy independently on a patient;
5. Directly supervise or have explicit knowledge concerning satisfactory skills and experience of a resident performing an invasive procedure;
6. Provide faculty on-call schedules to ensure that supervision is readily available to resident on call;
7. Provide an on-site, physical presence for all ambulatory care visits; supervisory involvement should be appropriate to resident's level of training and the complexity of the patient's problem; a faculty schedule delineating supervisory responsibility for clinic hours should be readily available.

F. Resident Participation in Educational Activities and Committees

1. All residency programs must be structured to allow residents to develop a personal program of learning. Residents are expected to fully participate in the educational and scholarly activities of their training programs. Attendance at conferences specifically organized for trainees is mandatory. Publications and presentations at professional meetings may be financially supported by the institution. Residents will participate in appropriate institutional committee meetings where activities effect their education. Specifically, residents should participate on the Graduate Medical Education Committee, Department Quality Improvement Committees and all other committees, which relate to relevant resident - patient care. Residents will participate in Medical Staff activities and responsibilities as outlined in the Medical Staff By-Laws. All residents are expected to observe the established practices, procedures and policies of the institution.
2. GME Committee (GMEC) – Two peer selected representatives from each Mercy Hospital sponsored residency will be chosen as voting members of the GMEC.
3. Resident Committee (See Below)

G. Residents' Committee

Residents have the right to raise and resolve issues without fear of intimidation or retaliation from the faculty or institution. All Mercy residents are members of the Resident Committee. Every year the Resident Committee will nominate and vote in a Vice President. The elected Vice President will serve as President of the Residents' Committee the subsequent year. The Chiefs of each residency program will communicate with the Residents' Committee President and Vice President to suggest items for the quarterly meeting agenda. The Chiefs will also help the President disseminate information back to

the individual residency programs. Resident Committee meetings will occur quarterly per academic year. The President and Vice President of the Resident Committee will also be voting members of the GMEC and will report the residents' concerns to the GMEC after each Resident Committee meeting. The responsibilities of the Committee include:

1. Assurance of ongoing communication between the residents and the GMEC.
2. Provide an organization for the residents to exchange information on their working environment and educational programs.
3. Provide a mechanism by which resident complaints and grievances may be addressed.
4. Provide a mechanism by which individual residents can address concerns in a confidential and protected manner.
5. Facilitate dissemination of information to the residents regarding institutional requirements of the ACGME.
6. Provide a conduit to the GMEC for adjudication of complaints and grievances.

H. Advancement and Reappointment

Advancement of residents to positions of higher responsibility is to be made on the basis of readiness for advancement. This assessment/evaluation is to be carried out by the Program Director and CCC of each residency. The GME office must be notified by April of each year of any resident who will not be advanced or reappointed. When a resident is subsequently advanced, the GME office must be notified so that this can be reflected in payroll. The GME office must also be notified by April of each year of any resident whose program will be extended.

I. Resident Evaluations

Rotation Evaluations will be reviewed with residents on regular basis. The Program must provide objective assessment of competence in all the core competencies, and pertinent milestones, use multiple evaluations and document progressive performance. Each resident must be provided with documented semiannual evaluations.

J. Resident Performance Deficiencies and Corrective Actions

When a resident's performance is unsatisfactory, the Program Director or his/her designee shall notify the resident, both verbally and in writing, as soon as can reasonably be arranged and initiate appropriate corrective and/or disciplinary action. In general, MERCY may use progressive discipline at its discretion, depending on the circumstances, which may include written concern or warning with remediation, probation, summary suspension or dismissal from the program or non-reappointment. In some cases, depending on the severity of the situation one or more steps may be bypassed. Additionally, if a resident's mental or physical condition appears to affect academic, clinical or professional performance, s/he may be referred for evaluation and treatment in accordance with the

GME Impaired Resident policy.

1. Concern or Warning with Remediation: A resident displaying unsatisfactory performance may be assigned a period of concern or warning with remediation. The Program Director or his/her designee shall issue written concern or warning to the resident, which, in most cases will include a) a description of the specific deficiencies leading to unsatisfactory performance, b) detailed goals and performance expectations for remediation and c) the specified period of time for remediation. The Program Director must inform the DIO of residents placed on remediation. At the end of the remediation, one of the following may occur:
 - a. termination of remediation, with a written statement provided to and signed by the resident stating conditions of remediation were satisfactorily resolved and no additional corrective action is planned, contingent upon continued satisfactory performance.
 - b. remediation extension, in the event the resident has performed satisfactorily on a significant portion but not all of the remediation and the Program Director agrees to an additional term of remediation, for a specified period of time.
 - c. imposition of probation, in the event of failure by the resident to satisfactorily meet the goals and performance expectations for remediation.
 - d. other action, deemed appropriate in consultation with the DIO.
 - e. academic credit, remediation may result in denial of part or all of an academic year's credit.

2. Probation: Probation is a serious designation that requires explanation on every licensing and privilege application for the duration of a physician's medical career.

A resident displaying unsatisfactory performance, which is sufficiently serious and/or not remediated may be subject to a period of probation lasting no less than three months and no greater than six months, provided the resident's continuation in the program does not constitute a material threat to the welfare of patients or the integrity of the program. In consultation with CCC and the DIO, a Program Director or his/her designee shall meet with the resident and present a written notice, which in most cases, will include; a) specific reasons leading to probation; b) detailed conditions, goals and performance expectations for the probation period; and c) specified period of time for probation. Assessment of the resident's performance by the program will generally occur and be periodically reviewed with the resident by the Program Director or his/her designee and the CCC. At the end of the probationary period, one of the following may occur:

- a. termination of probation, with a written statement provided to the resident stating conditions of probation were satisfactorily resolved and no further action is planned assuming continued satisfactory performance.
- b. probation extension, in the event the resident has performed satisfactorily on a

significant portion but not all requirements of probation and the Program Director agrees to an additional term of probation, for a specified period of time no less than three but no more than six months, with a written update of conditions, goals and performance expectations.

- c. dismissal of the resident from the program.
 - d. other action deemed appropriate in consultation with the DIO.
 - e. academic credit, Probation may result in denial of part or all of an academic year's credit.
3. Summary Suspension and Dismissal: A resident displaying unsatisfactory performance, which is not remedied after being placed on probation, or which recurs after a period of probation completed is subject to summary suspension and/or dismissal from the program. Additionally, the Program Director, the DIO or the President of the hospital may at any time recommend a resident's summary suspension or dismissal from the program for reasons including but not limited to unethical, immoral, unprofessional behaviors; suspected, admitted or convicted criminal action; misrepresentation, fraud or cheating; sanctions by medical licensing boards; conduct that threatens the welfare or safety of patients, co-workers or staff; conduct that threatens the integrity of the program; violation of hospital policies; or failure to meet program standards for academic, clinical or professional performance.

The process of summary suspension is initiated upon recommendation of the Program Director, in consultation with the DIO. The Program Director shall provide the resident with written confirmation of suspension, including the reasons, the term of suspension and any conditions that may be imposed for resumption of participation in the residency program. At the end of suspension, one of the following may occur:

- a. termination of suspension, with a written statement provided to the resident stating suspension has been withdrawn and there is no need for further action contingent upon continued satisfactory performance.
- b. probation, termination of suspension, with placement of the resident on probation.
- c. dismissal of the resident from the program.

The process of dismissal is initiated upon recommendation of the Program Director in consultation with the DIO. The resident shall receive written copy of dismissal and reasons thereof, as well as notice of his/her right to appeal.

Upon suspension or dismissal of a resident, all original related or subsequent administrative documentation shall be delivered by the program to the GME office until any appeal proceedings are complete. If the resident does not request an appeal pursuant to Section K below, the dismissal shall be final and effective as of the date of receipt of notice of dismissal by the resident.

Alternate actions to dismissal, including but not limited to requests for voluntary

resignation or counseling a resident to leave a program, may be offered at the Program Director's discretion based on individual circumstances and consultation with the DIO.

The President of the hospital, or similarly empowered Hospital official shall report such GME actions as are required by the Missouri State Board of Registration for Healing Arts.

4. Non-reappointment: A Program Director may, in consultation with program faculty and the DIO, decline reappointment of a resident for the upcoming academic year. The Program Director is generally expected to provide written notice of non-reappointment to the resident no later than four months prior to the end of a resident's current contract. If the circumstances leading to non-reappointment occur within four months of the contract expiration, the Program Director shall notify the resident verbally and in writing, as soon as possible after the non-reappointment decision is reached.
5. Certification of Eligibility for Specialty Board Exam: If, after an appropriate course of corrective action, a Program Director determines that a resident remains unqualified or ineligible for specialty board examination, the Program Director or his/her designee is responsible to provide written notice to the resident. Upon receipt, a resident may implement the appeals process of the appropriate specialty board.

K. Resident Appeal Rights and Due Process

A resident who receives notice (Notice) of non-reappointment, probation, suspension or dismissal may appeal the decision by written notice to the DIO within ten (10) days of resident's receipt of the Notice. Remediation may not be appealed. All original related or subsequent administrative documentation shall be delivered by the program to the GME office upon non-reappointment, suspension or dismissal of the resident, until any appeal proceedings are complete.

1. A resident who desires to appeal an appealable decision must submit a written request (Appeal Notice) for an appeals hearing (Appeal Hearing) to the DIO within ten (10) calendar days of receipt of Notice of an appealable corrective action. The Appeal Request must be delivered to the DIO by personal delivery, e-mail with confirmation by recipient, overnight courier or certified mail. If a valid Appeal Notice is not received by the DIO or designee within ten (10) days, the decision is final.
2. The DIO appoints an ad hoc Appeal Committee (Appeal Committee) to investigate the matter and to provide findings of fact to the GMEC. The Appeal Committee shall consist of three resident physicians and three faculty physicians from specialty programs other than the resident's program, none of whom have had prior direct involvement in the matter.
3. The Appeal Committee shall review program and GME documentation, including any relevant medical records, and conduct interviews as the Appeal Committee deems necessary or helpful in the course of its investigation.
4. The Appeal Committee shall complete its pre-hearing investigation and hold a hearing within twenty (20) calendar days of receipt of the Appeal Notice.

5. The DIO or designee provides the resident and the Program Director at least five (5) calendar days notice of the date for the appeal hearing.

6. Appeal Hearing process

- a. The appeal hearing is conducted informally and rules of evidence do not apply. The Appeal Committee shall make rules it deems necessary to assure prompt and fair handling of the appeal. Neither the resident, the program nor the Appeal Committee shall be permitted to have legal counsel present or statements provided by legal counsel during the hearing.
- b. The resident may present an oral statement at the appeal hearing and may be accompanied by one member of the medical staff, upon the resident's request and with such staff member's consent. A medical staff member who accompanies a resident to an appeal hearing is permitted to make a statement on behalf of the resident. The resident may suggest witnesses who possess relevant information and may also submit statements in writing from faculty, staff or other individuals who have knowledge of facts for consideration by the Appeal Committee. It remains the sole discretion of the Appeal Committee to determine if such witnesses will be interviewed or such statements will be considered.
- c. The Program Director or his/her designee may present an oral statement at the appeal hearing and may be accompanied by one representative with such individual's consent who is permitted to make a statement. The residency program may submit additional documentation and may suggest witnesses who possess information relevant to the appealed action, though it remains the sole discretion of the Appeal Committee to determine if such witnesses shall be interviewed.
- d. Minutes of the appeal hearing shall be maintained by GME office staff. Neither the resident, the program, nor their representatives or witnesses shall be allowed access to the deliberations of the Appeal Committee or the GMEC.

7. Appeal Committee Review and Action

- a. The Appeal Committee may require a physical or mental evaluation of the resident, consistent with applicable law in any case where the Appeal Committee has reasonable concern regarding the resident's physical or mental ability to perform the essential functions of the residency program with or without reasonable accommodations. Procedures for such evaluations are set out in the Mercy GME Impaired Resident Policy.
- b. Upon completion of review and consideration of all evidence, the Appeal Committee is responsible to make a recommendation to the DIO and GMEC at large on the following:

- 1) Was the action taken by the program substantially in compliance with the Mercy GME policies and procedures set forth in *Section J. Resident Performance Deficiencies and Corrective Actions*? **Did the program follow due process?**
 - 2) Was the decision of the program consistent with hospital policies and not arbitrarily or capricious?
 - 3) It is not the role of the Appeal Committee to substitute judgment for that of the resident's program. If the Appeal Committee determines the answer to b.1) is yes and the answer to b. 2) is yes, the Appeal Committee shall uphold the decision of the program. However, if the Appeal Committee determines that the program has failed to substantially comply with the procedures in *Section J. Resident Performance Deficiencies and Corrective Actions*, or that the decision of the program was made arbitrarily, capriciously or in violation of the hospital's policies, the Appeal Committee shall make recommendation to the GMEC for an appropriate remedy or reversal.
- c. Failure of the resident to personally appear at the appeal hearing without good cause constitutes acceptance of the corrective action and a waiver of the resident's right to appeal.
 - d. The Appeal Committee shall submit to the DIO and GMEC a written report and recommendation. Upon review of the Appeal Committee's report, the GMEC at large may uphold, reverse, revise or modify the recommendations of the Appeal Committee. This shall be based on a simple majority vote. It is not the role of the GMEC to hear statements, conduct interviews or review records, unless an exception is deemed necessary by the DIO, Appeal Committee or GME Committee at large.
8. Within ten (10) calendar days of the hearing, the DIO shall submit a final written recommendation to the President of the hospital or his/her designee. The decision of the President of the hospital is final and is issued in writing to the resident, the Program Director and the DIO.
 9. The proceedings and records of the Appeal Committee, GMEC and the President of the hospital shall be, so far as possible, confidential, and shall be retained as an institutional record consistent with the hospital's record retention policies.
- L. Failure to Certify Resident for Board Eligibility

After an appropriate course of remedial training, a Program Director may determine that a resident is not competent and qualified to take the specialty board examination. The resident has the right to appeal this decision by the process provided by the appropriate specialty board.

M. Resident Duty Hours and Work Environment

1. Providing residents with a sound academic and clinical education must be carefully planned and balanced with concerns for patient safety and resident well-being. Each program must ensure that the learning objectives of the program are not compromised by excessive reliance on residents to fulfill service obligations. Didactic and clinical education must have priority in the allotment of residents' time and energies. The structuring of duty hours and on-call schedules must focus on the needs of the patient, continuity of care, and the educational needs of the resident.

Duty hours must be monitored by both the GMEC and the individual Program Directors. Individual Programs must have in place mechanisms for monitoring duty hours. Residents are expected to cooperate as delineated by the Program Director to facilitate the acquisition of duty hour data for documentation of compliance. The GMEC will review individual program duty hour audits twice a year. Adjustments must be made to rectify excessive hours and/or resident fatigue. Faculty and residents must be educated to recognize the signs of fatigue, and adopt and implement policies to prevent and counteract its potential negative effects. Programs must provide appropriate back up support when patient care responsibilities are especially difficult or prolonged.

2. Duty Hours

- a. Duty hours are defined as all clinical and academic activities related to the residency program, i.e., patient care (both inpatient and outpatient), administrative duties related to patient care, the provision for transfer of patient care, time spent in-house during call activities, scheduled academic activities such as conferences, time spent away from the hospital completing documentation in the electronic medical record, Moonlighting internal and external must be counted toward the 80-hour maximum weekly limit. Duty hours do not include reading and preparation time spent away from the duty site.
- b. Duty hours for any given rotation must be limited to 80 hours per week, averaged over the one month rotation inclusive of all in-house call activities.
- c. Residents must be provided with 1 day in 7 free from all educational and clinical responsibilities, averaged over a four week period (single rotation), inclusive of call. One day is defined as one continuous 24-hour period free from all clinical, educational and administrative activities.
- d. Duty periods may be scheduled to a maximum of 24 hours of continuous clinical and educational work periods. Up to 4 hours of additional time may be used for transitions of care and/or education.

3. Night Float Activities

The objective of night float is to provide residents with the opportunity to provide care for patients overnight. Resident call rooms and food services are available overnight. Residents must know who their supervising attending is and how to reach him/her.

4. Moonlighting

- a. Because residency education is a full-time endeavor, the Program Director must ensure that moonlighting does not interfere with the ability of the resident to achieve the goals and objectives of the educational program. All moonlighting activity must be prospectively approved by the Program Director and/or Department Chairman. The Program Director should acknowledge approval in writing in the Resident's file and the GME office.
- b. The Program Director must comply with the sponsoring institution's written policies and procedures regarding moonlighting, and with the ACGME institutional requirements
- c. Internal and external moonlighting must be counted toward the 80 hour weekly limit on duty hours. Residents can not be required to moonlight.
- d. Program Directors are expected to monitor performance of residents who are moonlighting in order to assure that these activities do not have adverse effects on the resident's educational progress. Permission to moonlight may be withdrawn if, in the Program Director's opinion, the activity is having a deleterious effect on the resident's education and performance.

5. Exception to duty hour regulations.

- a. Mercy Hospital GMEC endorses the 80 hour work week. No Proposal for exceptions will be reviewed, endorsed or forwarded to any RRC.

N. Leave Policy

A resident who is unable to participate in his/her training is eligible for unpaid leave of absence up to a maximum of six months for legitimate reasons. All leaves of absence will be paid or unpaid depending on the vacation and sick leave time that is available, at the time of the request for leave, according to the resident contract. The different types of leaves are as follows: Medical, Parental, Family and Medical Leave (FMLA), Military, and Personal. Personal leaves are granted sparingly and each request is reviewed carefully.

Resident must give 30 days written notice, if leave is foreseeable; or as soon as practical if emergent or unplanned. Notice must include reason for leave and anticipated timing of leave. Resident will request all leaves of absence by completing the proper Mercy "Request for Leave of Absence" form as well as the Physician's Certification form for all medical leaves.

1. A resident is eligible to take Parental & FMLA Leave when he/she meets the following:
 - a. Been employed for 12 months, and
 - b. Worked 1250 hours during the 12 months immediately before the leave is to begin.

2. Family and Medical Leave may be taken only for the following reasons:
 - a. The birth of a child, and in order to care for that child;
 - b. The placement of a child with the employee for adoption or foster care;
 - c. Care of a spouse, child or parent who has a “serious health condition”, and
 - d. Employee’s own “serious health condition” which makes him/her unable to perform the essential functions of the job.

(See Mercy’s Leave of Absence Policy for details regarding request).

Program Director / Program Coordinator will need to contact GME department

3. Residents not eligible for Family and Medical Leave of Absence may take a medical leave of absence for their own illness, including pregnancy. With regard to pregnancy, the amount of time given for the leave will be as follows:
 - a. Six (6) weeks postpartum for normal deliveries;
 - b. Eight (8) weeks postpartum for cesarean sections.

Any additional time requested would need additional verification from the resident’s personal physician and will be reviewed by Chairman of Graduate Medical Education before this request can be approved.

Residents who are military reservists including the National Guard, called to active duty or who are committed to military service other than weekend duty shall be granted a military LOA. A resident must provide a copy of his/her military orders and complete proper Mercy leave paperwork before the start of the military leave of absence.

O. Training Obligations

The loss of training time as a result of any leave of absence may affect the resident’s training requirements and will vary among programs. It is the responsibility of each training Program Director to determine the nature and duration of the additional training that will be required of the resident to assure adequate education and compliance with the specific program requirements. The GME office must be notified by March if any resident will require an extension of his/her training into the new academic year.

P. Resident Stipends

Residents will be paid according to their post graduate year of training. All trainees at similar levels of experience and training should receive a comparable level of financial support. The position of chief resident may receive an additional level of compensation above the PGY level. Residents with extensive previous training prior to enrollment in a residency may receive a stipend at a higher post graduate level at the discretion of the Program Director with the approval of the GME Office. The reimbursement schedule for

each academic year will be reviewed and approved by the GMEC for presentation to Administration.

Q. Quality Improvement & Safety

All residents should receive education in quality-assurance/performance improvement and safety. Residents should participate in the quality improvement and safety activities of their respective departments.

R. Behavioral Health

Residents have access 24/7 to free confidential counseling and behavioral health services through Employee Assistance Program (EAP) at 314-729-4650.