The residency program is designed to provide residents with an extensive experience in the art and science of medicine in order to achieve excellence in the diagnosis, care, and treatment of patients. To achieve this goal, residents agree to abide by certain policies and guidelines. In return, they are given a number of benefits and the training they need to be successful in their careers.

Below is a look at the policies and fair process procedures of the residency program.
In accordance with the UAMS College of Medicine GME Committee Policy on Recruitment and Appointment, the following describes the eligibility requirements, the selection criteria, and procedures for appointment to the Internal Medicine training program.

The Internal Medicine residency program uses both objective and subjective criteria to select applicants. The selection and appointment of residents to the Internal Medicine program are the responsibility of the Chairman, Dr. James Marsh, and the Program Director, Dr. Michael Saccente. The application process meets all requirements of the Equal Employment Opportunity and the Americans with Disability Acts and does not discriminate with regard to sex, race, age, religion, color, national origin, disability, or veteran status. The criteria and processes for resident selection are below.

**Application Process**

The UAMS Department of Internal Medicine participates in the Electronic Residency Application System (ERAS), developed by the Association of American Medical Colleges (no paper applications) for the Categorical Internal Medicine Training Program (Quota 19). Applicants must be registered with the National Resident Matching Program (NRMP). Applicants should contact the residency coordinator, Linda Lindsey, at the following e-mail address: imresident@uams.edu for specific requirements.

Required documents for the application process:

- Completed and certified ERAS common application form
- Personal statement
- Curriculum vitae
- Medical school transcript for all medical schools attended
- Letter from the Dean of the medical school attesting to the applicant's good standing
- Three-letters of recommendation from faculty and/or preceptors who are knowledgeable of the applicant's clinical skills
- Letters from prior residency programs where applicable
- Current ECFMG certification
- Proof of citizenship or immigration status
- Certified USMLE transcripts

When received, these materials will be reviewed by the Program Director and Associate Program Directors, and interviews will be scheduled at their discretion.

**Eligibility**

As Program Director, Dr. Michael Saccente is responsible for verifying that an applicant is eligible for appointment and meets all of the eligibility requirements below.

1. An applicant must be able to carry out the duties as required of the Internal Medicine residency program.
2. An applicant must demonstrate the following English language proficiency to the satisfaction of the Program Director and/or selection committee:
   - Proficiency in reading printed and cursive English
   - Proficiency in writing (printing) English text
   - Proficiency in understanding spoken English on conversational and medical topics
   - Proficiency in speaking English on conversational and medical topics

3. An applicant must meet one of the following qualifications as established by the ACGME:
   - A graduate of a medical school in the United States or Canada accredited by the Liaison Committee on Medical Education (LCME).
   - A graduate of a college of osteopathic medicine in the United States or Canada accredited by the American Osteopathic Association (AOA).
   - A graduate of a medical school outside the United States who has completed a Fifth Pathway program provided by an LCME-accredited medical school.
   - A graduate who holds a full and unrestricted license to practice medicine in a U.S. licensing jurisdiction.
   - A graduate of a medical school outside the United States or Canada with one of the following qualifications:
     a. A currently valid certificate from the Education Committee for Foreign Medical Graduates, or
     b. A full and unrestricted license to practice medicine in a U.S. licensing jurisdiction.

4. An applicant is eligible for appointment only after a negative result on a pre-employment drug test as administered by the UAMS Drug Testing Program (UAMS Policy 3.1.14).

5. All appointments are contingent upon successful completion of a criminal background check (GME Policy 1.200.IV).

6. An applicant must meet all program-specific eligibility requirements. These may include, but are not limited to, the following:
   - Application only submitted through the Electronic Resident Application System (ERAS) and participation in the National Resident Matching Program (NRMP).
   - A minimum score of 213 on Parts I & II of the USMLE board examinations or documentation of successful completion of clinical work in a supervised setting in the U.S. medical system.
   - Not more than 7 years of time elapsed since completion of medical school training or the practice of medicine as a physician.
   - The ability to reside continuously in the U.S. for the length of training.

**Selection**

Applications are downloaded from ERAS on a daily basis and reviewed for completion and eligibility by the Program Director and/or Associate Program Directors. The following information must be received before the application will be considered and before an applicant is invited to an interview: common application form, Dean’s letter, medical school transcript, USMLE transcript, personal statement, and minimum of three letters of recommendation.
Once an applicant has been found to meet minimal selection criteria, the program coordinator contacts him/her by e-mail to schedule an interview. An applicant invited for an interview will receive in writing and/or will sign an attestation that he/she has seen the terms, conditions and benefits of appointment (and employment) including financial support, vacation, professional leave, parental leave, sick leave, professional liability insurance, hospital and health insurance, disability insurance, and other insurance benefits for the resident and their family, and conditions under which living quarters, meals and laundry or the equivalents are provided. Applicants can access this information through the UAMS Resident Handbook at www.uams.edu/gme/toc.htm. Applicants also complete a self-disclosure form listing all convictions, guilty pleas, and pleas of no contest (nolo contendere) to any felony, misdemeanor or any offense other than a minor traffic violation. This form is signed and returned to the program coordinator by the date the interview is conducted.

Hotel reservations are made by the House Staff Office for each applicant. An informal dinner is scheduled the evening prior to the interview day with 3-4 residents attending. The interview consists of a full day beginning with a brief introduction by the Program Director. The rest of the day consists of Morning Report, one-on-one interview with a faculty member, tours by the Chief Residents of the University Hospital and the VA Hospital, lunch with at least 4-6 residents, and exit interviews conducted by the Program Director.

Faculty members throughout the Department of Internal Medicine perform interviews and submit written evaluations that are included with the application. Current house staff will meet informally with each applicant during the interview process and will help determine suitability for ranking through a house staff committee meeting.

Criteria used for selection may include, but are not limited to, the following:

- Review and confirmation of eligibility requirements
- Performance on standardized medical knowledge tests
- Overall academic performance in medical school
- Recent clinical training or experience
- Demonstrated ability to choose goals and to complete the tasks necessary to achieve those goals
- Maturity and emotional stability
- Honesty, integrity, and reliability
- Lack of history of drug or alcohol abuse
- Motivation to pursue a career in the specialty of Internal Medicine
- Prior research and publication experience
- Verbal and written communication skills (personal statement and interviews)
- Letters of recommendation from faculty
- Dean’s letter
- Medical school transcript
- The ability to reside continuously in the U.S. for the length of training
Following the interview, the Program Selection Committee (Program Director, Associate Program Directors, Chief Residents, residents, and the residency coordinator) reviews the applicant’s file and written interview evaluations and ranks the applicant based on the criteria above. After discussion by the Program Selection Committee, the Program Director compiles a final list for submission to the NRMP.

**Appointment/Registration**

Upon verification by the Program Director that an applicant has met eligibility requirements, completed the application process, and been selected according to established criteria, the applicant will begin the process of appointment and registration with the UAMS College of Medicine. An applicant is considered fully appointed and registered only after all of the below documents have been completed and returned to the Director of the House Staff Records. Once the Director of House Staff Records has received all the documents, the applicant is registered in the payroll system to receive a stipend and may begin the residency program.

1. Documentation of a negative drug test
2. Successful completion of a criminal background check
3. Verification of successful graduation if previously anticipated. For graduates of US or Canadian medical schools, this includes a final official transcript, or letter from the Registrar, or a notarized copy of the diploma. For graduates of medical schools outside the US and Canada, this includes a currently valid ECFMG certificate.
4. All of the following forms (with valid signature):
   - Resident Agreement of Appointment (contract)
   - Medical Records Agreement
   - Attestation acknowledging receipt of GMEC policies/procedures
   - Confidential Practitioner Health Questionnaire
   - Employee Drug Free Awareness Statement
   - House Staff Medical Screening Form
   - Postdoctoral Medical Education Biographical Data Form
   - Copy of currently valid ECFMG certificate and valid visa (if applicable)
   - Long Term Disability Form
   - Acknowledgement of Benefits Policies
   - I-9, State & Federal Tax Forms
   - Copy of a valid visa (if applicable)
Reappointment
Educational appointments to the Internal Medicine residency programs are for a term not exceeding one year. The resident agreement of appointment, which outlines the general responsibilities for the College of Medicine and for the resident, is signed at the beginning of each term of appointment. Renewal of the resident agreement of appointment for an additional term of education is the decision of the Program Director and the Department Chair.

Promotion to the next level of training is dependent upon the resident performing at an acceptable level and meeting the requirements for clinical competence for that PGY year.

It is the intent of the Internal Medicine program to develop physicians clinically competent in the field of Internal Medicine. Physicians completing the Internal Medicine program will be eligible for certification by the American Board of Internal Medicine with an ultimate goal of a 100% pass rate on this examination.

Clinical competence requirements:

1. **Patient Care**: Gather essential, accurate patient information; order appropriate tests; make accurate diagnoses; perform competently; counsel patients and families; prescribe appropriate medication and treatment.

2. **Interpersonal and Communication Skills**: Document pertinent information clearly; write legibly; listen actively; use effective nonverbal behaviors; work effectively as member of a team.

3. **Medical Knowledge**: Know and apply basic sciences; demonstrate analytical approach to clinical care.

4. **Practice-Based Learning and Improvement**: Stay current with medical literature and technology; analyze your experiences to improve your practice; facilitate learning of students and others.

5. **Professionalism**: Demonstrate integrity, honesty, and empathy; respect patients’ autonomy and diversity; be timely and respond promptly.

6. **Systems-Based Practice**: Provide high quality cost-effective care; coordinate care effectively with other specialists; advocate for quality patient care in the system.

**Evaluations**
During the residency period, the above elements of clinical competence will be assessed in writing in a timely manner during each rotation or similar educational assignment by attending faculty, peers, students, and multi-raters (patient/family, nurses, social workers, self, etc.) with subsequent review by the Program Director. In addition, the following assessments will be conducted for each resident:
1. The resident will perform a complete history and physical examination under the direct observation of an attending physician and will formulate a diagnostic and therapeutic plan to discuss with the attending (Mini-CEX).

2. The resident will meet with their assigned faculty advisor twice a year to review results of evaluations, in-service scores, clinical exercises, procedural skills, and to discuss points of concerns and future plans.

3. The Program Director will meet with each resident annually.

4. The Program Director will prepare a summative evaluation which will be reviewed and signed by the resident.

The evaluations will be maintained in confidential files and only available to authorized personnel. Upon request, the resident may review his/her evaluation file at any time during the year.

**Reappointment and promotion** to a subsequent year of training require satisfactory ratings on these evaluations. A resident that receives written complaints or unsatisfactory evaluations during the year will immediately be reviewed by the Program Director and written recommendations made to him/her which may include the following:

- specific corrective actions
- repeating a rotation
- psychological counseling
- academic warning status or probation
- suspension or dismissal, if prior corrective action, academic warning and/or probation has been unsuccessful

The resident may appeal an unsatisfactory evaluation by submitting a written request to appear before the department’s Education Cabinet Committee in a meeting called by the Program Director. The Committee reviews a summary of the deficiencies of the resident, and the resident has the opportunity to explain or refute the unsatisfactory evaluation. After review, the decision of this Committee is final.

In instances where a resident’s agreement will not be renewed or when a resident will not be promoted to the next level of training, the Program Director will provide the resident with a written notice of intent no later than four months prior to the end of the residents’ current agreement. If the primary reason(s) for the non-renewal or non-promotion occurs within the four months prior to the end of the agreement, the Program Director will provide the resident with as much written notice of the intent not to renew or not to promote as circumstances will reasonably allow, prior to the end of the agreement.

At the completion of the residency program, the Program Director prepares a summative evaluation which documents the residents’ performance during the final period of education and verifies that the resident “has demonstrated sufficient competence to enter practice without direct supervision.” This evaluation is accessible for review by the resident and remains in the program’s files to substantiate future judgments in hospital credentialing, board certification, agency licensing, and in the actions of other bodies.
Probation/Suspension/Dismissal
Actions of Probation/Suspension/Dismissal will follow the guidelines in the Graduate Medical Education Committee Policy on Academic and Other Disciplinary Actions Policy. In addition, specific program guidelines follow:

1. Failure to perform satisfactorily at conferences, rounds, clinic and ward rotations.

2. Receiving more than one unsatisfactory performance on the resident end-of-rotation evaluation.

3. Failure to comply with the policies and procedures of the department, the program, the GME Committee, UAMS Medical Center, or the participating institutions.

4. Documented and recurrent failure to complete medical records in a timely and appropriate manner.

5. Misconduct that infringes on the principles and guidelines set forth by this training program.

6. Reasonably documented professional misconduct or ethical charges brought against the resident, that bear on his/her fitness to participate in the program.

A resident involved in the disciplinary actions of probation, suspension, and dismissal has the right to appeal according to the Graduate Medical Education Committee Policy, Adjudication of Resident Grievances.
In order to allow the current Program Director to make appropriate plans to fill a vacated position and to maintain professional relationships, ethical standards, and program stability for residents and program directors, the following procedure must be followed when a resident wishes to transfer to another program:

- Between programs sponsored by the UAMS College of Medicine (UAMS-COM), or
- From a program sponsored by UAMS-COM to a program sponsored by another institution, or
- From a program sponsored by another institution to a program sponsored by UAMS-COM.

It is unethical for a program director to initiate recruitment of a resident currently in a program at UAMS-COM or elsewhere and discuss specific positions or arrangements with the resident without first receiving written or verbal notification from the current Program Director. It is unethical for a resident to seriously pursue a transfer to a program within UAMS-COM or elsewhere without first discussing his/her plans with the current Program Director.

Failure to abide by the procedures outlined in the policies set by the GME 1.210 may result in the resident not being allowed to transfer or the filing of a complaint with the Residency Review Committees of the Accreditation Council for Graduate Medical Education or the specialty boards.

To determine the appropriate level of education for a resident who is transferring from another program, the Program Director must receive written verification of the previous educational experiences and a statement regarding the performance evaluation of the transferring resident, including an assessment of competence in the six general competency areas, prior to acceptance into the program. A Program Director is required to provide verification of residency education for any residents who may leave the program prior to completion of their education.
The Internal Medicine Program will supervise residents:

- to ensure the provision of safe and effective patient care.
- to ensure that the educational needs of the residents are met.
- to allow for progressive responsibility appropriate to the residents’ level of education, competence, and experience.
- according to specific supervision requirements in the Internal Medicine Program Requirements.

In compliance with the UAMS College of Medicine GME Committee policy on Resident Supervision, the following guidelines are followed for supervision of Internal Medicine residents:

1. Qualified faculty physicians supervise all patient care at each participating site (UAMS Medical Center, Central Arkansas Veterans Healthcare System, Arkansas Children’s Hospital, and Baptist Medical Center); and their schedules are structured so that adequate supervision is available at all times.

2. Rapid, reliable systems for communication with supervisory physicians are available.

3. Attending faculty physician supervision is provided appropriate to the skill level of the residents on the service/rotations.

4. Residents have progressive responsibility according to their level of education, competence and experience.

5. Specific responsibilities for patient care are included in the written description of each service/rotation; this information is reviewed with the resident at the beginning of the service/rotation. In general, the chief or senior level resident oversees the lower level resident at the beginning of each service/rotation or if/when there is a change in the schedule.

6. The following procedure is followed to address fatigue of the resident:
   - The chief resident is contacted and arrangements are made for the jeopardy resident to relieve the resident.
   - The chief resident determines when the resident should return to the education program.
   - The chief resident notifies the attending faculty physician about these arrangements.
In compliance with the UAMS College of Medicine Graduate Medical Education Committee policies on duty hours/work environment and moonlighting and considering that the care of the patient and educational clinical duties are of the highest priority, the following guidelines apply:

**Duty Hours**
1. Duty hours are limited to 80 hours per week, averaged over a four-week period, inclusive of all in-house call activities.

2. Vacation or leave days will be taken out of the numerator and the denominator for calculating duty hours, call frequency, and days off, i.e. if a resident is on vacation for one week, the hours for that rotation will be averaged over the remaining three weeks.

3. Residents are provided one day in 7 free from all educational and clinical responsibilities, averaged over a 4-week period, inclusive of call. One day is defined as one continuous 24-hour period free from all clinical, educational, and administrative activities.

4. In order to ensure adequate time for rest and personal activities, a 10-hour time period is provided between daily duty periods and after in-house call.

5. The Program Director must ensure that residents are provided appropriate back-up support when patient care responsibilities are especially difficult or prolonged.

**On-Call Activities**
The goal of on-call activities is to provide residents with continuity of patient care experiences throughout a 24-hour period.

**In-house Call**
1. Occurs no more frequently than every third night, averaged over a four-week period.

2. Does not exceed 24 consecutive hours of continuous on-site duty. However, residents may remain on duty for up to six additional hours to participate in didactic activities, transfer care of patients, conduct outpatient clinics, and maintain continuity care.

3. No new patients, defined as any patient to whom the resident has not previously provided care, may be accepted after 24 hours of continuous duty.

**At-home Call** (pager call)
1. The frequency of at-home call is not subject to the every third night limitation.

2. Residents taking at-home call are provided with 1 day in 7 free from all educational and clinical responsibilities, averaged over a 4-week period.

3. When residents are called into the hospital from home, the hours spent in-house are counted toward the 80-hour limit.

4. The Program Director and the teaching faculty will monitor the demands of at-home call and make scheduling adjustments as necessary to mitigate excessive service demands and/or fatigue.
The resident is expected to be on duty during normal working hours, Monday through Friday. Additional duty hours include on-call duties. Night, weekend, and holiday call schedules are formulated by the chief residents and depend on the specific educational rotation. Residents must be available by telephone or pager while on-call. Specific call schedules and responsibilities are delineated in the written goals/objectives of each rotation, which are reviewed with the resident at the beginning of the rotation.

**Work Environment**

The Internal Medicine Training Program and the UAMS College of Medicine jointly ensure the availability of adequate resources for resident education, as outlined in the specific program requirements of the ACGME.

1. **Meals:** Food is available for residents 24 hours a day while on duty in all institutions.

2. **Call Rooms:** Adequate and appropriate call rooms that are safe, quiet, and private are provided for all residents who take in-house call.

3. **Ancillary Support:** Adequate ancillary support for patient care is provided. Except in unusual circumstances, providing ancillary support is not the resident responsibility except for specific educational objectives or as necessary for patient care. This is defined as, but not limited to, the following: drawing blood, obtaining EKGs, transporting patients, securing medical records, securing test results, completing forms to order tests and studies, monitoring patients after procedures.

4. **Pagers:** Pagers are assigned at the beginning of the training period and a supply of batteries is available in the Internal Medicine House Staff Office.

5. **Mail:** Individual mail boxes are assigned which are located in the house staff lounge.

6. **E-mail:** E-mail accounts are issued by UAMS and must be checked daily.

7. **Book Fund:** An educational book fund is furnished at each level of training.

**Moonlighting**

In order to be eligible for moonlighting activities, the resident must follow the procedure as outlined in the UAMS College of Medicine Graduate Medical Education Committee policy, Moonlighting and Malpractice Insurance Coverage while Moonlighting. Residents are not required to moonlight. The resident must submit a written request to the Program Director and obtain his/her written approval. This information is contained in the resident’s file. The resident must obtain a valid Arkansas Medical License. Professional liability coverage (malpractice insurance) provided through UAMS does not cover moonlighting activities. Malpractice insurance for such activities is the sole responsibility of the resident. It is the responsibility of the clinical facility hiring the resident to determine whether the appropriate credentials, adequate liability coverage, and appropriate skill levels are in place. Internal moonlighting must be considered part of the 80 hour weekly limit on duty hours.

Moonlighting must not interfere with the ability of the resident to achieve the goals and objectives of the educational program. Moonlighting privileges will be withdrawn if the resident is no longer performing satisfactorily in the program. In the event permission to moonlight is withdrawn by the Program Director, the obligation to notify an outside employer is the
responsibility of the resident who established that employment and not the responsibility of the Program Director or UAMS.

Residents will be subject to dismissal from the program for the following:

1. Moonlighting without written approval of the Program Director.

2. Continuing to moonlight after permission to do so is withdrawn.

3. Using the University Hospital’s or Arkansas Children’s Hospital DEA number while moonlighting.
At times, various issues resulting from miscommunication, stress, or inappropriate behavior may arise. In compliance with the UAMS College of Medicine GME Committee Policy on Addressing Concerns in a Confidential and Protected Manner, the resident should follow these guidelines to raise and resolve issues of concern in a confidential and protected manner:

**Approach**
If a resident has an area of concern that should be addressed, the following approach is recommended:

1. A resident should discuss the concern with either the supervising-senior level resident or attending physician or the Chief Resident or the resident’s assigned faculty advisor.

2. If the above discussion does not resolve the concern, the resident should meet with the Program Director or his designee.

3. If the issue cannot be resolved by the Program Director, the resident should contact at least two members of the Resident Council (contact list found on the GME webpage) and/or the Associate Dean for Graduate Medical Education to discuss the issue confidentially. Members of the Resident Council can meet with the resident and offer advice on how to resolve or handle the problem and if further steps are necessary. Based on the discussion and advice of this meeting, the resident may resolve the problem, and no further action be necessary.

4. If the resident desires further discussion or for serious issues for which confidentiality is of the utmost importance, the resident may seek assistance directly from his Chairman and/or the Associate Dean for GME.
Internal Medicine resident physicians are in the unique position of having a role as students and employees. Although brief periods of leave can usually be accommodated, extended absences from the residency program for any reason may adversely affect both the resident’s completion of the educational program on schedule and the program’s responsibilities for patient care, allocation of clinical teaching opportunities, and funding for resident stipends. The resident must take into account these factors when requesting extended periods of leave from the program.

**The ABIM's Policies and Procedures for Certification:**
Up to one month per academic year is permitted for time away from training, which includes vacation, illness, parental or family leave, or pregnancy-related disabilities. 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.
The Internal Medicine residency program is committed to preventing and counteracting fatigue’s potential negative effects on patient care and learning in this training program. Both faculty and residents are required to complete an educational program about sleep loss and fatigue. Residents are also required to complete a WebCT module, SAFER (Sleep, Alertness, and Fatigue Education in Residency), as well. The Program Director and supervising faculty monitor the demands of individual rotations and call and make scheduling adjustments as necessary to mitigate excessive service demands and/or fatigue. The GMEC pamphlet on fatigue education is distributed to residents annually to educate them on the signs and symptoms of fatigue.

Fatigued residents - typical difficulties with the following:

- Appreciating a complex situation while avoiding distraction
- Keeping track of the current situation and updating strategies
- Thinking laterally and being innovative
- Assessing risk and/or anticipating consequences
- Maintaining interest in outcome
- Controlling mood and avoiding inappropriate behavior

More specific signs of fatigue:

- Involuntary nodding off
- Waves of sleepiness
- Problems focusing
- Lethargy
- Irritability
- Poor coordination
- Difficulty with short-term recall
- Tardiness or absences at work

High-risk times for fatigue-related symptoms:

- Midnight to 6:00 AM
- Early hours of day shifts
- First night shift or call night after a break
- Change of service
- First 2 to 3 hours of a shift or end of shift
- Early in residency or when new to night call

**Moves to limit fatigue-related problems:**

- The 80-hour limitation to which our programs are held will certainly help reduce the total number of hours worked.
- In general, the residency workload should allow for as little variation in work schedules as is feasible.
- Rapid or frequent shifts from day to night work are known to increase the risk of fatigue.
- Many physical illnesses can present as fatigue and should be ruled out when daytime fatigue seems out of proportion to the resident’s workload. The resident should be encouraged to consult his/her primary care physician. Sleep studies may be warranted.
- Depression and other psychiatric syndromes may first be manifest as fatigue. Proper diagnosis and treatment should be recommended.

In the event a resident experiences fatigue severe enough to interfere with his/her ability to function normally or to impair patient care or safety, the resident, chief resident, or a faculty member will contact Dr. Saccente, the Program Director. If Dr. Saccente is not available, the report may go to Dr. Vyas, Associate Program Director at UAMS or Dr. DelGiacco, Associate Program Director at the VA Hospital, or Dr. Robert Bradsher, Vice-Chairman for Education.

The resident will nap in the 8th floor call room until he/she can return to their clinical duties or safely drive home. The faculty member or the one who receives the original report of resident fatigue will notify the Chief Resident who will arrange coverage through the jeopardy system if needed. The Chief Resident will also report the incident to the Program Director by telephone or e-mail, if the program director was not involved in the original report.

In the event a resident experiences recurrent problems with sleepiness/fatigue, Dr. Saccente will refer the resident for medical evaluation or counseling as appropriate.
Signs and symptoms of impairment may include, without limitation, the following:

- Physical signs such as fatigue, deterioration in personal hygiene and appearance, multiple physical complaints, accidents, eating disorders.
- Disturbance in family stability or evidence of personal or professional relationship difficulties with resulting isolation.
- Social changes such as withdrawal from outside activities, isolation from peers, embarrassing or inappropriate behavior at parties, adverse interactions with police, driving while intoxicated, undependable and unpredictability, aggressive behavior, argumentative, or unusual financial problems.
- Professional behavior patterns such as unexplained absences, spending excessive time at the hospital, tardiness, decreasing quality or interest in work, inappropriate orders, behavioral changes, altered interactions with other staff, inadequate professional performance or significant change in well-established work habits.
- Behavioral signs such as mood changes, depression, slowness, lapses of attention, chronic exhaustion, risk taking behavior, excessive cheerfulness, flat affect.
- Signs of drug use or alcohol abuse such as excessive agitation or edginess, dilated or pinpoint pupils, self medication with psychotropic drugs, stereotypical behavior, alcohol on breath at work, uncontrolled drinking at social activities, black outs, binge drinking, changes in attire (e.g., wearing of long sleeve garments by parenteral drug users).

Repeated evaluations documenting substandard academic performance or other grounds for consideration by the residency training program director of academic probation or remedial work, existing in conjunction with one or more sign(s) or symptom(s) of impairment, such as those listed above, may be considered in determining whether or not medical and/or psychiatric evaluation of the resident in accordance with the procedure below is warranted. Members of the UAMS and ACH Medical Staff Health committees and staff members of the Employee Assistance Program (EAP), are available to assist in confirming or validating suspected abuse, dependency and/or impairment.
Admissions to the Internal Medicine services may come as direct admissions from a UAMS physician, transfers from other facilities, or through the emergency department. All patients are to be seen promptly by the accepting service or by the resident on duty if the patient arrives after hours. The patient is to be seen by both the intern and the resident and appropriate documentation should be performed. A single intern can be responsible for ongoing care for no more than 8 complete admission evaluations in a 48-hour period or 5 admission evaluations in a 24-hour period. An upper level resident can be responsible for ongoing care for no more than 16 complete admission evaluations in a 48-hour period or 10 in a 24-hour period. In special situations where a full evaluation is not required (e.g. chemotherapy patients with an attending note and orders written prior to patient arrival), these limits can be doubled. With the night float system in place and the rarity of overnight call in our program, the number of admissions should be well under these limits.
The number of patients under the care of a single resident varies somewhat by service. The overall maximum for an intern with on-call responsibilities is 10, and for a resident the limit is 20. Separate limits are set on particular services. The hematology/oncology service limit is 10 patients per intern. The geriatrics in-patient resident on the service also has a limit of 10 patients. In the rare event that a service is unable to adhere strictly to these policies, special arrangements have been made including the addition of nurse practitioners, increased responsibility of fellows, or the elimination of on-call duties. If a service with these limits demonstrates continued growth beyond these limits, alternative care delivery to resident service will be mandatory.
An hour-long morning report session is conducted daily at both the University Hospital and the Little Rock VA. The Internal Medicine Department Chairman and the VA Internal Medicine Service Chief of Staff or their designee conducts these rounds. At each session, individual patients (or cases) are discussed with emphasis on education in all areas such as diagnosis and therapeutic decision-making, natural history of the disorder, pertinent clinical research, pathophysiology, molecular mechanisms of disease, and even the history of medicine. In addition to this teaching session, attending physicians on the wards, critical care units, and consult services are required to conduct weekday rounds from 10:00 A.M. to 12:00 P.M. These rounds should be equally divided between pure teaching involving case examples and work rounds with the team seeing each patient on the service. The attending is responsible for educating both the residents and medical students. When possible, teaching rounds will include people from other disciplines. Pharmacists, nutritionists, and nurses, for example, can provide valuable education and insight to residents and medical students during their training.
There are a limited number of patients both at the University Hospital and the VA Hospital who are not admitted to a teaching service. These include patients admitted purely for chemotherapy, patients lodging for the diagnostic unit at the VA, patients admitted to observation units after procedures, and patients on the transitional care unit. The care for these patients is not the day-to-day responsibility of the Internal Medicine residents; their primary physician will deal with routine situations. Occasionally these patients will develop a need for acute care and will be evaluated by the resident either on an emergent basis at the request of nursing staff, or in evaluation for transfer to the in-patient service or ICU by request of the primary physician. This emergent evaluation is considered to be critical to the education of residents in Internal Medicine. Preliminary and Internal Medicine residents may participate in elective rotations at Arkansas Children’s Hospital and Baptist Health Medical Center. At these facilities there will be many non-teaching patients. The resident will not have responsibility for these patients but will, of course, participate in emergency care if needed.
UAMS Medical Center & Central Arkansas Veterans Healthcare System

**Ward Services**
Essentially, all admissions as well as daily orders are to be written by the resident, primarily the intern, and secondarily the upper level resident. Orders are not ordinarily written by the attending physician or consultation services unless agreed upon by the residents. Specialized orders (chemotherapy, dialysis, etc.) should be written by the subspecialty service. The intern is also expected to see each patient at least twice daily and to write a daily progress note. Medical students should be encouraged to write a history and physical and progress notes on each patient they follow; however, these are in addition to the required intern notes. At the time of discharge, the intern is responsible for completing discharge orders in a timely manner. Whenever possible, these orders should be written the day prior to the patient's discharge. At UAMS, the resident is responsible for a written discharge summary to be completed in a timely manner. The intern is responsible for this written discharge summary at the VA Hospital. Orders should not be written by the attending physician except in rare circumstances.

**ICU**
As on the ward services, the intern should be responsible for the writing of orders; however, as the patients are critically ill there will be more instances when orders are written on an emergent basis by the resident, fellow, or attending. Orders are not to be written by consultation services except as outlined above. The responsibility for the medical record is the same as on the ward service. An attending note should be written shortly after admission on every patient, and daily progress notes are required.

**Ambulatory Services**
It is the resident's further responsibility to ensure that recommendations are transmitted accurately with a well-organized clinic note. The note should detail the reasons for the suggested studies or changes in management. The attending physician must see the patient as is appropriate with subsequent documentation by a clinic note.

**Consultation Services**
It is the resident's further responsibility to ensure that recommendations are transmitted accurately with a well-organized chart note. The note should detail the reasons for the suggested studies or changes in management and not be a list of directives to the ward team or to the residents on another service.

Arkansas Children’s Hospital & Baptist Health Medical Center
Regulations governing the writing of orders for patients and the extent of bedside teaching shall be in compliance with the policies of Arkansas Children’s Hospital and Baptist Health Medical Center and its professional staff according to the guidelines developed in cooperation with the Operations Committee of the respective hospitals. The Operations Committee of either the H-2 or H-3 hospitals shall review grievances that might arise in relation to these matters.
IN-PATIENT SERVICES

Ward Services

PGY-1 Residents:
Residents in their first year of training for categorical Internal Medicine and the first 18 months of Medicine-Pediatrics (internship) are responsible for day-to-day management of patients admitted to the Internal Medicine wards. On admission, a complete history and physical should be performed by the intern and charted in the permanent medical record. Essentially, all admissions as well as daily orders are to be written by the resident, primarily the intern and secondarily the upper level resident. Orders are not ordinarily written by the attending physician or consultation services unless agreed upon by the residents. Specialized orders (chemotherapy, dialysis, etc.) should be written by the subspecialty service. The intern is also expected to see each patient at least twice daily and to write a daily progress note. Medical students should be encouraged to write a history and physical and progress notes on each patient they follow; however, these are in addition to the required intern notes. At the time of discharge, the intern is responsible for composing a written discharge note and completing discharge orders in a timely manner. Whenever possible, these orders should be written the day prior to the patient’s discharge. The written discharge summary is the responsibility of the intern at the VA hospital. If the patient had no primary care physician prior to admission, he or she should be assigned to the intern’s continuity clinic to allow for long term follow-up for the patient and an educational experience for the intern.

PGY-2/3/4 Residents:
Residents in their second and third year of categorical Medicine training and the last 30 months of Medicine-Pediatrics training are expected to guide and supervise the care of each patient. The resident should perform a history and physical exam on each patient admitted to the Internal Medicine wards, and a resident admission note should be written. If this is done by a resident who will not follow the patient during the hospitalization (night float or short call resident), the resident assigned to the in-patient team must write a resident accept note within 24 hours of admission. If a resident or faculty physician at UAMS cares for the patient on an outpatient basis, the resident is to notify that physician of the patient’s admission and condition. Every attempt should be made to notify referring physicians outside of UAMS of a patient’s admission and condition.

The resident is responsible for formulating a diagnostic and therapeutic plan for each patient. To fill this role, the resident should always be available to the intern and should know the patient’s condition, laboratory data, medications, and any other information necessary to formulate a therapeutic plan. The resident should see the patient at least daily, apart from work and teaching rounds, and should review the chart daily. All student notes must be co-signed by the resident. The resident is also responsible for all invasive procedures performed on the patient. Interns are encouraged to perform these procedures under the direct supervision of the resident and the attending when available. Procedures should be discussed with the attending to ensure they are necessary prior to obtaining written consent. The resident is to ensure that discharge planning is adequate and to dictate a complete discharge summary before the patient leaves the hospital. The discharge summary is the responsibility of the resident at the UAMS hospital, and of the intern at the VA hospital.
Residents in Internal Medicine are also expected to provide active supervision and teaching of medical students. Residents play a vital role in instruction of medical students, and these activities are an important part of training of Internal Medicine residents. The resident should assign patients to students as they are admitted and should ensure a balanced experience for each student. The resident should conduct daily teaching rounds for the students.

**Attending Physicians in Ward Services:**
The attending physician is expected to see every patient within 24 hours of admission. He/she is to write a note describing and confirming the patient's history, examination, problem and the diagnostic and therapeutic plans. The attending physician is also encouraged to discuss topics relevant to the patients on the service with the students, interns, and residents. The attending physician is to see every patient on the service daily and to write a daily progress note. The attending must take responsibility to ensure that all of the clinical decisions made on the patient are appropriate. Residents are to be taught how to arrive at those decisions, and as competence is proven the resident should be given the opportunity to make supervised clinical decisions. Orders should not be written by the attending physician except in rare circumstances. He or she must be certain that therapy is appropriate, that diagnostic studies and particularly invasive procedures are necessary, cost-effective and efficient, and that high quality care is provided.

The attending also has an obligation to provide high quality instruction in diagnosis, treatment and pathophysiology to both the residents and students on the service. Clinical rounds must be balanced into both work rounds and teaching rounds at the bedside (see teaching rounds below).

**Intensive Care Units**

**PGY-1, PGY-2, PGY-3 and PGY-4:**
The intern and resident are both expected to interview and examine every patient promptly on admission to the ICU or CCU or when called for a critical patient in the emergency department or on a ward. After that is completed and any urgently needed investigation or therapeutic measures have been instituted, the fellow and the attending physician on the service should be notified of the patient's admission and condition. In critically ill patients, very frequent observations and examinations are required. The resident must be aware of minute-to-minute changes in the patient’s condition. The upper level resident is expected to make decisions and to be the primary caregiver for the patient by exercising keen clinical judgment and seeking advice, support and agreement from the fellow and attending physician. As on the ward services, the intern should be responsible for the writing of orders; however, as the patients are critically ill there will be more instances when orders are written on an emergent basis by the resident, fellow, or attending. Orders are not to be written by consultation services except as outlined above. The responsibility for the medical record is the same as on the ward service (see above).

It is expected that rotations in the intensive care units will provide experience in invasive procedures. The resident may undertake, or supervise the intern on, procedures with which he or she has had adequate experience. Critical patients often require procedures (e.g. pulmonary artery catheterization, elective cardioversion) that are done rarely out of an ICU setting. In these cases, the procedure must be supervised by a fellow or attending physician.
Attending Physicians in Intensive Care Units:
The attending physician is responsible for all of the patient's care during the time in the ICU. The attending should be notified immediately of the patient's admission and should see each patient within a few hours. An attending note should be written shortly after admission on every patient, and daily progress notes are required. As on the ward services, education and teaching rounds are an important part of the attending physician's responsibility.

CONSULTATIVE SERVICES

PGY-1, PGY-2, PGY-3 and PGY-4 Residents:
The resident is expected to see promptly all patients on whom general medicine or subspecialty medicine consultations are requested. The chart should be reviewed to determine pertinent past history and investigations. The patient should be interviewed and a physical examination performed. The resident should assemble pertinent laboratory data, other diagnostic studies, and organize a concise presentation of the problem to the attending physician on the consultation service. It is the resident's further responsibility to ensure that recommendations are transmitted accurately with a well-organized chart note. The note should detail the reasons for the suggested studies or changes in management and not be a list of directives to the ward team or to the residents on another service. Personal or telephone communication to the primary team will vastly improve the response to the consultation and is common courtesy. Daily follow-up visits to determine results of studies suggested or responses to therapeutic changes are also necessary, as are daily notes.

If an Internal Medicine consult is needed after 4:00 P.M. on a weekday or on the weekend, it is the responsibility of the resident on call. The patient should be evaluated as above and the Internal Medicine attending on call should be contacted to discuss the patient and determine appropriate recommendations. If a subspecialty medicine consultation is needed, the resident should notify the appropriate consultative resident, fellow or attending according to the call schedule.

Attending Physicians in Consultative Services:
The attending physician must look upon a consultation as not only an encounter to advise the physician or group responsible for the patient regarding the patient's diagnosis, additional studies that might be needed, or changes in therapy, but also as an education exchange for the resident on his/her service and the team requesting the consult. When possible, the attending physician should speak with the residents on the team that initiated the consultation request and express an opinion and the reasons for suggestions for study or changes in treatment. A thorough initial consultation note must be written. The attending physician must see the patient as is appropriate with subsequent documentation by a chart note.

AMBULATORY SERVICES

Continuity Clinic
All Internal Medicine residents will participate in continuity clinic one afternoon a week throughout their residency training and will be assigned to a clinic at the UAMS Out-Patient Center or the VA Primary Care Clinic. Medicine/Pediatrics residents alternate between the UAMS Out-Patient Center and the Arkansas Children’s Hospital Out-Patient Center. This clinic will be held every week with only a few notable exceptions. Clinic will be canceled for all residents assigned to any night float rotation, as well as for upper level residents on rotations in the intensive care units (MICU and CCU). All residents will participate in clinic while on the ward
rotations. Overnight call in our residency is very limited with the night float system, but in the rare instance that a continuity clinic falls on a post-overnight call day, the clinic will be canceled. VA clinic is not canceled post-call. Continuity clinic is, of course, canceled during resident vacations. Because of this, a vacation change must be requested at least 90 days before the time off occurs to allow adequate time to re-schedule patient appointments. Residents are not to call the clinic personnel who schedule patients; either the Chief Resident or the administrators of the House Staff Office will make these calls.

PGY-1, PGY-2, PGY-3 and PGY-4 Residents:
The resident is expected to see promptly all patients on whom general medicine or subspecialty medicine ambulatory clinic visits are scheduled. The chart should be reviewed to determine pertinent past history and investigations. The patient should be interviewed and a physical examination performed. The resident should assemble pertinent laboratory data, other diagnostic studies, and organize a concise presentation of the problem to the attending physician on the ambulatory service. It is the resident's further responsibility to ensure that recommendations are transmitted accurately with a well-organized clinic note. The note should detail the reasons for the suggested studies or changes in management. Personal or telephone communication to the referral physician team will vastly improve the response to the clinic visit and is common courtesy. Follow-up visits to determine results of studies suggested or responses to therapeutic changes are often necessary.

Attending Physicians in Continuity Clinic:
The attending physician must look upon the ambulatory clinic visit as not only an encounter to provide primary or tertiary specialty care to a patient, but also as an education exchange for the resident on his or her service. When possible, the attending physician should speak with the residents on the team that initiated the ambulatory clinic request and express an opinion and the reasons for suggestions for study or changes in treatment. A thorough initial clinic note must be written. The attending physician must see the patient as is appropriate with subsequent documentation by a clinic note.